Your **Dental Plan**



Member Handbook

Ohio Individual Plan

YOUR 10 DAY RIGHT TO EXAMINE AND RETURN YOUR POLICY. You have the right to return this Policy within 10 calendar days of receipt. If you are not satisfied, the Policy may be returned to Us or to Our agent before midnight on the 10th day following receipt of the Policy. If you return the Policy within the 10 day period, it will be void and We will have no liability under any of the policy terms or provisions. There will be no coverage for any claim incurred. Any premium pay by You will be promptly refunded to You.

HRI DENTAL &VISION

Important Information about Your Plan

Insurance products are marketed by Health Resources of Ohio Inc (dba HRI) and underwritten and administered by Health Resources of Ohio Inc (dba HRI).

This Policy describes your HRI Benefits along with how your plan works.

This Policy is a legal document (a contract) between HRI (referred to as We, Us, our, HRI, or the Company) and You (referred to as You, Your, or the Member). It is to provide Benefits to You and is subject to the terms, conditions, Limitations and Exclusions stated herein.

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.

DENTAL POLICY

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Visit **HRI Dental & Vision** Online 24 hours a day/ 7 days a week at **InsuringSmiles.com**

Contact Member Services

Dental Plan Information
Monday-Friday: 8:00 am – 8:00 pm EST
800.727.1444

Vision Plan Information
844-961-2056
Monday-Friday: 7:30 a.m. – 11 p.m. EST
Saturday: 8 a.m. – 11 p.m. EST / Sunday: 11 a.m. – 8 p.m. EST

WELCOME TO YOUR PLAN

Thank You for enrolling in HRI! Your health is important and the benefits provided in this plan are a vital part of your overall health, and it is Our pleasure to be included in Your wellness plan. HRI collaborates with the industry professionals to design plans that promote Your health care along the most cost-effective path. As any health care professional will attest, the key to avoiding costly problems is prevention.

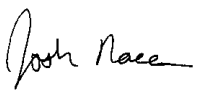
You have a wide choice of providers to choose from nationwide! Network providers submit Claim Forms for services performed for You and payments are paid directly to them. Network Dentists also sign contracts with HRI to accept certain agreed upon fees, therefore, You may realize significant savings.

HRI is also committed to providing the highest quality Member services to all Members. Our dedicated team is 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 policy for reference.

Your satisfaction is important. That is why every individual plan sold comes with a 10 Day Free review period. You have until 10 days after receiving your Member ID to contact HRI for a full refund.

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,



President

HRI Dental & Vision

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. The Policy does not dictate what treatment You receive. Only You and Your Dentist can determine that. However, the Policy does determine what services are covered. The Policy coverage selected by You pays for only those Covered Services under Your HRI Policy listed in this Policy and Your Summary of Benefits within the Limitations and restrictions presented. You will be financially responsible for any service which is not covered or for any service that is covered but is subject to Limitations and restrictions. The Policy will only cover services for In-Network Dentists. 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 recommended to ensure you know Your coverage details and Your out-of-pocket responsibilities.

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, meaning plan changes will not affect the limitations. 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 Policy. Network Dentists provide the same excellent service at a contracted fee, resulting in savings for You and Your family.

You should always review Your benefits as outlined in this Handbook prior to Your dental visit as it makes a difference in Your Coinsurance and savings. Network Dentists are independent contractors and are not HRI employees.

Eligibility/Eligibles

HRI is available to You and Your Dependents up to age 26, regardless of any combination of the following factors: financial dependency, residency, student status, employment status, or marital status.

Coverage provided under this Policy shall be in accordance with the Eligibility, Effective Date, and Termination provisions of the Policy.

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). A Member who is ordered by a QMSCO to provide dental coverage for a Child may enroll themself 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.

If You have Dependent(s) with a permanent mental, intellectual, or physical disability to the extent they cannot support themselves, they 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 HRI Member services.

10 Day Free Evaluation

HRI's goal is for you to be satisfied with your Plan purchase. You have until 10 days after we receive your first payment to terminate your plan with absolutely no penalty. Just contact HRI within that 10 day period and you will receive a full refund. If you incur any claims during this period of time, you will be responsible for the entire cost of the claim if you opt to terminate during this 10 Day Free evaluation.

