Your **Dental Plan**

SIST - Southeast Dubois County School
Group Number 09062017SEDC

Member Handbook

HRI DENTAL &VISION

Important Information about Your Plan

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY

IMPORTANT: If you opt to receive dental care or services that are not covered Benefits under this plan, a participating dental provider may charge you his or her normal fee for such care or services. Prior to providing you with dental care or services that are not covered Benefits, the dental provider will provide you with an estimated cost for each service and/or supply upon your request.

Please read this Certificate together with the Summary of Dental Plan Benefits. The Summary of Dental Plan Benefits lists the specific provisions of your group dental plan. If a statement in the Summary of Dental Plan Benefits conflicts with a statement in this Certificate, the statement in the Summary of Dental Plan Benefits applies to this plan and you should ignore the conflicting statement in this Certificate/Handbook.

Insurance products are marketed, underwritten, networks managed and administered by Health Resources, Inc.

Visit our website at **InsuringSmiles.com** for additional plan information and resources.

Contact Member Services
HRI Dental & Vision
7:00 am – 7:00 pm CST Monday through Friday 800.727.1444
P.O. Box 659, Evansville, IN 47704-0659

DENTAL PLAN HANDBOOK & CERTIFICATE OF INSURANCE

English	ATTENTION: If you speak English, free language assistance services are available. Call 1-800-727-1444 (TTY: 711).
Español Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-727-1444 (TTY: 711).
繁體中文 Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-727-1444 (TTY 711) 。
Tiếng Việt Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-727-1444 (TTY: 711).
Tagalog Tagalog - Filipino	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-727-1444 (TTY: 711).
한국어 Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-727-1444 (TTY: 711) 번으로 전화해 주십시오.
العربية Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1444 -727-800-1 (رقم هاتف الصم والبكم: 711)
Հայերեն Armenian	ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-727-1444 (TTY (հեռատիպ)՝ 711):
Русский Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-727-1444 (телетайп: 711).
日本語 Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-727-1444（TTY: 711）まで、お電話にてご連絡ください。
فارسی Farsi	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیرید.(TTY: 711) 1-800-727-1444
ਪੰਜਾਬੀ **Panjabi**	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-727-1444 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।
ខ្មែរ Cambodian	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-727-1444 (TTY: 711)។
Hmoob Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-727-1444 (TTY: 711).
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-727-1444 (TTY: 711) पर कॉल करें।
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-727-1444 (TTY: 711).
ภาษาไทย Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-727-1444 (TTY: 711).
Deitsch Pennsylvania Dutch	Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-727-1444 (TTY: 711).
ܣܘܪܝܐ Syriac	ܙܘܗܪܐ: ܐܢ ܐܢܬ ܗܡܙܡܝܬ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܐܝܬ ܠܘܟ ܬܫܡܫܝܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܝ ܥܠ ܡܢܝܢܐ 1-800-727-1444 (TTY: 711)
Français French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-727-1444 (ATS : 711).
Italiano Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-727-1444 (TTY: 711).

Notice of Nondiscrimination and Accessibility: Discrimination is Against the Law

HRI Dental & Vision (HRI) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HRI does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

HRI provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact HRI Member Services at 1-800-727-1444, for TTY users, 711, 7:00 a.m. to 7:00 p.m. CST, Monday through Friday.

If you believe that HRI has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person or by phone, mail, fax, or email.

HRI Member Services
P.O. Box 659
Evansville, IN 47715

Alternate In Person Deliver Addresss:

HRI Member Services
1449 Kimber Lane
Ste 103
Evansville, IN 47715
Toll Free Phone: 1-800-727-1444
TTY: 711
Fax: 812-401-3609
Email: Claims@InsuringSmiles.com

If you need help filing a grievance, Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services,
200 Independence Avenue SW
Room 509F, HHH Building Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Welcome to Your HRI Dental Plan

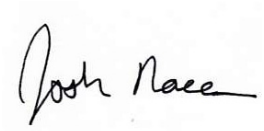
Thank you for selecting HRI for your dental plan! Oral health is a vital part of overall health, and it is our pleasure to be included in your wellness culture. HRI collaborates with the dental profession to design dental plans that promote oral health care along the most cost effective path. As any dental care professional will attest, the key to avoiding costly dental problems is prevention which starts with you and utilizing the preventive benefits included in your plan. We recommend making your first appointment as soon as possible to ensure you are on the road to great oral health!

You have a wide choice of Network Dentists, both generalists and specialists, nationwide! Network Dentists submit claim forms for services performed for you and payments are paid directly to them. Network Dentists also sign contracts with HRI to accept certain agreed upon fees, therefore, you and your employer may realize significant savings.

HRI is also committed to providing the highest quality member services to all Members. Our dedicated team members are available toll-free, Monday through Friday. You may also access information through our website, InsuringSmiles.com. It is your responsibility to be informed about Your Benefits and any associated Limitations and Restrictions, so please read and save this booklet for reference.

Our mission is to offer dental plans that "Improve Your Health and Well-Being". Since 1986, that is exactly what we have delivered to Our Members. We look forward to continuing that promise to our customers.

Sincerely,



Joshua Nace
President - HRI Dental & Vision

This Certificate of Coverage (referred to herein as Certificate) is part of the Master Group Policy that is a legal document (a contract) between HRI and the Employer. (Referred to herein as We, Us, Our, HRI, or the Company) and Your Employer Group (referred to herein as Employer) to provide Benefits to Eligible Members (referred to herein as you or your) and is subject to the terms, conditions, Limitations and Exclusions of the Policy. Reasonable effort has been made for this Certificate to represent the intent of the Master Group Policy language between HRI and Your employer.

HRI issues this Certificate based on Your Employer Group's Master Group Policy and payment of the required Policy charges. In addition to this Certificate, the Policy includes:

- Master Group Policy
- Group Application
- The Summary of Dental Plan Benefits
- Riders
- Amendments

Definitions

Adverse Determination
Any denial, reduction or termination, or a failure to provide or to make payment (in whole or part) of the benefit sought.

Balance Billing
Network Dentists agree to accept the network's contracted fees as payment in full. A participating network Dentist has agreed to not bill the patient for the difference between his fee charged and the contracted maximum allowable fee. This is referred to as "balance billing" and is not enforceable for Out-Of-Network Dentist as they are under no obligation to limit their fees.

Benefits
The amounts that the Plan pays for Covered Services under a Member's dental Plan. Benefits may be available whether through teledentistry or face-to-face with your Dentist.

Benefit Plan Year
The plan year, unless your employer or organization elects a different period to serve as the Benefit Year.
(See the Summary of Dental Plan Benefits for your Benefit Year.)

Children or Child
Your natural Children, stepchildren, adopted Children, Children by virtue of legal guardianship, or Children who are residing with you during the waiting period for adoption or legal guardianship.

Claim/Claim Form
Standard statement of dental services performed that is submitted by a Dentist or Member to request payment from the Payor. Network dentists always file Claim Forms on behalf of members and accept payment directly from the Payor. Claim forms are also used to request a Pre-Treatment estimate.

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

- For dentures and partial dentures, on the delivery dates;
- For crowns and bridgework, on the permanent cementation date;

- For root canals and periodontal treatment, on the date of the final procedure that completes treatment.

Copayment / Coinsurance
The Member's share, expressed as a fixed percentage, of the covered dental service.

Coordination of Benefits (COB)
A process that carriers use to determine the order of payment and amount each carrier will pay when a person receives dental services that are covered by more than one benefit plan. COB ensures that no more than 100 percent of the lowest allowable charges for services are paid when a Member has coverage under two or more benefits plans (dual coverage) – for example, a Child who is covered by both parents' plans.

Covered Services
Dental care services for which a reimbursement is available under a Member's plan contract, or for which a reimbursement would be available but for the application of contractual Limitations such as Deductibles, Copayments, Coinsurance, waiting periods, annual or Lifetime Maximums, frequency Limitations, alternative benefit payments, or any other Limitation.

Custodial Parent
The parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the plan year excluding any temporary visitation.

Deductible
The amount a person and/or a family must pay toward Covered Services before HRI begins paying for those services under this Certificate. The Summary of Dental Plan Benefits lists the Deductible that applies to you, if any.

Deny/Denied
If a service is denied, the service is not considered a benefit of the patient's coverage and the allowable amount is collectible from the patient.

Dentist
Dental care provider who is skilled in and licensed to practice the prevention, diagnosis, and treatment of diseases, injuries, and malformations of the teeth, jaws, and mouth and who makes and inserts false teeth.

Dependent/Dependent Child
Any Member of a Subscriber's family who meets all the applicable Eligibility requirements, has been enrolled in the plan and for whom the payment required by the employer's group agreement has been received by HRI.

Dependent Child may include the enrolled employee's biological Child, stepchildren, adopted Children placed with the enrolled employee whether or not the adoption is final, foster Children, Children subject to legal court or administrative order to provide health coverage.

Dependent Child also includes any child, regardless of age, who is incapable of self-sustaining employment by reason of being intellectually disabled or physical handicap. We reserve the right to require proof of incapacity, but not more than annually following the two year period after the Child attains limiting age.

Disallow(ed)
If a service is Disallowed, the fee is not collectible from the patient by a Network Dentist or the plan.

Effective Date
The date a dental benefits policy begins. Effective date may also be used to describe the date that benefits begin for a Member. The Effective Date is determined in accordance with waiting periods and employment terms enforced by the employer group and applicable State and Federal regulatory entities.

Eligibility
An Eligible Member who has met the eligibility requirements set forth by the Enrolled Employee's Employer.

Eligible Persons –
(Employees + Spouses + Dependents)
An Eligible Member who has met the eligibility requirements set forth by the Enrolled Employee's Employer. Generally, Eligible persons typically include your legal spouses and Dependents.

HRI will acknowledge each individual employer's definition for Dependent(s) as long as the definition is compliant with the guidelines set forth by the U.S. Department of Health & Human Services, State and other Federal regulatory entities associated with health care regulations and oversight. Dependent children are subject to the employer group's dependent age limitation, which must be no less than age 26.

Dependent Child may include the Enrolled Employee's biological Children, stepchildren, adopted Children, foster Children, Children subject to legal guardianship, newborn Children, or any Child for whom the Member is the legal guardian or is required by a court or administrative order to provide health coverage.

Coverage for adopted Children is effective upon the earlier of: the date of placement for the purpose of adoption or the date of entry of an order granting the adoptive parent custody of the Child for the purposes of adoption.

Exclusions
Services that are not covered under the Employer Group Dental Insurance Plan.

Explanation of Benefits (EOB)
The statement received after a claim is processed, detailing how Your claim was processed, includingidentification of services rendered, fees, application of plan Limitations, calculation of Plan payment, and the amount for which you are responsible.

Fee Charged
The amount that the Dentist bills and is entered on a claim as the charge for a specific service.

Handbook
This document. HRI will provide Benefits as described in this Handbook. It also serves as your Certificate of Coverage. Any changes in this Handbook will be based on changes to the contract, including the Summary Plan Dental Benefits, between HRI and your employer or organization.

Lifetime Maximum
The cumulative dollar amount that a plan will pay for dental care incurred by an individual Member for the life of the Member. Lifetime maximums usually apply to specific services such as orthodontic treatment.

Limitations
A list of conditions or circumstances that limit or exclude services from Plan coverage.

Limitations may be related to time or frequency (the number of services permitted during a stated period).

Master Group Policy
The written, legally binding agreement between HRI and an Employer Group.

Maximum Allowable Amount
The maximum amount of reimbursement the Plan will pay for covered dental services provided by a Dentist to a Member and which meets our definitions of a Covered Service. The maximum allowable/expense is determined by a) the lesser fee of the primary or secondary insurance carrier as it applies to network participation, associated agreed discounts and Patient Responsibility or b) the fee considered for the global service. For network Dentists, this is the dollar amount that the attending Dentist has agreed to accept as payment in full for the plan and the patient. This amount is shown on the notice that accompanies payment of the claim.

Maximum Allowable Fee
The Maximum Allowable fee amount is the maximum amount of reimbursement the Plan will pay for covered dental services provided by a Dentist to a Member and which meet our definitions of a Covered Service. For Network participating Dentists, the Maximum Allowed Amount will be reimbursed according to a Schedule of Maximum Allowable Charges. Unless specified within the Summary of Dental Plan Benefits of this Policy, the Maximum Allowed Amount for Out-Of-Network Dentists will be reimbursed according to a Table of Allowances as specified in your Summary of Plan Benefits. HRI's portion of payment for eachcovered service is the lesser of the Dentist's fee or the maximum allowable fee, minus the co-insurance.

Plan Annual Maximum Benefit
The total maximum dollar amount the Employer Group HRI Plan will pay toward the cost of dental care incurred by an individual Member in a Plan Year.

Member
A person covered under the Employer Group HRI Plan. There are two subsets of Members: The Primary Member who is the Employer Group Member under whom the family is enrolled, and the enrolled family members including spouse, domestic partner and eligible children.

Network Dentist
A dentist who contracts with HRI or leased network carrier and agrees to accept contracted fees as payment in full and abide by certain administrative guidelines.

Network
A panel of Dentists that contractually agree to provide treatment according to administrative guidelines, including limits to the fees accepted as payment in full.

Open Enrollment Period
A period (usually a two-week or one-month period during the year) when qualified individuals (eligible employees) can enroll in or change their choice of coverage in-group benefits plans.

Out of Network Dentist
A dentist who does not contract with HRI to participate in the network and the associated administrative guidelines including claim submission requirements and Maximum Allowable Fee capitations.

Patient Responsibility
The portion of a Dentist's fee that a Member must pay for dental services, including Deductible, Coinsurance, any amount over plan maximums, services the plan does not cover and Covered Services for which the patient is not eligible.

