JANUARY 1 – DECEMBER 31, 2026



SUMMARY OF DENTAL BENEFITS

HRI DENTAL & VISION

Elite Plus Plan

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH AND/OR DENTAL 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 PROVIDERS 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.

Summary of Dental Plan Benefits

This Summary of Dental Plan Benefits is provided to show how much HRI pays for some of the more frequently performed dental procedures. This Summary of Dental Plan Benefits should be read along with your Policy Handbook. Your Policy Handbook provides additional information about your HRI dental plan, including plan exclusions and limitations. If a statement in this Summary of Dental Plan Benefits conflicts with a statement in the Policy Handbook, the statement in this Summary of Dental Plan Benefits applies to you and you should ignore the conflicting statement in the Policy Handbook.

Plan Name: Elite Plus Plan

Plan Annual Maximum	**$1500**
Deductible (waived for preventive and diagnostic services)	**$50**

Diagnostic & Preventive	**Plan Pays In Network***
Evaluation: periodic, limited, comprehensive	100%
Teeth Cleaning (prophylaxis)	100%
Fluoride - topical application or varnish.	100%
X-Rays - bitewings, periapical, panoramic, full mouth	100%
X-Rays - vertical bitewings	100%
Sealants	100%
Space Maintainer: fixed & removable	80%
Teledentistry	100%

Basic (6 month waiting period)		
Minor Restorative	*Fillings – silver/amalgam or white/composite (anterior and posterior teeth)*	80%
Periodontic	*Scaling & root planning, periodontal maintenance*	80%
Oral Surgery	*Extractions, Alveoloplasty, and other surgical procedures***	80%
Adjunctive	*Emergency palliative treatment*	80%
	Anesthesia – general and IV sedation, nitrous	0%

Major (12 month waiting period)		
Major Restorative	*Crowns, crown repair, recement, core buildup*	50%
Endodontic	*Root canal therapy, Apexification*	80%
	Apicoectomy	50%
Prosthodontic	*Bridges, retainer crown, partial and complete dentures*	50%
	Relining, rebasing, repairs, replacement of teeth and adjustments	50%

***In Network** dentists have agreed to accept contracted maximum allowable fees on covered dental services. Your co-insurance percentage is based on that contracted fee. There is no coverage if you see an out of network provider.

****Other surgical procedures** refer to several oral & maxillofacial surgeries codes. Please submit a pre-treatment estimate with the help of your dentist or by contact our customer support center for a full breakdown of all ADA codes covered.

- Oral evaluations are payable 2 per 12 consecutive month period.
- A routine teeth cleaning (prophylaxis) is payable 2 per 12 consecutive month period regardless of the dentist's specialty, unless performed within 6 months of periodontal scalings and root planing, periodontal full mouth debridement, or periodontal maintenance.
- Fluoride treatment excluding varnish is payable 2 per 12 consecutive months. Including varnish is payable 2 per 12 consecutive months. Including varnish is payable 4 times per Benefit Plan Year for dependents age 0 - 2.
- Bitewing x-rays are payable to a maximum of 4 films in a 12-month period. Full mouth x-ray or Panoramic film are payable once per 4 years. The maximum amount considered for all radiographic images 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.
- Sealants are payable once per 5 years for permanent molar teeth only and for dependents under 15 years of age.
- Space Maintainers are only eligible to Children under the age of 13. They are payable once per 3 years.
- A restoration (amalgam or resin-based composite) is payable once in any 2-year period per tooth for anterior and posterior teeth.
- Replacement of crowns are payable per tooth every 5 years.
- A core buildup will not be payable if performed within 3 years of restoration and/or replacement within 7 years on the same tooth. Coverage for a core buildup requires the submission of a duplicate, diagnostically acceptable, pre-operative radiographic image or intraoral photo.
- Root canal treatment includes periapical x-rays, cultures, follow up care, treatments, pulpotomy. Not eligible for retreatment within 4 years of the date of the original treatment.
- A periodontal scaling and root planing (4 or more active periodontal diseased and qualified teeth) is payable once in any 3-year period per quadrant and subject to the submission of full mouth probe chart with six points per tooth probings and diagnostic full mouth radiographs and/or vertical bitewings to determine if procedure meets plan criteria. A pretreatment estimate is recommended to determine coverage.
- Replacement of dentures, partial dentures, and fixed bridges are payable once per 5 years.
- Teledentistry is available for a variety of dental concerns.

Deductible – $50 per Benefit Plan Year. The deductible does not apply to diagnostic and preventive services. Please reference your Master Group Policy for your Benefit Deductible methodology definition.

Plan Annual Maximum – $1500 per adult per Benefit Plan Year on all services.

Benefit Plan Year – The Plan will expire at the end of calendar year for which the Enrollee and their dependents have enrolled in.

Eligibility – You and, if applicable, your legal spouse (or domestic partner) and your children who meet the dependent age requirements are eligible on the policy effective date.