Enrollment Periods

Initial Enrollment

At the time You enroll, You are given a coverage Effective Date which starts on the first day of the month and is effective until December 31st of the year. Renewal dates are always on January 1st each year.

Annual Open Enrollment Period

Annual Open Enrollment period where you can make changes to Your plan selection and add or delete dependents starts November 1 and runs until December 15 of each year.

Special Enrollment Periods

Members may not add, drop or change coverage for themselves and their Dependents during the plan year unless a Qualifying Event unless a qualifying event 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 31 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.

Special Enrollment Period (SEP) Qualifying Event Categories

You may qualify for a SEP to enroll in or change plans outside of annual Open Enrollment if you experience a qualifying event in one (1) of the following categories:

1. Loss of qualifying coverage;
    a. Loss of qualifying coverage includes; losing job-based coverage, losing coverage through family member, losing eligibility through student health plan, losing eligibility for a plan because you no longer live in the plan's service area.
2. Marriage;
3. Change in household;
    a. Birth, adoption, placement for adoption or foster care;
4. Legal separation or divorce;
5. Death of Member or Dependent;
6. Change in residence (Outside of your current state);

Reinstatement

If a policy has lapsed or terminated for non-payment for reasons that are out of the control of member, Your plan may be reinstated if previously missed payments are received within sixty (60) days of your termination date. Any payments made will be applied to current open balances that are no later than sixty (60) days old. Contact with HRI will be required to complete the reinstatement process. This contact can be made through our customer service representatives or via email.

If a member is reinstated, and previously missed payments are received, no lapse in coverage will be noted and the member's effective start date will remain the same as their original.

Billing and Payment

Billing for Your plan is done in advance and due no later than the 1st of the month. For example, Your coverage for July is due no later than July 1st.

How to Pay Your Monthly Premiums

You can access copies of Your billing in the billing portal. You can pay via ACH, Check and Credit Card. Your billing contains instructions for making payments.

You have three methods to make your monthly premium payment:

Pay Online
insuringsmiles.com/pay

Pay by Phone
(855) 675-1493

Pay by Mail
Checks Payable to:
Health Resources, Inc.

Send Payment to:
Health Resources, Inc.
PO Box 267
Evansville, IN 47702

We encourage the use of autopay to ensure there is no jeopardy in Your plan being cancelled for non-payment. You may sign up for autopay on the portal.

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.

During the grace period, no claims will be paid or authorized. Any claims received will be released and processed upon payment of premium.

Renewals, Cancellations, and Terminations

Renewals

For Your convenience, your plan is setup with an auto-renewal feature. It will renew January 1st.

Cancellation of Coverage

To request a cancellation of Your dental coverage, you must contact HRI through email or through mailed letter. You will not be eligible for individual coverage with HRI for 1 year. HRI will return any unearned portion of any premiums paid. If you cancel Your dental coverage, any claims for services you received before the cancellation date are still covered and can be paid. Cancelling Your Plan will not affect those claims and they will be handled as usual.

Termination of Coverage

Your dental coverage may be automatically terminated when You fail to pay timely Premium payments or fees to HRI, subject to the Grace Period. You are still responsible for any outstanding balances for Your entire plan year.

At renewal time, to ensure Your coverage continues, please ensure all payments are made by Your renewal date, or Your policy will be subject to non-renewal.

If you are terminated for non-payment, you will be ineligible to rejoin the plan for a period of 1 year. Before being allowed to rejoin, you must have paid all outstanding balances due to the Plan.

In the event of the death of a Member, unearned premium will be refunded on a pro-rated basis.

If you wish to terminate at your renewal date, please contact HRI. You have up until renewal date, December 15th of the Plan Year, to terminate coverage. You will need to elect to terminate your Plan.

How to Request Cancellation or Termination of Coverage

You will be required to contact HRI through email or mailed letter to request Your Plan not automatically renew or if you with to cancel or terminate Your coverage. This can be done by emailing our member services at:

callcenter@insuringsmiles.com; or

Mailing a letter to:

P.O. Box 659
Evansville, IN 47704

Be sure to include your name, member ID, and the request to cancel or terminate Your coverage.

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,
- Pay Your monthly invoice and change payment method.
- Print Member Cards,
- Review Benefit history,
- Download brochures,
- Acquire oral health and wellness tips, and
- See additional member Perks.