Plan Administrator
The Employer/Sponsor of the Plan or such third party hired by the Employer/Sponsor who performs certain activities for the Plan.

Pre-Authorization
A requirement that recommended treatment must first be approved by the Plan before the treatment is rendered in order for the Plan to pay benefits for those Covered Services.

Premiums
The money billed and paid to HRI for each month of dental coverage. Payment must be made by an Employer group in order for claims to be paid.

Pre-Treatment Estimate
A non-binding estimate of the Benefits available and Patient Responsibility for a proposed treatment plan after the application of Plan Limitations, restrictions, and exclusions, remaining plan annual maximum and determination of Covered Services.

Qualifying Event
Change in marital status, change in the number of Dependents, or change in employment status.

Resin/Composite
Tooth-colored filling material. Although cosmetically superior, it is less durable than other materials.

Submitted/Billed Amount
The amount a Dentist bills to HRI for a specific treatment or service. A Participating Dentist cannot charge you or your Eligible Dependents for the difference between this amount and the amount HRI approves for the treatment.

Subscriber
You, when your employer or organization notifies HRI that you are eligible to receive Benefits under This Plan.

Summary of Dental Plan Benefits
A description of the specific provisions of your group dental coverage. The Summary of Dental Plan Benefits is and should be read as a part of this Certificate, and supersedes any contrary provision of this Certificate.

Waiting Period for Plan Eligibility and For Covered Services
Waiting periods are designated by an Employer Group. If an Employer Group establishes a plan-waiting period, it is the stated period of time that a Member must be enrolled in the Plan before being eligible for benefits or for a specific category of benefits. A waiting period limits reimbursement for various services until the insured has been covered for a specific amount of time. Waiting period can apply to specific/individual procedures as well as at the group level.

Eligibility

HRI is available through employers for their employees. Your Employer selected the Plan and the level of coverage available for You and Your dependents. Coverage provided under the Plan for Employees and their Dependents shall be in accordance with their Eligibility, Effective Date, and Termination provisions of the Plan, including any coverage classifications. For more information, please contact Your Benefits Administrator.

HRI will acknowledge each individual employer's definition for dependent(s) as long as the definition is compliant with the guidelines set forth by the U.S. Department of Health & Human Services, State and other Federal regulatory entities associated with health care regulations and oversight.

Qualified Medical Child Support Order (QMCSO)
Under certain circumstances, You might be required to provide coverage for a child even if You do not have custody, or if the child is not Your dependent. Those circumstances must be established through a Qualified Medical Child Support Order (QMSCO). An Employee who is ordered by a QMSCO to provide dental coverage for a child may enroll himself and such child under the Plan. If Your spouse also has dental insurance, he/she may enroll under your plan but special rules apply (see Coordination of Benefits).

Extended Coverage for a Dependent Child
HRI will acknowledge each individual Employer's definition for Dependent(s) as long as the definition is compliant with the guidelines set forth by the U.S. Department of Health & Human Services, State and other Federal regulatory entities associated with health care regulations and oversight. If You have Dependent(s) with a permanent physical disability or mental disability to the extent they cannot support themselves, they may qualify for coverage beyond the applicable age limit for dependent(s).

In order to extend coverage, You must provide Us with proof of the Child's incapacity and dependency within 120 days of the Child's attainment of the limiting age and, subsequently, at reasonable intervals during the 2 year period following the Child's attainment of the limiting age.

To request special enrollment or obtain more information, contact your Benefits Administrator or HRI member services.

Enrollment Periods

Initial Enrollment

At the time You enroll, You are given a coverage Effective Date. Employees may NOT add, drop or change coverage for themselves and their dependents during the plan year unless a Qualifying Event under HIPAA Special Enrollment, COBRA, or termination of employment occurs. You must notify Your employer if You have a change of marital status or other Qualifying Event relating to You or Your dependents within thirty (30) days from the time the Qualifying Event occurs. Otherwise, changes may be made only at Open Enrollment or Plan renewal.

Open Enrollment

Open Enrollment is designated by the Employer and is usually the thirty (30) day period immediately preceding the renewal date of Your Employer's policy with HRI. During this period, You may drop Your coverage or change dependent coverage. Any changes will be effective on the renewal date of Your HRI Plan.

Special Enrollment

Employees may NOT add, drop or change coverage for themselves and their dependents during the plan year unless a Qualifying Event under HIPAA Special Enrollment, COBRA, or termination of employment occurs. A special enrollment period can occur if an Eligible Employee or Dependent(s) loses coverage under another health plan. A special enrollment period may also begin when Dependent (s) become newly eligible due to marriage, birth, court order, adoption or placement of a child in the home of the Eligible Employee.

The Eligible Employee must request enrollment within 30 days of the Qualifying Event date. During the Special Enrollment Period, the Employee may enroll himself for coverage under the Plan. Subject to coverage of the Employee under the Plan, the Covered Employee may also enroll any newly eligible Dependent(s) of the Employee under the Plan.

Web Services

HRI offers information and various services on its website. The website is continually revised, improved and enhanced for Your convenience. Members may:

- Find a Network Dentist,
- Verify benefit plan, renewal dates, dependent coverage, Claim status,
- Print Member Cards,
- Review benefit history,
- Download brochures and Certificates, and
- Acquire oral health and wellness tips.

Online materials serve as the primary source of information for groups, Members, dentists and advisers. Any printed documents that you may have is based on information at a certain point in time and may not be inclusive of all benefits, restrictions and limitations. All documents may also be requested by contacting our Customer Service Center at: 1-800-727-1444.

Member ID Card

A HRI Member ID Card will be issued to you upon enrollment.

Selecting a Dentist – Receiving Dental Care

Dentistry is a highly personal service. You may have any dental treatment performed as decided by You and Your dentist. Your Dental Plan does not dictate what treatment You receive. Only You and Your dentist can determine that. However, Your Plan does determine what services are covered and by what type of Dentist (In-Network vs. Out-of-Network). The coverage selected by Your Employer pays for only those Covered Services under Your HRI Plan listed in this certificate and Summary of Dental Benefits within the Limitations and restrictions presented. You must personally pay for any service which is not covered or for any service that is covered but is subject to Limitations and restrictions. Your Claim will only be processed after completion of the dental service. If You are not sure whether a particular dental treatment is covered or how much You will be required to pay, You may request a Pre-Treatment Estimate from Your dentist. It is a free service offered by HRI and highly encouraged so you are never surprised about your dental coverage.

Some services are limited by the age of the patient, by how often the service may be performed, or by specific teeth. All time intervals (frequency Limitations) required by coverage are independent of calendar year or plan year. Frequency limitations regarding how often services may be performed are continuous. Change of dental plan coverage, termination and reinstatement of coverage does not eliminate the frequency Limitations.

HRI also offers a large, nationwide, network of credentialed dentists to accommodate oral health needs of You and Your family. Simply visit the Find a Dentist link on InsuringSmiles.com, to view a complete listing of general

and specialty Network Dentists in Your geographical area. The Network listing generated from the website includes access to all HRI and leased Networks included in your Plan offered by your Employer that is outlined your Summary of Dental Benefits. Network Dentists provide the same excellent service at a contracted fee, resulting in savings for You and Your family.

You should always verify the plan and your Summary of Dental Plan Benefits selected by Your Employer prior toYour dental visit as it makes a difference in Your Coinsurance and savings. Network Dentists are independent contractors and are not HRI employees.

Benefit Categories – What is Covered by My Plan?

Important - It is very important to understand that your employer will select which plan services are included in your plan. Please review both this Certificate and the Summary of Dental Plan Benefits carefully. **ONLY the dental services listed in your Summary of Dental Plan Benefits will be covered by your plan.** The Summary of Dental Plan Benefits is part of this Certificate and supersedes any provision of this Certificate. Covered services are also subject to exclusions and Limitations and are included in a later section of this certificate.

The various dental services provided by a Dentist are classified into the following categories:

1. Diagnostic and Preventative
2. Restorative
3. Endodontic
4. Periodontics
5. Prosthodontics (removable and fixed)
6. Oral Surgery
7. Orthodontics
8. Adjunctive

Diagnostic and Preventive Services

These services are important to your overall oral health and the detection and prevention of dental disease. They include examinations and evaluations (routine and problem focused), prophylaxes (routine teeth cleanings), radiographs (x-rays), fluoride treatments, and sealants and space maintainers (for Children).

Restorative Services

- Minor Restorative Services – these procedures rebuild and repair your teeth damaged by disease, decay, fracture or injury. Both amalgam (silver) and Composite (white tooth colored) fillings on baby and adult teeth and anterior and posterior teeth are considered in this category.
- Major Restorative Services – these services include crowns and crown related services. Crowns may be covering a natural tooth or an implant.

Endodontic Services

These procedures treat teeth with diseased or damaged nerves. Root canals are included in this category.

Periodontic Services

- **Non-surgical Periodontics Services** – these procedures involve the treatment of diseases of the gums and supporting structures of the teeth. Nonsurgical procedures include periodontal scaling and root planning, full mouth debridement and periodontal maintenance following a periodontal therapy (periodontal cleanings).
- Surgical Periodontal Services – procedures that related to surgery of your gums which can include osseous surgery and gingivectomy.

Prosthodontic Services (fixed and removable)

- Bridges, partial and complete dentures are in this category.
- Relines and Repairs – these procedures reline and repair existing dentures (partial and complete) and repair existing bridges.
- Implant Services – the placement of an endosteal implant and the associated abutment.

Oral Surgery

- Simple Extractions – this procedure is an extraction of a tooth that is erupted or exposed root.
- Surgical extractions of tooth/teeth are included in this category and include the removal of impacted teeth and other extractions including removal of bone. An incisional biopsy of oral tissue for the detection of cancer or other suspected disease is also included in oral surgery services.

Adjunctive/Other Services

Your Summary of Dental Plan Benefits will list any other Benefits that may have been selected.

Orthodontic Services

A “Rider” to your Plan must be selected and included in your Summary of Dental Plan Benefits to have Orthodontic Services covered. Orthodontic covers traditional braces, clear orthodontic treatment (Invisalign) and removable appliances. Retainers are considered part of the orthodontic treatment.

How Payment is Made for These Benefits Categories

When filing claims, your dental office will use the appropriate dental code(s) found in the American Dental Association’s current CDT Code Book. The codes are too numerous to list, however the staff at your dental office is well versed in using these codes and the staff can explain them more thoroughly at your request.

It is best, though not necessary, to have your dentist file a

pretreatment estimate for services totaling over $300 to fully identify what Benefits are available to you. This will avoid any confusion as to the balance you may owe your Dentist. Not all plans cover the same procedures, and if there is any doubt to the coverage of your plan a representative of HRI would be glad to go over it with you. Your dentist also has access to your specific coverage and can review it with you.

Coinsurance

Covered Services and the percentage of covered expense provided by the Plan and limitations to covered services are indicated on Summary of Dental Plan Benefits. The percentage of plan payment (co-insurance) is valid only for services obtained from participating network Dentists contracted with HRI or a leased network. A participating network Dentist has agreed to not bill the patient for the difference between his fee charged and the contracted maximum allowable fee. This is referred to as "Balance Billing" and is not enforceable for Out-of-network Dentists as they are under no obligation to limit their fees.

Plan Features

This list of plan features describes the features that are available through HRI but may not be included in the coverage that you or your employer has selected. To see a list of plan features that are specific to your benefit coverage, please refer directly to Summary of Dental Plan Benefits. If a plan feature is not listed on your Summary of Dental Plan Benefits then it is not a part of your Dental Benefit Plan.

Plan Annual Maximum Benefits/Plan Year

Benefits payable under the Plan, regardless of whether coverage is continuous or not, shall be subject to the Plan Annual Maximum for each plan year. Payments under your Certificate for ALL Covered Services apply to the Plan Annual Maximum benefit excluding orthodontic services. Change of the dental plan coverage, termination, and reinstatement of coverage does not eliminate frequency limitations or Plan Annual Maximum benefit used.

Annual maximum benefits are based on a policy/benefit year unless otherwise noted on the Summary of Dental Plan Benefits beginning with the Plan's Effective Date of Coverage,

After the Plan Annual Maximum Benefit is exhausted, you are responsible for all subsequent charges to your Dentist.

Lifetime Maximum Benefit – Orthodontics

If your plan includes orthodontics coverage, your Summary of Dental Benefits will list a lifetime maximum of orthodontic benefits per member. This is the cumulative dollar amount that will be paid for orthodontic dental care for the life of the Member.

Deductible

The Plan Year Deductible (if any) is applicable to Covered Services incurred in each Plan Year. Your policy will determine the Deductible application method chosen by Your employer. The available methods include:

Out of Pocket Deductible-

An out of pocket deductible is the specified & consistent amount reduced from the plan's covered expense which must be paid in full by the Member each plan year. It is applied chronologically according to the dates in which the Covered Services were completed and increases the patient responsibility by the specified amount until the earlier of two events 1) individual Deductible is met, or 2) family Deductible is satisfied.

Ex: (Fee Allowed X Co-Insurance) – Deductible = Plan Payment
Patient A receives major services covered at 50% under the plan. This patient is responsible for a $50 individual deductible.

Benefit Deductible

A benefit deductible is the amount a Member must pay toward Covered Services before the carrier will reimburse for those Covered Services. This amount may vary based upon the co-insurance of the Covered Service.

Ex: (Fee Allowed – Deductible) X Co-Insurance = Plan Payment
Patient B receives major services covered at 50% under the plan. This patient is responsible for a $25 individual Deductible.

Waiting Period

The Waiting Period is the period of time beginning on the Member's Effective Date before benefits for certain Covered Service become eligible for reimbursement. Unless otherwise specified, the most recent Effective Date is utilized in the application of the Waiting Period, this includes a change to Your dental plan coverage such as termination and reinstatement of coverage.