Dependent Age Limit – Dependent coverage includes children up to age 26, regardless of any, or a combination of any, of the following factors: financial dependency, residency, student status, employment status, or marital status.

Grace Period – Your premium is due no later than the first day of Your coverage month. A grace period of thirty-one (31) days will be allowed for the payment of each Premium due after the first Premium. After the Grace Period expires Your coverage will be terminated.

Waiting Period for Covered Services – Services categorized as basic, such as minor restorative, periodontal services, oral surgery, and adjunctive services will not be covered until after a member has been enrolled in the dental plan for **6** consecutive months. Services categorized as major, such as major restorative services, endodontics, and prosthodontic services will not be covered until after a member has been enrolled in the dental plan for **12** consecutive months.

Out of Network Coverage – This policy does not cover services completed by an out of network provider.

Insurance products are marketed and administered, with network management services by HRI. HRI plans are underwritten and insured by Health Resources of Ohio, Inc. Please visit www.InsuringSmiles.com where you can find your Certificate, Summary of Dental Plan Benefits, as well as finding a dentist and any other plan information.

HRI DENTAL & VISION

Summary of Vision Plan Benefits

IMPORTANT: If you opt to receive vision care services or vision care materials that are not covered benefits under this plan, a participating vision care provider may charge you his or her normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon Your request.

To locate a Vision Provider, go to: https://member.eyemedvisioncare.com/hri/en

BENEFIT FREQUENCY	
Vision Examination(s)	
Comprehensive Eye Examination	once every contract year
Vision Materials	
Frames	once every two years per contract
Lenses and Lens Options	once every two years per contract
Contact Lenses	once every two years per contract

BENEFIT	In-Network Provider	Out-of Network Provider (Reimbursement up to)
Vision Examinations Unless otherwise indicated, the various Vision Examinations are in addition to the Comprehensive Eye Examination if recommended by the Provider.		
Exam with Dilation as Necessary	$25 Copayment	$40
Retinal Imaging Benefit	Up to $39	N/A
Exam Options: Standard Contact Lens Fit and Follow-Up:	$25 Copay, Paid-in-full fit and two follow-up visits	$32
Premium Contact Lens Fit and Follow-up:	$25 Copay, 10% off retail prices, then apply $55 allowance	$44
Vision Materials		
Frames: Any available frame at provider location	$0 Copayment; $75 Allowance, 20% off balance over $75	$36
Contact Lenses: *(Contact lens allowance includes materials only)*		
Conventional	$0 Copayment; $120 allowance, 15% off balance over $120	$100
Disposable	$0 Copayment; $120 allowance, plus balance over $120	$100
Medically Necessary	$0 Copayment, Paid-in-Full	$210

Standard Plastic Lenses		
Single Vision	$25 Copayment	$40
Bifocal	$25 Copayment	$60
Trifocal	$25 Copayment	$80
Lenticular	$25 Copayment	$80
Progressive-Standard **Progressive-Premium**	$90 Copayment See attached Fixed Premium Progressive price list	$60 $60
Lens Options		
Anti-Reflective Coating – Standard Premium	 $45 See attached Fixed Premium Progressive price list	 N/A N/A
UV Treatment	$15	N/A
Photochromic Non-Glass Lens	$75	N/A
Polycarbonate Lenses – Standard – Adults Standard – Kids under 19	 $40 $40	 N/A N/A
Polarized	20% off Retail Price	N/A
Scratch Coating – Standard Plastic	$13	N/A
Tint (Solid and Gradient)	$15	N/A
Other Add-Ons	20% off Retail Price	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Laser Vision Correction		
Lasik	15% off Retail Price or 5% off promotional price	N/A

*The Insured Person, Dependent children are eligible for one additional Comprehensive Eye Examination, beyond 60 days of the initial examination, Refraction, Lenses, Frame and Lens Options or Contact Lenses if prescription has changed by 0.50 diopter sphere/cylinder >20 degrees axis, or visual acuity improvement by two lines on standard chart in the same Benefit Frequency.

Premium Progressive Lens

Progressive Price List*	Member In-Network Cost (Includes Lens Copay)
Standard Progressive	$90 Copay
Premium Progressives as Follows:	
Tier 1	$110 Copay
Tier 2	$120 Copay
Tier 3	$135 Copay
Tier 4	$90 Copay, 20% off charge less $120 allowance
Anti-Reflective Coating Price List	**Member In-Network Cost**
Standard Anti-Reflective Coating	$45
Premium Anti-Reflective Coatings as Follows:	
Tier 1	$57
Tier 2	$68
Tier 3	20% off retail
Other Add-ons Price List	**Member Cost In-Network**
Photochromic (Plastic)	$75
Polarized	20% off retail
EyeMed Vision Care reserves the right to make changes to the products on each tier and the member of out-of-pocket costs.	
*Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.	

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