Online materials serve as the primary source of information for Members, Dentists and advisers. Any printed documents that You may have are 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

You will be issued an HRI Member ID Card upon effectuation. This occurs after Your initial payment has been processed. You do not need this card to receive coverage.

HRI Perks

HRI has created a number of value-added services that are available to you and all covered members. Login to your Dental and/or Vision Portal to learn more.

Benefit Categories – What is Covered by My Dental Policy?

Important – It is very important to understand that You have selected which services are included in Your Policy. Please review both this Policy 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 Policy.** The Summary of Dental Plan Benefits is part of this Policy.

Covered Services are also subject to Exclusions and Limitations and are included in a later section of this Policy.

The various dental services provided by a Dentist that are covered on this plan include these categories:

1. Diagnostic and Preventive Services
2. Basic Services
3. Major Services
4. Adjunctive/Other Services

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.

Basic Services

Basic services include a variety of specialized 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.
- Endodontic Services – these procedures treat teeth with diseased or damaged nerves. Root canals are included in this category.
- Non-surgical Periodontics Services – these procedures involve the treatment of diseases of the gums and supporting structures of the teeth. Non-surgical procedures include periodontal scaling and root planning, full mouth debridement and periodontal maintenance following a periodontal therapy (periodontal cleanings). Periodontal procedures that are surgical in nature are considered major procedures.
- Simple Extractions – this procedure is an extraction of a tooth that is erupted or exposed root.
- Relines and Repairs – these procedures reline and repair existing dentures (partial and complete) and repair existing bridges.
- Oral Surgery Services – 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.

Major Services

Major services typically involve major restorative procedures, surgical procedures and services that replace missing natural teeth, such as bridges, partial dentures, and complete dentures.

- Major Restorative Services – these services include crowns. Crowns may be covering a natural tooth or an implant.
- Prosthodontic Services – bridges, partial dentures and complete dentures are in this category.

Please review your Summary of Benefits and your schedule of covered services at the end of this booklet

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 Code on Dental Procedures and Nomenclature (CDT). 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 Policy 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 Policy and Limitations to Covered Services are indicated on Summary of Dental Plan Benefits. The percentage of Policy 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, otherwise known as "Balance Billing," the patient for the difference between his Fee Charged and the contracted maximum allowable fee.

Policy Features

This list of Policy features describes the features that are available through HRI but may not be included in the coverage that You have selected. To see a list of Policy features that are specific to Your Benefit coverage, please refer directly to Summary of Dental Plan Benefits. If a Policy feature is not listed on Your Summary of Dental Plan Benefits then it is not a part of Your Dental Benefit Policy.

Policy Annual Maximum Benefits/Plan Year

Benefits payable under the Policy, regardless of whether coverage is continuous or not, shall be subject to the Policy Annual Maximum for each plan year. Payments under Your Policy for ALL Covered Services apply to the Policy Annual Maximum Benefit. Change of the dental Policy coverage, termination, and reinstatement of coverage does not eliminate Frequency Limitations or Policy Annual Maximum Benefit used. You will continue to receive Network savings on all Covered Services after Your Annual Maximum has been reached.

Deductible

The Policy Year Deductible (if any) is applicable to Covered Services incurred in each Policy Year. This is the amount you must pay before your plan benefits start. This is applied to all services except for diagnostic or preventive procedures.

Waiting Period

When a new dental policy is purchased with HRI, the plan may include a waiting period before the dental procedures in that category of services are covered. This starts on Your Effective Date and will be restarted if you terminate and later reapply for coverage. The one exception is if a Member has continuous coverage with HRI on their Dental Policy (even with a HRI Group Plan) and change their selected plan. Although they will have a new Effective Date, the waiting period time period does not restart.

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 their 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 Policy 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 Dental Plan Benefits or listed in the procedure list at the end of this booklet. All charges for the same will be Your responsibility (though Your payment obligation may be satisfied by insurance or some other arrangement for which You are eligible):

General Exclusions

All Policies issued or administered by HRI are subject to the following General Exclusions.

This Policy will not pay for:

1. Dental services that are not listed in the Policy Covered Services and Policy General Exclusions, Limitations and Restrictions attached to this Policy.
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 Members 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 and are only applicable to Children under age 13. Not eligible if performed within 3 years of a previous space maintainer.
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 if Benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.
13. Dental services or charges separately billed by hospitals, laboratories, pharmacies or other institutions other than a Dentist practice.
14. Experimental or investigational dental treatment.
15. Dental services as a result of Your participation in a misdemeanor, felony, riot or insurrection.