Alternate Benefits

There is often more than one service that can be used to appropriately treat a dental problem or disease. In determining the Benefits payable on a claim, different materials and methods of treatment will be considered. If applicable, the amount payable will be limited to the Covered Expense for the least costly Service, which meets

broadly accepted standards of dental care as determined by Us. A Member and his Dentist may decide on a more costly service or material than We have determined to be satisfactory for the treatment of the condition. In this case, the Plan will be a benefit toward the cost of the more expensive service or material, but the payment will be limited to the benefits payable for Covered Expenses for the least costly Covered Service.

Unbundling
When charges for less complicated Services performed in conjunction with the more comprehensive/extensive definitive treatment are separated, these less complicated components may be considered as parts of the primary Service. If the Dentist bills separately for the primary Service and each of its component parts, the total benefit payable for all related charges will be limited to the benefits payable for Covered Expenses for the primary Service.

Service Exclusions

HRI will make no payment for the following services or supplies, unless otherwise specified in the Summary of Benefits. All charges for the same will be your responsibility (though your payment obligation may besatisfied by insurance or some other arrangement for which you are eligible):

General Exclusions
All Master Group Policies and Certificates issued or administered by HRI are subject to the following General Exclusions.

This plan will not pay for:

1. Dental services that are not listed in the Plan Covered Services and Plan General Exclusions, Limitations and Restrictions attached to this Certificate.
2. Claims for dental services rendered before the Effective Date or after coverage is terminated.
3. Claims for dental services covered under non-dental insurance.
4. Claims for services performed primarily to rebuild occlusion or for full mouth reconstruction.
5. Claims for Enrollees until HRI receives the appropriate contracted payment(s) for Premiums.
6. Claims for services which are not completed.
7. For duplicates, lost, or stolen prostheses, appliances, and/or radiographic images.
8. A Claim must be received within one year from the date of service.
9. Space maintainers, except when needed to preserve space resulting from the premature loss of deciduous (baby) teeth.
10. Orthodontic treatment, unless otherwise specified in your Summary of Dental Plan Benefits.
11. Treatment of temporomandibular joint or jaw joint disorder (TMJ).
12. Dental services provided by a non-network participating Dentist to the extent that the charges exceed the amount payable for services under the nonparticipating Dentist fee schedule.
13. Pediatric dental Essential Health Benefits (EHB) as mandated by the Affordable Care Act (ACA).
14. Dental services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.
15. Dental services or charges separately billed by hospitals, laboratories, pharmacies or other institutions other than a dentist practice.
16. Experimental or investigational dental treatment.
17. Dental services as a result of your participation in a misdemeanor, felony, riot or insurrection.
18. Dental services charged and filed on a claim under an unspecified CDT service code X999.
19. Submitted claims for which HRI has not received the dentist documentation (federal W9 form, documentation requirements – radiographs, primary explanation of benefits, etc., or unable to process due to incorrect filing information) required to determine and finalize the claim benefit.

Service Limitations

The Benefits for the following services or supplies are limited as follows, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for the services or supplies that exceed these Limitations will be your responsibility. All time limitations are measured from the applicable prior dates of services in our records with any HRI plan or, at the request of your group, any dental plan:

Diagnostic Evaluations and Treatments
Evaluations (examinations), including any and all procedure codes, are payable as stated in your Summary of Benefits. These include all examinations and evaluations performed by any general Dentist or specialist.

A comprehensive oral evaluation or a comprehensive periodontal evaluation for a new or established patient is payable according to the time period specified in your Summary of Benefits. A comprehensive periodontal evaluation will only be payable for Members that are age 14 and above.

Diagnostic Imaging, Tests, and Examinations
The maximum amount considered for all radiographic images (also referred to as X-rays) taken on one day will be equivalent to an allowance of a full mouth X-ray. The difference may not be billed to the Enrollee.

Panoramic (including image capture only) or full mouth X-rays are payable according to your Summary of Benefits. If a full mouth X-ray is performed within 12 months of any bitewing image(s), the allowable amount for the full mouth X-ray will be

reduced by the charges for bitewing(s). Panoramic or full mouth X-rays will not be payable if performed within 12 months of a set of vertical bitewings images.

Periapical images (including image capture only) are payable up to a maximum of 3 during a 12-month period.

Occlusal images (including image capture only) are payable only once per arch per 12 months.

Vertical bitewings (including image capture only) are payable once per 12 months unless a complete series of images or four bitewings were paid in that same 12 months.

Bitewing radiographic images (including image capture only) are limited to the amount specified in your Summary of Benefits. Bitewings will not be payable if performed within 12 months of a complete series of images or a set of vertical bitewings images.

2D cephalometric images or 2D oral/facial photographic images (including image capture only) will be payable only if performed in conjunction with a Plan that covers orthodontic services and treatment. Cephalometric images are payable every 2 years unless image captures only were paid during the same 2 years. 2D oral/facial images are payable every 5 years unless image captures only were paid during the same 5 years.

Pulp vitality tests are payable for one charge per date of service.

Diagnostic casts are payable once per 5 years and only if the procedure is performed in conjunction with the Plan orthodontic covered services and treatment.

Preventive Services:
Prophylaxis: A teeth cleaning (includes prophylaxis, periodontal scalings and root planning, periodontal full mouth debridement and periodontal maintenance) is payable according to the Limitations listed in your Summary of Benefits., regardless of the dentist's specialty. A teeth cleaning for children under the age of 14 will be payable when filed as a Child's cleaning.

Fluoride: A preventive fluoride treatment is payable as listed in your Summary of Benefits.

Sealants: Will be payable on permanent molar teeth (per tooth) as listed in your Summary of Benefits. A replacement for a sealant will not be payable for a period of 5 years. If a sealant was applied to a tooth, a restoration on the same tooth will not be payable for a period of 3 years.

Space Maintenance: Space maintainers are payable once every 3 years for Children under 13 years of age The re-cementation or re-bonding of a space maintainer is payable only after 12 months after the initial placement and only once per 12 months.

Restorative Services:
A restoration/filling (amalgam or resin-based composite) is payable as listed in your Summary of Benefits. An additional restoration on the same tooth surface will not be payable for a 2-year period. A restoration will not be payable within 2 years of placing a crown on the same tooth or a sealant on the same surface within 2 years. If two or more restorations are performed on the same tooth, on the same date of service, only the total number of unique surfaces will be considered for payment.

Crowns, or Inlays/Onlays (in any combination including implant supported) are payable as listed in your Summary of Benefits. A charge for a crown or an inlay/onlay on a tooth following the placement of an amalgam or Resin-based Composite restoration on the same tooth is not eligible for payment for a period of 2-years. Crowns, other than prefabricated steel crowns, are not payable for primary teeth. Composite/Resin inlays must be laboratory processed. Coverage requires the submission of a duplicate, diagnostically acceptable, pre-operative radiograph or intraoral photos that substantiates completion of root canal therapy or a narrative which addresses the existence of caries or other pathology, cracked tooth syndrome, missing cusp(s), the amount of remaining tooth structure or the amount of circumferential decay. Charges not meeting established criteria will be disallowed. A pre-treatment estimate is recommended to determine coverage.

A Resin-based composite (indirect) crown is payable on anterior teeth only.

Individual crowns over implants are payable as listed in your Summary of Benefits.

Not all crowns or inlay/onlays procedure codes are considered covered if a corresponding procedure code using new and advanced materials is determined to be available.

Crowns, inlays/onlays may be subject to review for extensive loss of tooth structure due to caries (decay) or fracture to determine coverage. A pre-treatment estimate is recommended to determine coverage.

A recementation of an inlay, onlay, or crown is payable only once per 12 months and will not be considered for payment if within 12 months of the original cementation.

A protective restoration is payable once every 2 years. Not eligible if performed in conjunction with endodontics, an amalgam/Composite restoration, inlay, onlay, crown, or fixed prosthesis retainer prepared or cemented at the same appointment. Charges for a subsequent definitive treatment are subject to an adjustment if performed within 12 months of a protective restoration.

A core buildup will not be payable if performed as specified in your Summary of Benefits. Coverage for a core buildup

requires the submission of a duplicate, diagnostically acceptable, pre-operative radiographic image or intraoral photo that substantiates one of the following three criteria: 1) more than 50% of the tooth crown is missing due to fracture or decay; 2) less than 3 mm of sound tooth structure remaining around the gum line; 3) previous root canal filling completed except where a prior crown through which the access is made remains on the tooth. Charges not meeting established criteria will be Disallowed. A pre-treatment estimate is recommended to determine coverage.

A pin retention is payable per tooth and limited to posterior teeth only. Additional pins will be Disallowed.

A post and core in addition to a crown is payable once per 5 years per tooth. A payment is not eligible if performed within 5 years of a core buildup or another post and core. Procedure is not payable without history of root canal therapy.

Endodontics:
A therapeutic pulpotomy is payable for primary teeth only and only once per tooth per lifetime. Charges are exclusive of the final restoration charge.

All pulpal and endodontic therapy and apexification/recalcification should be coded by the tooth receiving treatment, not the number of canals per tooth. A single periapical will be considered for payment with an endodontic therapy or an apexification/recalcification only (not pulpal). Separate fees for other radiographs and images are considered part of the treatment plan and will be Disallowed. Charges are exclusive of the final restoration charge. Charges for “elective” root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment.

Pulpal therapy is not eligible for payment for retreatment within 4 years of the date of the original treatment.

Endodontic therapy is not eligible for payment for retreatment within 4 years of the date of the original treatment.

Apexification/recalcification is limited to children under 16 years of age and once per lifetime. Not eligible for payment for retreatment within 4 years of the date of the original treatment.

An apicoectomy is payable only once per lifetime.

A canal preparation and fitting of preformed dowel or post is payable once per 7 years. Charges will be disallowed if submitted in conjunction with a post and core, fabricated post, or prefabricated post/core.

Non-Surgical and Other Periodontal Services:
Periodontal maintenance is payable as listed in your Summary of Benefits. This procedure will not be payable if performed within 6 months of or same date of service as a prophylaxis, a scaling and root planning, a scaling in the presence of gingival inflammation, or a full mouth debridement.

A scaling and root planing (4 or more active periodontal diseased and qualified teeth) is payable as listed in your Summary of Benefits. Will not be payable if performed within 6 months of or same date of service as a prophylaxis, a scaling in the presence of gingival inflammation, a full mouth debridement or periodontal maintenance. The enrollee must exhibit periodontal disease showing loss of clinical attachment and bone loss. Not payable on deciduous teeth. This procedure requires the submission of full mouth probe chart with six points per tooth probings AND diagnostic full mouth radiographs and/or vertical bitewings. Only two quadrants are considered on the same date of service, additional quadrants will be Disallowed. Separate charges for local anesthetic are Disallowed. Charges not meeting established criteria will be Disallowed. A pretreatment estimate is recommended to determine coverage. Dental Review Team maintains discretionary authority regarding review requirements.

A scaling in presence of generalized moderate or severe gingival inflammation – full mouth is payable once every 5 years and only for enrollees over 15 years of age. Will not be payable if performed within 6 months of or same date of service as a prophylaxis, a scaling and root planning, a full mouth debridement or periodontal maintenance.

A full mouth debridement is payable only for enrollees over 15 years of age. Procedure is payable once every 3 years and 3 years must lapse between any associated periodontal scalings (scaling and root planning and scaling in the presence of gingival inflammation) were performed. Will not be payable if performed within 6 months of or the same date of service as a prophylaxis, a scaling and root planning or a scaling in the presence of gingival inflammation, or periodontal maintenance.

Periodontic Surgical
The following services are payable only once per area treated within a 5-year period:

- Gingivectomy or gingivoplasty (four or more teeth/tooth per quadrant only)
- Clinical crown lengthening (per tooth)
- Osseous surgery
- Guided tissue regeneration (includes barrier and its removal, as necessary)

Two tissue grafts (of any type, including pedicle soft, autogenous connective, non-autogenous connective, and free soft) are payable once per area treated/quadrant every 5 years.

Prosthodontics:
One upper and one lower denture (including complete,

immediate, partial, immediate partial, overdenture and interim) are payable as listed in your Summary of Benefits. Charges for a conventional, removable partial dentures or a complete denture are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch or of any repairs, relines, rebases. Separate charges for diagnostic casts will be disallowed. An immediate denture will not be payable if used to replace a complete denture.

A repair to a complete or partial denture is payable once per 6 months only after 6 months has elapsed since the initial date of delivery of the appliance. A repair to a partial denture that replaces all teeth and acrylic on framework is payable once per 4 years only after 4 years has elapsed since the initial delivery of the appliance.

A rebase or reline to a complete or partial denture is payable once per 4 years only after 6 months has elapsed since the initial date of deliver of the appliance.

Two tissue conditioning charges will be payable only within 6 months of delivery of immediate partial/denture only.

Fixed partial dentures, including partial denture pontics (non-Resin), partial denture retainers (cast metal and porcelain/ceramic retainers only), and partial denture retainers-crowns (non-Resin) are payable as listed in your Summary of Benefits. Charges are subject to the same definitions and restrictions as single restoration crowns. Each unit of a fixed partial denture must be identified on the claim. Not eligible for pontics to replace third molars. All fixed prosthodontic services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch. Not eligible for replacement of a removable partial denture by a fixed partial denture within 5 years of the original placement.

A re-cement or re-bond of a fixed partial denture is payable only once per 12 months per fixed partial denture and only after 12 months of the original cementation.

Oral Surgery:
Surgical extraction of an erupted tooth requiring removal on bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated, and the removal of residual tooth roots procedures include alveoloplasty. Requires the submission of a duplicate, diagnostically acceptable, pre-operative periapicial and/or panoramic radiograph with all claim submission. Charges not meeting established criteria will be disallowed. A pre-treatment estimate is recommended to determine coverage.

An exposure of an unerupted tooth or the placement of a device to facilitate the eruption of an impacted tooth will be payable only once per lifetime if the procedure is performed in conjunction with a Plan orthodontic covered services and treatment.

An incisional biopsy of soft oral tissue will be Disallowed if performed in conjunction with an apicoectomy.

A transseptal fiberotomy/supra crestal fiberotomy is payable only on anterior permanent teeth and bicuspids and only if the procedure is performed in conjunction with the Plan orthodontic covered services and treatment.

Alveoplasty in conjunction with routine extractions are subject to review. Charges not meeting generally accepted standards of care will be Disallowed.

Vestibuloplasty, ridge extension, procedures charges in conjunction with implant services will be Disallowed.

Removal of torus mandibularis is payable only once per arch per lifetime.

Incision and drainage of abscess filed in conjunction with definitive treatment will be Disallowed.

A frenectomy is payable once per lifetime. Charges are subject to review if performed in conjunction with definitive treatment. Charges not meeting generally accepted standards of care will be Disallowed.

Excision of pericoronal gingiva filed in conjunction with definitive restorative treatment will be Disallowed.

Implant Services
A surgical placement of an implant body (endosteal) or a mini implant is payable as listed in your Summary of Benefits. Allowance includes the treatment plan, local anesthetic and post-surgical care. Coverage is limited to enrollees over 15 years of age.

A prefabricated abutment or a custom fabricated abutment is payable once per 5 years per tooth site. Coverage is limited to enrollees over 15 years of age.

Single crowns and fixed partial denture retainers (abutment or implant supported) will be payable once every 5 years and subject to the same Limitations as non-implant supported single crowns and fixed partial dentures. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch.

Removable dentures and fixed dentures (abutment or implant supported) will be payable once every 5 years and subject to the same limitations as non-implant supported removable dentures and fixed dentures. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch.

Adjunctive/Other Services Limitations
Palliative (emergency) treatments will be payable 2 per 12-month period. Charges filed in conjunction with definitive treatment will be Disallowed.

Deep sedation/general anesthesia and intravenous moderate (conscious) sedation/analgesia will be payable up to a total of 30 minutes per date of service.

Inhalation of nitrous oxide/analgesia will be payable once per date of service.

An athletic mouth guard is payable once per 12 months.

Occlusal guards are payable once every 5 years. Charges to modify the appliance or for occlusal adjustment are not payable.

Teledentistry benefits are payable as specified in your Summary of Benefits.

Disallowed Services

Participating Dentists may not charge eligible persons for disallowed services or supplies. All charges fromnon-participating dentists for the disallowed services areyour responsibility.

How Payment Is Made

In-Network Dentists

In-Network Dentists are responsible for submitting claims to HRI on Your behalf for rendered services. HRI will reimburse the In-Network Dentist directly for Covered Services.

A Member is responsible for the Deductible and any out-of-pocket expenses required by the Plan including the co-insurance and the cost of services that are not covered by the Plan. It is possible that Your dentist's charges for one or more of the services may be higher than the maximum allowable under Your HRI. If so, an In-Network Dentist must reduce the charged amounts. If a Member is billed by an In-Network Dentist for a Covered Service (other than the Deductible, co- insurance, or amount above the maximum allowable fee), the Member should contact either the In-Network Dentist or HRI.

Out-Of-Network Dentists

If You visit an Out-Of-Network Dentist, you may be personally responsible for submitting claims directly to HRI. Some Out-Of-Network Dentist will file the claim as a courtesy to their patients, but they are under no obligation to do so. A Member must provide all of the information the Plan needs to process such claims, including an ADA approved claim form, an invoice of the charges and proof of payment. If a Member does not provide this information, a Member may not be paid or the payment will be distributed to the Out-Of-Network Dentist.

A Member is responsible for the Deductible, any out-of-pocket expenses required by the Plan including the co-insurance and the cost of services that are not covered by the Plan, and any charges above the maximum allowable for the service.

Your out-of-pocket expenses will most likely be higher by seeing an out-of-network dentist because your dentist can Balance Bill the amount that is not covered by HRI to you and you are responsible for all charges not covered by your Dental Plan.

Filing a Claim

Network Dentists are responsible for submitting claims to HRI on your behalf. Out-Of-Network Dentist may file the claim as a courtesy to their patients, but are under no obligation to do so. All claims should be submitted to the HRI address provided in a separate section of this document. The following information should be included on a standard ADA claim form:

1. Covered Employee's name, address, and member number
2. Patient's name, date of birth, and member number
3. Itemized bill including the ADA code, description of each charge, and date of service.
4. Name and address of the Rendering Dentist.
5. Rendering Dentist's Tax ID Number (W-9 Form)

Note: To be considered for payment, a claim must be submitted within 1 year from the date of service. Some services may require additional information, such as a radiograph image or a periodontal chart before being processed. Benefit payment can only be determined at the time that that claim is submitted with all required documentation. Reference the Plan General Exclusions, Limitations, and Restrictions, including provider supporting documentation provision for more information.

Notice of Claim

We must receive written notice within sixty (60) days after a Claim starts or as soon as reasonably possible. Failure to give notice within that time will not invalidate nor reduce any claim if it can be shown that it was not reasonably possible to give notice at that time, but such notice was given as soon as was reasonably possible. The notice shall be sent to HRI or given to Our agent. Notice given by or on behalf of the Member or the Member's beneficiary to Us or to any of our authorized agents with information sufficient to identify the Member is considered notice to Us. If You visit an Out-of-Network Dentist, You may personally be responsible for submitting Claims directly to HRI.

Claim Forms

Your dentist will file Your claim or provide You with the forms necessary to file the claim. If Your dentist does not provide these forms within fifteen (15) days, You may send Us a

written statement to satisfy this requirement. This statement should include enough information to identify You as well as the nature and extent of the Claim. It should be sent to Us within the time stated in the Proof of Loss provision.

Once HRI processes Your dental Claim, You will receive an Explanation of Benefits explaining payment amounts. It is possible that Your dentist's charges for one or more of the procedures may be higher than the maximum allowed under Your HRI. If so, a contracted Network Dentist must reduce the charged amounts. An Out-of-Network Dentist may charge You for the difference since they are not contractually liable to accept Your plan's fee schedule.

Proof of Loss

We must receive written proof of loss within ninety (90) days of a Claim. If it is not possible for proof to be provided withinthe ninety (90) days, We will not Deny a Claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless You are legally incapacitated.

Time of Payment of Claims

Benefits for loss covered by the Policy will be paid when HRI receives all information necessary, including premium payment, to correctly adjudicate the claim, but not more than thirty (30) days after receipt of all necessary information. Upon the Member's death, any payments outstanding will be paid, at our option, to the Member's beneficiary or to the Member's estate.

If We fail to pay or Deny a clean claim in the time required, and We subsequently pay the claim, We will pay the provider that submitted the claim interest on the allowable amount of the claim.

Legal Actions

A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Coordination of Benefits

Coordination of Benefits ("COB") applies to this plan when an eligible person has dental benefits under more than one plan. The objective of COB is to make sure the combined payments of the plans are no more than your actual dental bills. COB rules establish whether this plan's Benefits are determined before or after another plan's Benefits.

You must submit your bills to the primary plan first. The primary plan must pay its full Benefits as if you had no other coverage. If the primary plan denies your claim or does not pay the full bill, you may then submit the remainder of the bill to the secondary plan.

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for Benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay Benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Terms:

1. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
    a. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
    b. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under a. or b. is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

2. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

3. Allowable Expense is a health care expense, including

Deductibles, Coinsurance and Copayments, which is associated with a Covered Service for which reimbursement is available or for which reimbursement would be available but for the application of contractual Limitations. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

4. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the plan year excluding any temporary visitation.

5. Benefit reserve is the savings recorded by a plan for claims paid for a covered person as a secondary plan rather than as a primary plan.

Order of Benefit Determination Rules:

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
2. A Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
3. Each Plan determines its order of benefits using the first of the following rules that apply:

a. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, Member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a Dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a Dependent (e.g. a retired employee); then the order of Benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

b. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent Child is covered by more than one Plan the order of benefits is determined as follows:

(1) For a Dependent Child whose parents are married or are living together, whether or not they have ever been married:

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(2) For a Dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:

i. If a court decree states that one of the parents is responsible for the Dependent Child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

ii. If a court decree states that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent Child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

iv. If there is no court decree allocating responsibility for the Dependent Child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(3) For a Dependent Child covered under more than one Plan of individuals who are the parents of the Child, the provisions of Subparagraph (a) or (b) above shall determine the order of Benefits as if those individuals were the parents of the Child.

c. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of Benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a. can determine the order of benefits.

d. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, Member, Subscriber or retiree or covering the person as a dependent of an employee, Member, Subscriber or retiree is the Primary plan and the

COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a. can determine the order of Benefits.

e. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber, or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

f. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary plan.

Effect on the Benefits of this Plan:
When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

Right To Receive and Release Needed Information
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. HRI may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. HRI need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give HRI any facts it needs to apply those rules and determine benefits payable.

Facility of Payment
Whenever payments which should have been made under the Plan in accordance with this provision have been made under any other plan or plans, HRI will have the right, exercisable alone and at its discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision. The amounts so paid will be deemed to be Benefits paid under the Plan and to the extent of such payments; HRI will be fully discharged from liability under the Plan. The benefits that are payable in accordance with this provision will be charged against any applicable maximum payment or benefit of the Plan rather than the amount payable in the absence of this provision.

Right of Recovery

Whenever payments have been made in excess of the amount due under the Plan, the HRI shall have the right, exercisable alone and in its sole discretion, to recover such excess payments from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person.

Termination of Coverage

Your dental coverage may be automatically terminated:
When Your employer advises HRI to terminate Your coverage;

When Your employer fails to pay timely Premium payments or fees to HRI; or

For any other reason stated in the Policy.

A person whose Eligibility is terminated may not continue coverage under their Employer's contract, except as required by the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) or comparable, nonpreempted state law.

Continuation of Coverage

Continuation Coverage Rights Under The Consolidated Omnibus Budget Reconciliation Act Of 1985 (COBRA)

Introduction
The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to an Enrolled Employee who would otherwise lose coverage under the Plan. It can also become available to Enrolled Dependents covered under the Plan when they would lose their coverage under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should review the COBRA Procedures or contact the Plan Administrator. In the event that an individual receives a COBRA election form with incorrect plan information, the Plan will notify the individual of the accurate Plan terms. The election will be in accordance with the accurate Plan benefit, terms, and coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." Specific Qualifying Events are listed below. After a Qualifying Event, COBRA continuation coverage will be offered to each person who is a "Qualified Beneficiary." The Enrolled Employee and each Enrolled Dependent could become Qualified Beneficiaries if coverage under the Certificate is lost because of the Qualifying Event. Under the Master Group Policy, Qualified Beneficiaries who elect COBRA continuation must pay for COBRA continuation coverage.

An Enrolled Employee will become a Qualified Beneficiary if coverage under the Master Group Policy ends as a result of either the following:

- Hours of employment are reduced, or
- Employment ends for any reason other than gross misconduct by the Enrolled Employee.

An Enrolled Spouse will become a Qualified Beneficiary if coverage under the Master Group Policy ends as a result of the following:

- The Enrolled Employee dies;
- The Enrolled Employee's hours of employment are reduced;
- The Enrolled Employee's employment ends for any reason other than his/her gross misconduct;
- The Enrolled Employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- The Enrolled Employee becomes divorced or legally separated from his/her Enrolled Spouse

An Enrolled Child will become a Qualified Beneficiary if coverage under the Master Group Policy ends as a result of any of the following:

- The Enrolled Employee dies;
- The Enrolled Employee's hours of employment are reduced;
- Employment of the Enrolled Employee ends for any reason other than his/her gross misconduct;
- The Enrolled Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The Enrolled Employee becomes divorced or legally separated from his/her spouse; or
- The Enrolled Child is no longer eligible for coverage under the Plan as a "Dependent Child."

When is COBRA Coverage Available?

The Master Group Policy will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred.

Enrolled Employee or Dependent must notify the Plan Administrator within 60 days after the Qualifying Event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Eligible Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children who are Qualified Beneficiaries.

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the Enrolled Employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the divorce or legal separation of the Enrolled Employee, or an Enrolled Dependent losing eligibility for coverage under the Certificate as a Dependent Child, COBRA continuation coverage lasts up to a total of 36 months. When the Qualifying Event is the end of employment or reduction of the Enrolled Employee's hours of employment, and the Enrolled Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. Otherwise, when the Qualifying Event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage. If an Enrolled Person covered under Your Certificate is determined by the Social Security Administration to be disabled and You notify the Plan Administrator in a timely fashion, each Enrolled Person may be entitled to receive up to an additional 11 months of COBRA continuation coverage (while the disability continues), for a total maximum of 29 months.

Second Qualifying Event extension of 18-month period of continuation coverage
If an Enrolled Person experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the Enrolled Spouse and Dependent Children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Plan Administrator.

Questions concerning Your Certificate, the Master Group Policy or Your COBRA continuation coverage rights should be addressed to Your Plan Administrator or contacts identified below. For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area (EBSA Regional Office: Cincinnati Regional Office,

1885 Dixie Highway, Ste 210, Ft. Wright, KY 41011-2664, Tel 859.578.4680/Fax 859.578.4688) or visit the EBSA website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Change In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members.

Questions and Assistance

Questions regarding your policy or coverage should be directed to:
HRI Dental & Vision
Claims Department
P.O. Box 659 Evansville, IN 47704-0659
800.727.1444 press 9
7:30 am – 5:00 pm CST Monday through Friday

General Conditions and Additional Information

Section titles are for convenience of reference only and are not to be considered in interpreting the Plan. No failure to enforce any provision of the Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of the Plan.

Entire Contract & Changes

The Policy, including the endorsements, Certificates, Summary of Dental Plan Benefits, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in the Policy will be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions. We will consider any statement made by You or the Employer, in the absence of fraud, as a representation and not a warranty.

We may amend coverage, limitations to the Covered Services, General Exclusions, Annual Maximum, benefit payments or any other terms of this Certificate or the Master Group Policy upon thirty (30) days written notice to You and Your employer. This Certificate will pay for any Covered Services rendered prior to the Effective Date of the change. If there are any discrepancies as to coverage, limitations to Covered Services, General Exclusions, Annual Maximum or other provisions stated herein and as stated in the Master Group Policy, the provisions of the Master Group Policy will supersede those set forth herein.

Claims Appeal Procedure

Informal Claims Appeal Procedure
Your HRI plan has been carefully designed to provide You with the maximum amount of covered benefits for Your level of payment/Premium. Since HRI is always looking for ways to make Our Master Group Policies and Certificates even better, Your suggestions are encouraged. Occasionally, even after You have reviewed the applicable sections of this Certificate pertaining to Your issue at hand, You may have a question. Your questions may involve dentists, Covered Services, the agents who sold and serviced Your HRI plan, policies, or procedures.

HRI always notifies You or Your authorized representative of a benefit determination after Your Claim is filed. This notice is made via an Explanation of Benefits (EOB). An adverse benefit determination is any denial, reduction or termination of the benefit for which You filed a Claim, or a failure to provide or to make payment (in whole or in part) of the benefit You sought. This includes a determination based on Eligibility, the administration of Covered Services, Limitations or restrictions, and payment amounts. If You receive notice of an adverse benefit determination, and if You think that HRI incorrectly denied all or part of Your Claim, You may take the following steps:

First, You or Your dentist should contact HRI's Member Services team and ask them to check the Claim to make sure it was correctly processed. If You contact Us in writing, please enclose a copy of Your Explanation of Benefits and describe the problem. HRI provides this opportunity for You to describe problems and submit information that might indicate that Your Claim was improperly denied and allow HRI to correct this error quickly.

Formal Claims Appeal Procedure
Whether or not You have contacted HRI informally, as described above, to recheck the initial determination of Your Claim, You or Your authorized representative may submit Your Claim to a formal review through the Claims Appeal Procedure described here. To request a formal appeal of Your Claim, You must send Your request in writing to the Dental Claims Review Team at HRI.

You must include Your name and address, the Member's ID number, the reason You believe Your Claim was wrongly denied, and any other information You believe supports Your Claim, including sections of Certificate that support Your appeal. If You would like a record of Your request and proof that is was received by HRI, You should mail it certified mail, return receipt requested. You or Your authorized representative should seek a review as soon as possible after You receive Your EOB; however, You must file Your appeal within ninety (90) days of the date of which You receive Your notice of the adverse benefit determination You are asking HRI to review.

The Dental Claims Review Team will make their decision and notify You in writing within 30 days of receiving Your request. Their notice of any adverse determination will: (a) inform You of the specific reasons for the denial; (b) list the pertinent Master Group Policy/Certificate provision on which the denial is based; (c) contain a statement that You are entitled to receive upon request and at no cost, reasonable access to and copies of the documents, records and other information relevant to the decision to deny Your Claim; and (d) contain a statement that You may seek to have Your Claim re-evaluated by the appropriate Department of Insurance in Your state of domicile. You may also have the right to seek to have Your Claim paid by filing a civil action in court.

Notice of Privacy Practices

In compliance with certain applicable laws, the Gramm-Leach-Bliley Act (GLBA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), HRI has adopted these policies. HRI acknowledges participants' privacy rights as specified in these laws, and has adopted policies and procedures to ensure Your privacy rights are protected.

This Notice describes how nonpublic personal financial information (NPFI) and protected health information (PHI) about You may be used and disclosed and how You can access this information. In this Notice, We explain how We protect the privacy of Your NPFI and PHI, and how We will allow it to be used and given out (disclosed). We are required to provide You with a copy of this Notice of privacy practices upon request. We must follow the privacy practices described in this Notice while it is in effect.

Our Commitment Regarding Your Confidential Information:
We understand the importance of Your NPFI and PHI (hereafter known as Confidential Information), and follow strict policies (in accordance with state and federal privacy laws) to keep Your information private.

Our Privacy Principles:

- We do not sell customer Confidential Information.
- We do not provide customer Confidential Information to persons or organizations outside HRI and Our business associates for marketing purposes.
- We contractually require any person or organization providing products or services on Our behalf to protect the confidentiality of information We obtain from You.

We afford prospective and former customers the same protections as existing customers with the respect to the use of Confidential Information. Your privacy is a high priority for Us and it is treated with the highest degree of respect. We collect and use Confidential Information We believe is necessary to administer Our business and to provide You with customer service. We use Confidential Information to underwrite Your policies, process Your Claims, ensure proper billing, and service Your accounts. We share Confidential Information as necessary to handle Your Claims and to protect You against fraud and unauthorized transactions. However, We want to emphasize that We are committed to maintaining the privacy of this information in accordance with law. All individuals with access to Confidential Information about Our customers are required to follow this policy.

Confidential Information Collected:

- Confidential Information includes demographic data that can reasonably be used to identify You and that relates to Your past, present or future physical or mental health, the provision of health care to You, or the payment for that care.
- Confidential Information includes Your name, address, date of birth, marital status, sex, social security number, dental information, and Enrollee information, including information about Your transactions with Us, such as Claim history and Premium payments.
- Information Disclosed:
- We may provide Confidential Information to You in order to supply You with information about Your Benefits, or if You request to inspect Your Confidential Information.
- We may provide Your Confidential Information to health care providers and to Our business associates who request Confidential Information for payment-related activities and for health care operations.
- We may provide Your Confidential Information to someone who has the legal right to act on Your behalf.
- We may provide Confidential Information to the extent necessary to comply with laws related to Workers' Compensation or similar programs.
- We may provide Confidential Information without Your written permission for matters in the public interest such as public health and safety activities or averting a serious threat to the health or safety of others.
- We may provide Confidential Information that We collect to third-parties involved in the underwriting, processing, servicing and marketing of Your HRI insurance products. We will not provide this information to any other third party for purposes other than set forth above unless We have a written agreement that requires such third party to protect the confidentiality of this information or Your written authorization.

- The law or the courts may require Us to provide Confidential Information to persons or agencies involved in regulatory, enforcement, or civil or criminal judicial activities.
- When We provide Your Confidential Information to any third party, We will provide only a limited data set, or if needed, the minimal amount of information that We deem is necessary.
- We do not disclose any Confidential Information about Our customers to anyone except as permitted or required by law.
- We must obtain Your written authorization for any disclosures of Your Confidential Information for purposes other than those listed above, including disclosures of psychotherapy notes or for marketing purposes.
- We are prohibited from using or disclosing genetic information of an individual for underwriting purposes.

Security of Your Confidential Information:

- Access of Your Confidential Information is available from Us only to persons involved in underwriting, processing information, marketing company products, or providing dental care for Your benefit. Access must be granted to those entities to enable them to provide the excellent service You have come to expect from HRI.
- We maintain physical, electronic, and procedural safeguards that comply with state and federal standards to guard Your Confidential Information.
- If We become aware that an item of Confidential Information may be materially inaccurate, We will make a reasonable effort to confirm its accuracy and correct any error as appropriate.
- If We believe Your Confidential Information has been breached, You will receive a written notification of the suspected breach.

Individual Rights:

- You have a right to learn about the nature and substance of any Confidential Information HRI has in its files about You. We reserve the right to charge a reasonable cost-based fee for copying and postage.
- You have the right to an accounting of certain disclosures of Your Confidential Information.
- You have the right to request that We place restrictions on the way We use and disclose Your Confidential Information. We will inform You within thirty (30) days of Our decision concerning Your request. We will agree to any request to restrict the disclosure of Your Confidential Information if the disclosure is for carrying out payment or health care operations and You have paid the provider in full out of Your pocket.
- You have a right to inspect Your Confidential Information and request that We amend it in Our files.
- You have a right to obtain a copy of Your Confidential Information that We use or maintain in an electronic health record. We reserve the right to charge a reasonable cost-based fee to provide such information to You or Your specific designee.
- Individual Enrollees who believe that the way we communicate decisions related to payment and Benefits may endanger their Confidential Information may request that We communicate with them using a reasonable alternative means or location.

Duties:

- HRI Dental is required to abide by the terms of this Notice, and reserves the right to change the terms of this Notice at any time, provided that applicable law permits such changes. These revised practices will apply to Your Confidential Information regardless of when it was created or received. Before We make a material change to Our privacy practices, We will provide You with a revised Notice of Privacy Practices.
- Where multiple state or federal laws protect the privacy of Your Confidential Information, We will follow the requirements that provide the greatest privacy protection.

Further information:

If You need more information about Our privacy policy, or are concerned that We may have violated Your privacy rights, please contact HRI's Privacy Officer.

You may also submit a written complaint to:
Attn: Region V, Office of Civil Rights
U.S. Dept. of Health and Human Services 233 N. Michigan Ave, Ste 240
Chicago, IL 60601
Voice mail: 312.866.2359
Fax: 313.866.1807

We support Your right to protect the privacy of Your Confidential Information. We will not take action against You.

Physical Examinations and Autopsy

We reserve the right, at our own expense, to examine a Member when and as often as may be reasonably required for the determination of a claim. We may request an autopsy in case of death where it is not forbidden by law.

ERISA

As a participant in a HRI plan, You may be entitled to certain rights and protections under ERISA. You should check with Your employer to determine whether ERISA applies in Your situation. If You are covered by ERISA, then You may:

- Obtain the Plan Administrator's name, address, and telephone number from Your employer.
- Examine (without charge) at the Plan Administrator's office and at certain other locations, all plan documents, including the group insurance contracts, and copies of all documents filed by the Plan Administrator with the Internal Revenue Service such as annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.
- Receive a Summary Annual Report (SAR), Summary Plan Description (SPD) and a Summary of Material Modifications (SMM).
- Receive a written explanation if Your Claim for Benefits has been Denied. You have the right to request a review of any such denial. If Your Claim is still denied, You may sue for Your Benefits.
- File suit in Federal court if materials You requested aren't received within thirty (30) days (unless the materials weren't sent because of matters beyond the administrator's control), or if You feel Benefits have been improperly Denied, or if You have been discriminated against exercising Your rights under ERISA. If You are successful, the court may require the administrator to provide the materials You requested and pay up to $110 a day until You receive them. The court will decide who should pay the court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your Claim frivolous.

First, consult HRI or Your employer to be certain You thoroughly understand the dental Benefits coverage and Claims procedures. If, after following all procedures, satisfactory resolution has not been reached, You may wish to contact the appropriate state department of Insurance or the United States Department of Labor for assistance. Your exercise of any rights under ERISA will not adversely affect Your employment status or plan Benefits.

Grace Period

A grace period of thirty-one (31) days will be allowed for the payment of each Premium due after the first Premium. This coverage will remain in effect during the grace period unless the Employer has given advance written notice of discontinuance of coverage.

Notification to Insureds

HRI will notify the Employer in writing by mail to the Employer's last known address at least thirty (30) days prior to the Effective Date of the termination of Your insurance, a change in Your Premium, a change in Eligibility or a change in Your Benefits. This notice will also be provided to You, the agent, and the Plan Administrator, if any.

Misstatement of Age

If the age of any individual covered under the Policy has been misstated, all amounts payable under this policy shall be such as the Premium paid would have purchased at the correct age.

Incontestability

After the Policy has been in force for three (3) years,,We will not use any statements made in the application of the Employer to void the Policy. After You have been covered under the Policy for three (3) years, We will not use any statement made in Your enrollment form to defend a Claim.

After the Policy has been in force for three (3) years, We will not use any statements made in the application of the Employer to void the Policy. After You have been covered under the Policy for three (3) years, We will not use any statement made in Your enrollment form to defend a Claim.

Conformity with State Statutes

If any provisions of the Plan is contrary to any law to which it is subject, such provision will be amended to conform to the minimum extent necessary to satisfy legal requirements.
Questions regarding your policy or coverage should be directed to:

HRI Dental & Vision
P.O. Box 659 Evansville, IN 47704-0659
800.727.1444 press 9
7:00 am – 7:00 pm CST Monday through Friday

Benefit Details

ADA Code	Service Description	In/Out %
D0120	PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT	100/100
D0140	LIMITED ORAL EVALUATION-PROBLEM FOCUSED	100/100
D0145	ORAL EVALUATION FOR A PATIENT UNDER 3 YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER	100/100
D0150	COMPREHENSIVE ORAL EVALUATION-NEW OR ESTABLISHED PATIENT	100/100
D0160	DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY REPORT	100/100
D0170	RE-EVALUATION - LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT NOT POST-OPERATIVE VISIT)	100/100
D0180	COMPREHENSIVE PERIODONTAL EVALUATION-NEW OR ESTABLISHED PATIENT	100/100
D0210	INTRAORAL-COMPLETE SERIES OF RADIOGRAPHIC IMAGES	100/100
D0220	INTRAORAL-PERIAPICAL FIRST RADIOGRAPHIC IMAGE	100/100
D0230	INTRAORAL-PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE	100/100
D0240	INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE	100/100
D0251	EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE	100/100
D0270	BITEWING-SINGLE RADIOGRAPHIC IMAGE	100/100
D0272	BITEWINGS-TWO RADIOGRAPHIC IMAGES	100/100
D0273	BITEWINGS-THREE RADIOGRAPHIC IMAGES	100/100

Benefit Details

ADA Code	Service Description	In/Out %
D0274	BITEWINGS-FOUR RADIOGRAPHIC IMAGES	100/100
D0277	VERTICAL BITEWINGS-7 TO 8 RADIOGRAPHIC IMAGES	100/100
D0320	TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCLUDING INJECTION	100/100
D0321	OTHER TEMPOROMANDIBULAR JOINT RADIOGRAPHIC IMAGES BY REPORT	100/100
D0330	PANORAMIC RADIOGRAPHIC IMAGE	100/100
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE ACQUISITION, MEASUREMENT AND ANALYSIS	100/100
D0350	2D ORAL/FACIAL PHOTOGRAPHIC IMAGES OBTAINED INTRAORALLY OR EXTRAORALLY	100/100
D0372	INTRAORAL TOMOSYNTHESIS – COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES	100/100
D0373	INTRAORAL TOMOSYNTHESIS – BITEWING RADIOGRAPHIC IMAGE	100/100
D0374	INTRAORAL TOMOSYNTHESIS – PERIAPICAL RADIOGRAPHIC IMAGE	100/100
D0388	INTRAORAL TOMOSYNTHESIS – BITEWING RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	100/100
D0389	INTRAORAL TOMOSYNTHESIS – PERIAPICAL RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	100/100
D0460	PULP VITALITY TESTS	100/100
D0470	DIAGNOSTIC CASTS	100/100
D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	100/100
D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	100/100

Benefit Details

ADA Code	Service Description	In/Out %
D0703	2-D ORAL/FACIAL PHOTOGRAPHIC IMAGE OBTAINED INTRA-ORALLY OR EXTRA-ORALLY – IMAGE CAPTURE ONLY	100/100
D0706	INTRAORAL – OCCLUSAL RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	100/100
D0707	INTRAORAL – PERIAPICAL RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	100/100
D0708	INTRAORAL – BITEWING RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	100/100
D0709	INTRAORAL – COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES – IMAGE CAPTURE ONLY	100/100
D1110	PROPHYLAXIS-ADULT	100/100
D1120	PROPHYLAXIS-CHILD	100/100
D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH	100/100
D1208	TOPICAL APPLICATION OF FLUORIDE- EXCLUDING VARNISH	100/100
D1351	SEALANT-PER TOOTH (PERMANENT MOLAR TEETH)	100/100
D1510	SPACE MAINTAINER-FIXED, UNILATERAL - PER QUADRANT	100/100
D1516	SPACE MAINTAINER-FIXED-BILATERAL,MAXILLARY	100/100
D1517	SPACE MAINTAINER-FIXED-BILATERAL,MANDIBULAR	100/100
D1520	SPACE MAINTAINER - REMOVABLE - UNILATERAL - PER QUADRANT	100/100
D1526	SPACE MAINTAINER-REMOVABLE-BILATERAL,MAXILLARY	100/100
D1527	SPACE MAINTAINER-REMOVABLE-BILATERAL,MANDIBULAR	100/100

Benefit Details

ADA Code	Service Description	In/Out %
D1551	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER - MAXILLARY	100/100
D1552	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER - MANDIBULAR	100/100
D1553	RE-CEMENT OR RE-BOND UNILATERAL SPACE MAINTAINER - PER QUADRANT	100/100
D1575	DISTAL SHOE SPACE MAINTAINER - FIXED, UNILATERAL - PER QUADRANT	100/100
D2140	AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT	90/90
D2150	AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT	90/90
D2160	AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT	90/90
D2161	AMALGAM-FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	90/90
D2330	RESIN-BASED COMPOSITE-ONE SURFACE, ANTERIOR	90/90
D2331	RESIN-BASED COMPOSITE-TWO SURFACES, ANTERIOR	90/90
D2332	RESIN-BASED COMPOSITE-THREE SURFACES, ANTERIOR	90/90
D2335	RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES (ANTERIOR)	90/90
D2390	RESIN-BASED COMPOSITE CROWN, ANTERIOR (PRIMARY ONLY)	90/90
D2391	RESIN-BASED COMPOSITE-ONE SURFACE, POSTERIOR	90/90
D2392	RESIN-BASED COMPOSITE-TWO SURFACES, POSTERIOR	90/90
D2393	RESIN-BASED COMPOSITE-THREE SURFACES, POSTERIOR	90/90

Benefit Details

ADA Code	Service Description	In/Out %
D2394	RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES, POSTERIOR	90/90
D2520	INLAY-METALLIC-TWO SURFACES	90/90
D2530	INLAY-METALLIC-THREE OR MORE SURFACES	90/90
D2542	ONLAY-METALLIC-TWO SURFACES	90/90
D2543	ONLAY-METALLIC-THREE SURFACES	90/90
D2544	ONLAY-METALLIC-FOUR OR MORE SURFACES	90/90
D2610	INLAY-PORCELAIN/CERAMIC-ONE SURFACE	90/90
D2620	INLAY-PORCELAIN/CERAMIC-TWO SURFACES	90/90
D2630	INLAY-PORCELAIN/CERAMIC-THREE OR MORE SURFACES	90/90
D2642	ONLAY-PORCELAIN/CERAMIC-TWO SURFACES	90/90
D2643	ONLAY-PORCELAIN/CERAMIC-THREE SURFACES	90/90
D2644	ONLAY-PORCELAIN/CERAMIC-FOUR OR MORE SURFACES	90/90
D2651	INLAY-RESIN-BASED COMPOSITE-TWO SURFACES	90/90
D2652	INLAY-RESIN-BASED COMPOSITE-THREE OR MORE SURFACES	90/90
D2663	ONLAY-RESIN-BASED COMPOSITE-THREE SURFACES	90/90
D2664	ONLAY-RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES	90/90

Benefit Details

ADA Code	Service Description	In/Out %
D2710	CROWN-RESIN-BASED COMPOSITE (INDIRECT)	90/90
D2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE	90/90
D2750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL	90/90
D2751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	90/90
D2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	90/90
D2753	CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	90/90
D2780	CROWN-3/4 CAST HIGH NOBLE METAL	90/90
D2781	CROWN-3/4 CAST PREDOMINANTLY BASE METAL	90/90
D2782	CROWN-3/4 CAST NOBLE METAL	90/90
D2783	CROWN-3/4 PORCELAIN/CERAMIC	90/90
D2790	CROWN-FULL CAST HIGH NOBLE METAL	90/90
D2791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	90/90
D2792	CROWN-FULL CAST NOBLE METAL	90/90
D2794	CROWN-TITANIUM AND TITANIUM ALLOYS	90/90
D2799	INTERIM CROWN – FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	90/90
D2910	RE-CEMENT OR RE-BOND INLAY, ONLAY, VENEER OR PARTIAL COVERAGE RESTORATION	90/90

Benefit Details

ADA Code	Service Description	In/Out %
D2915	RE-CEMENT OR RE-BOND INDIRECTLY FABRICATED OR PREFABRICATED POST AND CORE	90/90
D2920	RE-CEMENT OR RE-BOND CROWN	90/90
D2930	PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH	90/90
D2931	PREFABRICATED STAINLESS STEEL CROWN-PERMANENT TOOTH	90/90
D2933	PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW (PRIMARY TOOTH)	90/90
D2934	PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN-PRIMARY TOOTH	90/90
D2940	PROTECTIVE RESTORATION	90/90
D2950	CORE BUILDUP, INCLUDING ANY PINS WHEN REQUIRED	90/90
D2951	PIN RETENTION, PER TOOTH, IN ADDITION TO RESTORATION	90/90
D2952	POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED	90/90
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	90/90
D2960	LABIAL VENEER (RESIN LAMINATE) – DIRECT	90/90
D2962	LABIAL VENEER (PORCELAIN LAMINATE) – INDIRECT	90/90
D2971	ADDITIONAL PROCEDURES TO CUSTOMIZE A CROWN TO FIT UNDER AN EXISTING PARTIAL DENTURE FRAMEWORK	90/90
D2975	COPING	90/90
D3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION)-REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION OF MEDICAMENT	90/90

Benefit Details

ADA Code	Service Description	In/Out %
D3230	PULPAL THERAPY (RESORBABLE FILLING)-ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)	90/90
D3240	PULPAL THERAPY (RESORBABLE FILLING)-POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)	90/90
D3310	ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION)	90/90
D3320	ENDODONTIC THERAPY, BICUSPID TOOTH (EXCLUDING FINAL RESTORATION)	90/90
D3330	ENDODONTIC THERAPY, MOLAR (EXCLUDING FINAL RESTORATION)	90/90
D3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-ANTERIOR	90/90
D3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-BICUSPID	90/90
D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-MOLAR	90/90
D3351	APEXIFICATION/RECALCIFICATION-INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC)	90/90
D3352	APEXIFICATION/RECALCIFICATION-INTERIM MEDICATION REPLACEMENT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, PULP SPACE DISINFECTION, ETC)	90/90
D3353	APEXIFICATION/RECALCIFICATION-FINAL VISIT (INCLUDES COMPLETED ROOT CANAL THERAPY-APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC)	90/90
D3410	APICOECTOMY-ANTERIOR	90/90
D3421	APICOECTOMY-BICUSPID (FIRST ROOT)	90/90
D3425	APICOECTOMY - MOLAR (FIRST ROOT)	90/90
D3426	APICOECTOMY (EACH ADDITIONAL ROOT)	90/90
D3430	RETROGRADE FILLING-PER ROOT	90/90

Benefit Details

ADA Code	Service Description	In/Out %
D3450	ROOT AMPUTATION-PER ROOT	90/90
D3920	HEMISECTION (INCLUDING ANY ROOT REMOVAL), NOT INCLUDING ROOT CANAL THERAPY	90/90
D3950	CANAL PREPARATION AND FITTING OF PREFORMED DOWEL OR POST	90/90
D4210	GINGIVECTOMY OR GINGIVOPLASTY-FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	90/90
D4249	CLINICAL CROWN LENGTHENING-HARD TISSUE	90/90
D4260	OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE)-FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	90/90
D4261	OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE)-ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	90/90
D4266	GUIDED TISSUE REGENERATION, NATURAL TEETH – RESORBABLE BARRIER, PER SITE	90/90
D4267	GUIDED TISSUE REGENERATION, NATURAL TEETH – NON-RESORBABLE BARRIER, PER SITE	90/90
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	90/90
D4273	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURGICAL SITES) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT	90/90
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	90/90
D4275	NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT (INCLUDING RECIPIENT SITE AND DONOR MATERIAL) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT	90/90
D4277	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT AND DONOR SURGICAL SITES) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT	90/90
D4278	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT AND DONOR SURGICAL SITES) EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	90/90
D4283	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURGICAL SITES)-EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	90/90

Benefit Details

ADA Code	Service Description	In/Out %
D4285	NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT SURGICAL SITE AND DONOR MATERIAL)-EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	90/90
D4341	PERIODONTAL SCALING AND ROOT PLANING-FOUR OR MORE TEETH PER QUADRANT (4 TEETH WITH 4+MM POCKETS)	90/90
D4346	SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION - FULL MOUTH, AFTER ORAL EVALUATION	90/90
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE A COMPREHENSIVE PERIODONTAL EVALUATION AND DIAGNOSIS ON A SUBSEQUENT VISIT	90/90
D4910	PERIODONTAL MAINTENANCE	90/90
D5110	COMPLETE DENTURE-MAXILLARY	50/50
D5120	COMPLETE DENTURE-MANDIBULAR	50/50
D5130	IMMEDIATE DENTURE-MAXILLARY	50/50
D5140	IMMEDIATE DENTURE-MANDIBULAR	50/50
D5211	MAXILLARY PARTIAL DENTURE-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	50/50
D5212	MANDIBULAR PARTIAL DENTURE-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	50/50
D5213	MAXILLARY PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	50/50
D5214	MANDIBULAR PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	50/50
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE-RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	50/50
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE-RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	50/50
D5223	IMMEDIATE MAXILLARY PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	50/50
D5225	MAXILLARY PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH)	50/50
D5226	MANDIBULAR PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH)	50/50
D5511	REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR	50/50
D5512	REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY	50/50
D5520	REPLACE MISSING OR BROKEN TEETH-COMPLETE DENTURE (EACH TOOTH)	50/50
D5611	REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR	50/50
D5612	REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY	50/50
D5621	REPAIR CAST PARTIAL FRAMEWORK, MANDIBULAR	50/50
D5622	REPAIR CAST PARTIAL FRAMEWORK, MAXILLARY	50/50
D5630	REPAIR OR REPLACE BROKEN CLASP-PER TOOTH	50/50
D5640	REPLACE BROKEN TEETH-PER TOOTH	50/50
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	50/50
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE PER TOOTH	50/50
D5670	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY)	50/50
D5671	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR)	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D5710	REBASE COMPLETE MAXILLARY DENTURE	50/50
D5711	REBASE COMPLETE MANDIBULAR DENTURE	50/50
D5720	REBASE MAXILLARY PARTIAL DENTURE	50/50
D5721	REBASE MANDIBULAR PARTIAL DENTURE	50/50
D5730	RELINE COMPLETE MAXILLARY DENTURE (DIRECT)	50/50
D5731	RELINE COMPLETE MANDIBULAR DENTURE (DIRECT)	50/50
D5740	RELINE MAXILLARY PARTIAL DENTURE (DIRECT)	50/50
D5741	RELINE MANDIBULAR PARTIAL DENTURE (DIRECT)	50/50
D5750	RELINE COMPLETE MAXILLARY DENTURE (INDIRECT)	50/50
D5751	RELINE COMPLETE MANDIBULAR DENTURE (INDIRECT)	50/50
D5760	RELINE MAXILLARY PARTIAL DENTURE (INDIRECT)	50/50
D5761	RELINE MANDIBULAR PARTIAL DENTURE (INDIRECT)	50/50
D5820	INTERIM PARTIAL DENTURE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MAXILLARY	50/50
D5821	INTERIM PARTIAL DENTURE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MANDIBULAR	50/50
D5850	TISSUE CONDITIONING, MAXILLARY	50/50
D5851	TISSUE CONDITIONING, MANDIBULAR	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D5863	OVERDENTURE-COMPLETE MAXILLARY	50/50
D5864	OVERDENTURE-PARTIAL MAXILLARY	50/50
D5865	OVERDENTURE-COMPLETE MANDIBULAR	50/50
D5866	OVERDENTURE-PARTIAL MANDIBULAR	50/50
D6010	SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT	90/90
D6013	SURGICAL PLACEMENT OF MINI IMPLANT	90/90
D6056	PREFABRICATED ABUTMENT-INCLUDES PLACEMENT	90/90
D6057	CUSTOM ABUTMENT-INCLUDES PLACEMENT	90/90
D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	90/90
D6059	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)	90/90
D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINANTLY BASE METAL)	90/90
D6061	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL)	90/90
D6062	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)	90/90
D6063	ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINANTLY BASE METAL)	90/90
D6064	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)	90/90
D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	90/90

Benefit Details

ADA Code	Service Description	In/Out %
D6066	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	90/90
D6067	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	90/90
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	50/50
D6069	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	50/50
D6070	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINANTLY BASE METAL)	50/50
D6071	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)	50/50
D6072	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)	50/50
D6073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINANTLY BASE METAL)	50/50
D6074	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)	50/50
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	50/50
D6076	IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	50/50
D6077	IMPLANT SUPPORTED RETAINER FOR METAL FPD - HIGH NOBLE ALLOYS	50/50
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE OF INFLAMMATION OR MUOSITIS OF A SINGLE IMPLANT, INCLUDING CLEANING OF THE IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE	90/90
D6082	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS	90/90
D6083	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO NOBLE ALLOYS	90/90
D6084	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	90/90

Benefit Details

ADA Code	Service Description	In/Out %
D6086	IMPLANT SUPPORTED CROWN - PREDOMINANTLY BASE ALLOYS	90/90
D6087	IMPLANT SUPPORTED CROWN - NOBLE ALLOYS	90/90
D6088	IMPLANT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS	90/90
D6092	RE-CEMENT RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN	90/90
D6094	ABUTMENT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS	90/90
D6097	ABUTMENT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	90/90
D6098	IMPLANT SUPPORTED RETAINER - PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS	50/50
D6099	IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO NOBLE ALLOYS	50/50
D6110	IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH-MAXILLARY	50/50
D6111	IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH-MANDIBULAR	50/50
D6112	IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH-MAXILLARY	50/50
D6113	IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH-MANDIBULAR	50/50
D6114	IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH-MAXILLARY	50/50
D6115	IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH-MANDIBULAR	50/50
D6116	IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH-MAXILLARY	50/50
D6117	IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH-MANDIBULAR	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D6120	IMPLANT SUPPORTED RETAINER - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	50/50
D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	50/50
D6195	ABUTMENT SUPPORTED RETAINER - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	50/50
D6210	PONTIC-CAST HIGH NOBLE METAL	50/50
D6211	PONTIC-CAST PREDOMINANTLY BASE METAL	50/50
D6212	PONTIC-CAST NOBLE METAL	50/50
D6214	PONTIC-TITANIUM AND TITANIUM ALLOYS	50/50
D6240	PONTIC-PORCELAIN FUSED TO HIGH NOBLE METAL	50/50
D6241	PONTIC-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	50/50
D6242	PONTIC-PORCELAIN FUSED TO NOBLE METAL	50/50
D6243	PONTIC - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	50/50
D6245	PONTIC-PORCELAIN/CERAMIC	50/50
D6545	RETAINER-CAST METAL FOR RESIN BONDED FIXED PROSTHESIS	50/50
D6548	RETAINER-PORCELAIN/CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	50/50
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	50/50
D6750	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D6751	RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	50/50
D6752	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	50/50
D6753	RETAINER CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	50/50
D6780	RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL	50/50
D6781	RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	50/50
D6782	RETAINER CROWN - 3/4 CAST NOBLE METAL	50/50
D6783	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	50/50
D6784	RETAINER CROWN 3/4 - TITANIUM AND TITANIUM ALLOYS	50/50
D6790	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	50/50
D6791	RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	50/50
D6792	RETAINER CROWN - FULL CAST NOBLE METAL	50/50
D6794	RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS	50/50
D6930	RE-CEMENT OR RE-BOND FIXED PARTIAL DENTURE	50/50
D6940	STRESS BREAKER	50/50
D7111	EXTRACTION, CORONAL REMNANTS-DECIDUOUS TOOTH	90/90
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)	90/90

Benefit Details

ADA Code	Service Description	In/Out %
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	90/90
D7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	90/90
D7230	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY	90/90
D7240	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY	90/90
D7241	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS	90/90
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	90/90
D7251	CORONECTOMY – INTENTIONAL PARTIAL TOOTH REMOVAL, IMPACTED TEETH ONLY	90/90
D7252	PARTIAL EXTRACTION FOR IMMEDIATE IMPLANT PLACEMENT	90/90
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH	90/90
D7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH	90/90
D7283	PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH	90/90
D7286	INCISIONAL BIOPSY OF ORAL TISSUE-SOFT	90/90
D7291	TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY, BY REPORT	90/90
D7310	ALVEOLOPLASTY IN CONJUCTION WITH EXTRACTIONS-FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	90/90
D7311	ALVEOLOPLASTY IN CONJUCTION WITH EXTRACTIONS-ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	90/90
D7320	ALVEOLOPLASTY NOT IN CONJUCTION WITH EXTRACTIONS-FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	90/90

Benefit Details

ADA Code	Service Description	In/Out %
D7321	ALVEOLOPLASTY NOT IN CONJUCTION WITH EXTRACTIONS-ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	90/90
D7340	VESTIBULOPLASTY-RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	90/90
D7350	VESTIBULOPLASTY-RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT AND MANAGEMENT OF HYPERTROPHIED AND HYPERPLASTIC TISSUE)	90/90
D7410	EXCISION OF BENIGN LESION UP TO 1.25 CM	90/90
D7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM	90/90
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER UP TO 1.25 CM	90/90
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER GREATER THAN 1.25 CM	90/90
D7471	REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)	90/90
D7472	REMOVAL OF TORUS PALATINUS	90/90
D7473	REMOVAL OF TORUS MANDIBULARIS	90/90
D7509	MARSUPIALIZATION OF ODONTOGENIC CYST	80/80
D7510	INCISION AND DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE	90/90
D7511	INCISION AND DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE-COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)	90/90
D7830	MANIPULATION UNDER ANESTHESIA	90/90
D7922	PLACEMENT OF INTRA-SOCKET BIOLOGICAL DRESSING TO AID IN THE HEMOSTASIS OR CLOT STABILIZATION, PER SITE	90/90
D7961	BUCCAL / LABIAL FRENECTOMY (FRENULECTOMY)	90/90

Benefit Details

ADA Code	Service Description	In/Out %
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	90/90
D7970	EXCISION OF HYPERPLASTIC TISSUE-PER ARCH	90/90
D7971	EXCISION OF PERICORONAL GINGIVA	90/90
D7980	SIALOLITHOTOMY	90/90
D8010	LIMITED ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION	50/50
D8020	LIMITED ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	50/50
D8030	LIMITED ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	50/50
D8040	LIMITED ORTHODONTIC TREATMENT OF THE ADULT DENTITION	50/50
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	50/50
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	50/50
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADULT DENTITION	50/50
D8091	COMPREHENSIVE ORTHODONTIC TREATMENT WITH ORTHOGNATHIC SURGERY	50/50
D8210	REMOVABLE APPLIANCE THERAPY	50/50
D8220	FIXED APPLIANCE THERAPY	50/50
D9110	PALLIATIVE TREATMENT OF DENTAL PAIN – PER VISIT	90/90
D9944	OCCLUSAL GUARD-HARD APPLIANCE, FULL ARCH	90/90

Benefit Details

ADA Code	Service Description	In/Out %
D9945	OCCUSAL GUARD-SOFT APPLIANCE, FULL MOUTH	90/90
D9946	OCCLUSAL GUARD-HARD APPLIANCE,PARTIAL ARCH	90/90

Plan General Exclusions, Limitations and Restrictions

Including provider supporting documentation requirements.

Eligibility is determined by the last date(s) of service and not based on a calendar or plan year. The last date(s) of service are determined by the prior completion date(s) in which the enrollee was eligible to receive benefits. Covered services for which a patient is not eligible, may be billed to the patient. Covered services that are disallowed by the plan, may not be billed to the patient.

ADA Range	Limitations/Exclusions
D0120, D0145, D0160, D0170	Evaluations - Not eligible for more than two evaluations, of any procedure code combination, within any consecutive 12 month period.
D0140	An evaluation limited to a specific oral health problem or complaint. The use of this procedure code is also appropriate in dental emergencies, trauma, acute infection, etc. Evaluations - Not eligible for more than two evaluations, of any procedure code combination, within any consecutive 12 month period.
D0150, D0180	Eligible only once every 4 years. D0180 applies to age 14 and above. Evaluations - Not eligible for more than two evaluations, of any procedure code combination, within any consecutive 12 month period.
D0210, D0372, D0709	A complete series includes bitewings. Eligible only once per 4 years. Not eligible if performed within 4 years of D0330, D0701 or D0709. If D0210 is performed within 12 months of D0270, D0272, D0273, D0274, D0708 the allowable amount for D0210 will be reduced by the charges for D0270, D0272, D0273, D0274, D0708. Not eligible if performed within 12 months of D0277. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0220, D0230, D0374, D0389, D0707	Eligible for a maximum of 3 during a 12 month period. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0240	Eligible only once per arch per 12 months. Not eligible if performed within 12 months of D0706. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0251, D0274	"Bitewing" radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210 or D0277. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. "Bitewing" radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210 or D0277.

ADA Range	Limitations/Exclusions
D0270, D0373, D0388, D0708	"Bitewing" radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210, D0277 or D0709. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0272, D0273	Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. "Bitewing" radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210 or D0277.
D0277	Not eligible if performed within 12 months of D0210 or D0274. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0320, D0321	Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0330, D0701	Eligible only once per 4 years. Not eligible if performed within 4 years of D0210, D0701 or D0709. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0340	Eligible only once per 2 years. Not eligible if performed within 2 years of D0702. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment.
D0350, D0703	Eligible only once per 5 years. Not eligible if performed within 4 years of D0703. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment.
D0460	Eligible for one charge per date of service.
D0470	Eligible only once per 5 years. It is included in the charges for complete or partial dentures, separate charges are disallowed. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment.

ADA Range	Limitations/Exclusions
D0702	Eligible only once per 2 years. Not eligible if performed within 2 years of D0340. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment.
D0706	Eligible only once per arch per 12 months. Not eligible if performed within 12 months of D0240. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D1110, D1120	Not eligible for more than 2 cleanings per 12 consecutive month period which includes utilization of codes D4341, D4346, D4355, or D4910. Reimbursement for D1120 is limited to enrollees under the age of 14.
D1206	Not eligible for more than 2 fluoride treatments per 12 consecutive month period. Eligible only for children under 14 years of age.
D1208	Not eligible for more than 2 fluoride treatments per 12 consecutive month period. Age limitation may apply.
D1351	Eligible on permanent molar teeth (per tooth) only. Not eligible for replacement for a period of 5 years. Eligible only for children under 15 years of age. Not eligible for a restoration on the O, OB, or OL surfaces following the placement of a sealant on that surface or if a restoration involving the O surfaces has been performed for a period of 3 years.
D1510, D1516, D1517, D1520, D1526, D1527, D1575	Eligible only for children under 13 years of age. Not eligible if performed within 3 years of D1510, D1515, D1520, D1525, or D1575.
D1551, D1552, D1553	Not eligible within 12 months of the initial placement of the space maintainer. Eligible once per 12 months.
D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394	Not eligible for the replacement of or an additional restoration on the same surface for a period of 2 years. Not eligible if performed within 3 years of placing a crown on the same tooth or a sealant on the same surface within 3 years. If two or more restorations are performed on the same tooth, on the same date of service, only the total number of unique surfaces will be considered.

ADA Range	Limitations/Exclusions
D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2651, D2652, D2663, D2664	Not eligible for a replacement by any type of inlay, onlay, or crown for 5 years. A charge for a crown following the placement of a restoration is not eligible for a period of 3 years (a courtesy adjustment may be applied). Crowns, other than prefabricated steel crowns, are not eligible for primary teeth. Composite/resin inlays must be laboratory processed.
D2710	Eligible on anterior teeth only. Not eligible for a replacement by any type of inlay, onlay, or crown for 5 years. A charge for a crown following the placement of a restoration is not eligible for a period of 3 years (a courtesy adjustment may be applied). Crowns, other than prefabricated steel crowns, are not eligible for primary teeth. Composite/resin inlays must be laboratory processed.
D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794	Not eligible for a replacement by any type of inlay, onlay, or crown for 5 years. A charge for a crown following the placement of a restoration is not eligible for a period of 3 years (a courtesy adjustment may be applied). Crowns, other than prefabricated steel crowns, are not eligible for primary teeth. Composite/resin inlays must be laboratory processed. Requires either the submission of a duplicate, diagnostically acceptable, pre-operative radiograph or intraoral photos that substantiates completion of root canal therapy or a narrative which addresses the existence of caries or other pathology, cracked tooth syndrome, missing cusp(s), the amount of remaining tooth structure or the amount of circumferential decay. Crowns are not covered when increasing vertical dimension and restoring occlusion. Charges not meeting established criteria will be disallowed. A pre-treatment estimate is recommended to determine coverage.
D2910, D2915, D2920, D6092	Not eligible for the recementation of an inlay, onlay, or crown within 12 months of the original cementation. Eligible once per 12 months.
D2930, D2931, D2933, D2934	Charges are subject to the same restrictions and conditions as D2520 through D2794.
D2940	Not eligible for replacement by another protective restoration for a period of 3 years. Not eligible if performed in conjunction with endodontics, an amalgam/composite restoration, inlay, onlay, crown, or fixed prosthesis retainer prepared or cemented at the same appointment. Charges for definitive treatment are subject to an adjustment if performed within 12 months of D2940.
D2950	Not eligible within 3 years of restoration and/or replacement within 7 years on the same tooth. Coverage for core buildups requires the submission of a duplicate, diagnostically acceptable, pre-operative radiographic image or intraoral photo that substantiates one of the following three criteria: 1) more than 50% of the tooth crown is missing due to fracture or decay; 2) less than 3 mm of sound tooth structure remaining around the gum line; 3) previous root canal filling completed except where a prior crown through which the access is made remains on the tooth. Charges not meeting established criteria will be disallowed.
D2951	Charge is per tooth and limited to posterior teeth only. Additional pins will be disallowed.
D2952, D2954	Not eligible if performed within 7 years of D2950, D2952, or D2954. Eligible once per 7 years per tooth. Not allowable without history of root canal therapy.

ADA Range	Limitations/Exclusions
D2960	Not eligible for a replacement for 3 years. Placement is restricted to anterior permanent teeth only.
D2962	Not eligible for a replacement for 7 years. Placement is restricted to anterior permanent teeth only. Charges for veneered crowns replacing labial veneers (porcelain) are not allowable for 7 years.
D3220	Eligible for primary teeth only and only once per tooth. Charges are exclusive of the final restoration charge.
D3230	Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. Separate fees for radiographs are disallowed. Charges are exclusive of the final restoration charge. Charges for "elective" root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment.
D3240	Eligible on primary posterior teeth only. Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. Separate fees for radiographs are disallowed. Charges are exclusive of the final restoration charge. Charges for "elective" root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment.
D3310, D3320, D3330, D3346, D3347, D3348	Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. A single periapical will be considered however, fees for any additional radiographs will be disallowed. Charges are exclusive of the final restoration charge. Charges for "elective" root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment.
D3351, D3352, D3353	Limited to children under 16 years of age. Eligible once per lifetime. Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. A single periapical will be considered however, fees for any additional radiographs will be disallowed. Charges are exclusive of the final restoration charge. Charges for "elective" root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment.
D3410, D3421, D3425, D3426, D3430, D3450, D3920, D7472	Eligible once per lifetime.
D3950	Eligible once per 7 years. Charges will be disallowed if submitted in conjunction with D2952, D2953, D2954, or D2957.

ADA Range	Limitations/Exclusions
D4210, D4260, D4261	Eligible only once per area treated for a 5 year period.
D4249	Eligible only once on a per tooth basis. Eligible only once per tooth per lifetime.
D4266, D4267	Charges include the charge for the barrier, and its removal, if necessary. Eligible only once per area treated for a 5 year period.
D4270, D4273, D4275, D4277, D4278	Two soft tissue grafts of any type are eligible per quadrant every 5 years. Eligible only once per area treated for a 5 year period.
D4274	Eligible only when this procedure is performed in an edentulous area adjacent to a periodontally involved tooth. The tooth and proximal area must be identified. Eligible only if no additional surgery is performed in the immediate area, eligible every 5 years. Eligible only once per area treated for a 5 year period.
D4283, D4285	Two soft tissue grafts of any type are eligible per quadrant every 5 years. Teeth #24-25 are considered one site.
D4341	Eligible per quadrant (4 or more active periodontal diseased and qualified teeth). The enrollee must exhibit pocket depths of at least 4 mm around at least 4 teeth in each quadrant to qualify for coverage for this procedure. Otherwise refer to D1110 and D4355. Not eligible on deciduous teeth. Not eligible for retreatment of any quadrant for 3 years. Charges require the submission of full mouth probe chart with six points per tooth probings AND diagnostic full mouth radiographs and/or vertical bitewings. Only two quadrants are considered on the same date of service, additional quadrants will be disallowed. Separate charges for local anesthetic are disallowed. A D1110 cannot be charged within 6 months if 4 quadrants of D4341/D4342 are performed. Charges not meeting established criteria will be disallowed. A pretreatment is suggested. Dental Review Team maintains discretionary authority regarding review requirements.
D4346	Eligible only for enrollees over 15 years of age. Eligible once per 5 years. Not eligible within 6 months of or same date of service as D1110, D1120, D4341/D4342 (quadrant allottment may apply), D4355, or D4910.
D4355	Eligible only for enrollees over 15 years of age. To be eligible, procedure must be performed before and not on the same date of service as D1110, D4341, D4342, D4346, or D4910, or more than 3 years has lapsed since D1110, D4341, D4342, D4346, D4355, or D4910 was performed.

ADA Range	Limitations/Exclusions
D4910	Not eligible if performed within 6 months of or same date of service as D1110, D1120, D4341/D4342 if four quadrants were treated, D4346 or D4355. Not eligible for more than 2 per 12 consecutive month period. Eligible only for enrollees over 15 years of age.
D5110, D5120	Not eligible for the replacement of a denture, including an immediate or partial denture, within 5 years. Separate charges for diagnostic casts (D0470) are disallowed. Charges for a conventional, removable partial dentures or a complete denture (D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, and D5226) are subject to an adjustment if performed within 5 years of an interim partial denture (D5820 & D5821) in the same arch or of any repairs, relines, rebases (D5510 through D5761).
D5130, D5140	An immediate denture cannot be used to replace a complete denture. Other restrictions are the same as D5110 & D5120.
D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226	Eligible every 5 years and are subject to the same conditions and restrictions listed for D5110 & D5120. Separate charges for diagnostic casts (D0470) are disallowed. The teeth replaced by the appliance must be identified on the claim form.
D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660	Not eligible if the procedure is performed within 6 months of the date of delivery of the appliance. Eligible once per procedure code per 6 months.
D5670, D5671	Eligible only once per 4 years per prosthesis. Not eligible if performed within 4 years of D5213 or D5214. Not eligible for charges for rebase, reline or repairs for 6 months.
D5710, D5711, D5720, D5721, D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761	Not eligible within 6 months of the date of delivery of the appliance except when an immediate partial/denture is performed. Eligible for any of these procedures only once per 4 years per prosthesis.
D5820, D5821	Charges for a conventional, removable partial dentures or a complete denture (D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, and D5226) are subject to an adjustment if performed within 5 years of an interim partial denture (D5820 & D5821) in the same arch.
D5850, D5851	Eligible for two tissue conditioning charges within 6 months of delivery of immediate partial/denture only.

ADA Range	Limitations/Exclusions
D5863, D5864, D5865, D5866	Charges are subject to the conditions listed for D5110/D5120 and D5213/D5214.
D6010, D6013, D6056, D6057	Eligible once per 7 years per tooth site. Allowance includes the treatment plan, local anesthetic and post-surgical care. Coverage is limited to enrollees over 15 years of age. Pre-existing conditions do not apply.
D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6194, D6195	Charges are subject to the same definitions and restrictions listed for D2710 thru D2794 and D6210 thru D6974. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch.
D6081	Eligible 12 months after the original placement of the implant. Not eligible for retreatment for a period of 3 years. Not eligible if performed on the same date of service as D1110, D4341, D4342, D4346, D4355, or D4910.
D6110, D6111, D6112, D6113, D6114, D6115, D6116, D6117	Charges are subject to the same definitions and restrictions listed for D5110 thru D5866. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch.
D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6545, D6548, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794	Charges are subject to the same definitions and restrictions listed for D2520 thru D2794. Each unit of a fixed partial denture must be identified on the claim. Not eligible for pontics to replace third molars. All fix prosthodontic services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch. Not eligible for replacement of a removable partial denture by a fixed partial denture within 7 years of the original placement.
D6930	Not eligible within 12 months of the original cementation. Eligible only once per 12 months per fixed partial denture.
D7210, D7250	Surgical extractions: use when either (1) removal of bone and/or (2) sectioning of tooth, including elevation of mucoperiosteal flap if indicated, is necessary. Surgical extraction charges include alveoloplasty. Primary teeth, teeth 7-10 and 23-26 require the submission of a duplicate, diagnostically acceptable, pre-operative periapicial and/or panoramic radiograph with claim submission. Charges not meeting established criteria will be disallowed.
D7252	Eligible once per tooth per lifetime.

ADA Range	Limitations/Exclusions
D7280, D7283	Eligible once per lifetime. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment.
D7286	Charges will be disallowed in performed in conjunction with D3410, D3421, D3425, D3426, or D3427.
D7291	Eligible on anterior permanent teeth and bicuspids. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment.
D7310, D7311	Charges are subject to review if performed in conjunction with D7210 thru D7250. Charges not meeting generally accepted standards of care will be disallowed (see D7210 thru D7250).
D7340, D7350	Charges filed in conjunction with implant services will be disallowed.
D7471, D7473	Eligible once per quadrant per lifetime.
D7510	Charges filed in conjunction with definitive treatment will be disallowed.
D7922	Not eligible for more than a combination of two D7922 or D9110 per 12 month period. Charges filed in conjunction with definitive treatment will be disallowed.
D7961, D7962	Eligible once per lifetime. Charges are subject to review if performed in conjunction with definitive treatment. Charges not meeting generally accepted standards of care will be disallowed.

ADA Range	Limitations/Exclusions
D7970	Eligible only once per 5 years.
D7971	Charges filed in conjunction with definitive restorative treatment will be disallowed.
D9110	Not eligible for more than two palliative (emergency) treatments per 12 month period. Charges filed in conjunction with definitive treatment will be disallowed.
D9944, D9945, D9946	Occlusal guards are removable dental appliances designed to minimize the effects of bruxism and other occlusal factors. Eligible once every 5 years. Charges to modify the appliance or for occlusal adjustment are not eligible.

Orthodontic Benefit Rider

Covered Orthodontic Benefits

Not all plans include benefits for orthodontic treatment. Orthodontic benefits, if included in the dental plan, cover certain orthodontic services and follow certain administration policies as indicated below.

The Standard Plan benefit covers the following orthodontic services:

Limited Orthodontic Treatment	Interceptive Orthodontic Treatment
Comprehensive Orthodontic Treatment	Minor Treatment to Control Harmful Habits

1. The Dentist providing orthodontic services must file an initial Claim Form on behalf of the Member and identify when services began, the anticipated length of the treatment period and the total cost of the treatment plan.

2. The Plan will indicate which Plan members qualify for the benefit and/or to what age the Member is covered. The Standard Plan benefit covers only dependent children to a certain age, regardless of any treatment that may be in progress. Some Plans also cover adults.

3. The Plan will indicate the payment cycle for which benefits are paid. The Standard Plan benefit payment cycle makes payments of equal installments directly to the Dentist on a monthly basis over a period of 24 months. The Member must be an active Member and be in active treatment during the entire 24 months to receive the full lifetime orthodontic benefit. If the treatment period is less than 24 months, the Member's benefit will be paid only over the active treatment period and the full benefit will not be realized. If a non- standard payment cycle is selected, such as over the course of the treatment plan designated with the original claim filing, the terms will be indicated in the Plan. In the event a treatment plan is not defined with the original claim filing, the plan payment cycle will default to 24 months.

4. Active treatment is defined as treatment requiring periodic visits resulting in the movement and retention of teeth.

5. The Plan will indicate the Coinsurance percentage that the Member is responsible for. The Plan Coinsurance may be different based on whether the Dentist is a participating Network or Out-Of-Network Dentist/Orthodontist.

6. The Plan will indicate the amount of the Lifetime Orthodontic Maximum Benefit. A Lifetime Maximum benefit is the maximum amount paid on behalf of a Member during that Member's lifetime, regardless of whether a previous employer or carrier paid for the services (subject to availability of claim's information). A Member is responsible for the difference between the Lifetime Maximum and the Dentist's fee.

7. Members enrolled after the placement of braces may be eligible to receive Benefits for the treatment in progress. The Plan will only consider a benefit based on the remainder of the treatment plan and will require the Dentist to submit a claim for the remaining treatment plan. The Member's Benefit will be paid only over the remaining active treatment period and the full benefit may not be realized.

8. The Orthodontic benefit does not include Benefits for lost, stolen, repairs, re-cementation, or replacement retainers. The benefit does not cover the removal of appliances for reasons other than completion of treatment.

9. Orthodontic benefits are paid "monthly" over a period of time and at the designated Plan payment amount in effect at the inception of the Member's Orthodontic treatment plan. Adjustments to monthly payments will be made if the Plan Lifetime Annual benefit changes (increases or decreased) during the course of an existing treatment plan. This adjustment will only affect Plans with the Standard Benefit feature. Plans that pay benefits over a treatment plan personal to that member will "lock in" at the inception of a member's treatment plan and will not adjust over the course of the treatment as long as the Plan covers an Orthodontic Benefit. No lump sum payments will be made for any reason.

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