16. Dental services charged and filed on a Claim under an unspecified CDT service code X999.
17. 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 Policy:

Diagnostic Evaluations and Treatments

Evaluations (examinations), including any and all procedure codes, are payable twice within any Benefit Plan Year. 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 only once every 4 years.

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 Member.

Panoramic (including image capture only) or full mouth X-rays are payable once every 4 years. 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.

Bitewing radiographic images (including image capture only) are limited to a maximum of 4 in a 12-month period. 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 Policy that covers orthodontic services and treatment or Pediatric (under 19). 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.

Preventive Services:

Prophylaxis: A teeth cleaning (includes prophylaxis, periodontal scalings and root planning, periodontal full mouth debridement and periodontal maintenance) is payable once every 6 months, regardless of the Dentist's specialty. A teeth cleaning for Children under the age of 19 will be payable when filed as a Child's cleaning.

Fluoride: A preventive fluoride treatment is payable once per 6 months.

Sealants: Will be payable on permanent molar teeth (per tooth) only for Children under 19 years of age. 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.

Restorative Services:

A restoration/filling (amalgam or Resin-based Composite) is payable once in any 2 year period per tooth. An additional restoration on the same tooth surface will not be payable for a 2 year period. A restoration will not be payable within 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 once in any 5 year period per tooth. 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 5 years. Crowns, other than prefabricated steel crowns, are not payable for primary teeth. Composite/Resin inlays must be laboratory processed.

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

Individual crowns over implants are payable once in a 5 year period.

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 are 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 protective restoration is payable once every 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 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 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 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 7 years per tooth. A payment is not eligible if performed within 7 years of a core buildup or another post and core. Procedure is not payable without history of root canal therapy.

Endodontics:

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 19 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.

Non-Surgical and Other Periodontal Services:

Periodontal maintenance is payable once per 6 months for Members over 19 years of age. 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 once in any 3 year period per quadrant. 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 Member 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 Members under 19 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 Member under 19 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.

Periodontal maintenance is payable once per 6 months for Members over 19 years of age. 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.

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. Teeth #24-25 are considered one site.

Prosthodontics:

One upper and one lower denture (including complete, immediate, partial, immediate partial, overdenture and interim) are payable once in any 7 year period. 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.

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 once in a 7 year period. 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 7 years of the original placement.

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 Claim submission. Charges not meeting established criteria will be Disallowed.

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 Policy orthodontic Covered Services and treatment.

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

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

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

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

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.

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

Teledentistry visits are included.

Disallowed Services

Participating Dentists may not charge Eligible Persons for Disallowed services or supplies. All charges from non-participating Dentists for the Disallowed services are Your responsibility.

How Payment to Your Dentist 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 Policy including the co-insurance and the cost of services that are not covered by the Policy. It is possible that Your Dentist 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.

Filing a Claim

Network Dentists are responsible for submitting Claims to HRI on Your behalf. 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:

- Members name, address, and identification number (Member Number)
- Patient's name, date of birth, and identification number (Member Number)
- Itemized bill including the ADA code, description of each charge, and date of service
- Name and address of the Rendering Dentist
- 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 Policy 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.

Mailing a letter to:

P.O. Box 659
Evansville, IN 47704

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 Plan. If so, a contracted Network Dentist must reduce the charged amounts.

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 within the 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. All benefits will be paid to You, or at Your discretion, to Your Provider.

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.

Right of Recovery

Whenever payments have been made in excess of the amount due under the Policy, 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.

General Conditions and Additional Information

Entire Contract, Changes

The Policy, including endorsements, Summary of Dental Plan Benefits, riders, application and the attached papers, if any, constitute 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, 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 Policy upon thirty (30) days written notice to You. This Policy will pay for any Covered Services rendered prior to the Effective Date of the change.

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

Claims Appeal Procedure

Informal Claims Appeal Procedure

Your HRI Policy 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 plans even better, Your suggestions are encouraged. Occasionally, even after You have reviewed the applicable sections of this Policy pertaining to Your issue at hand, You may have a question. Your questions may involve Providers, Covered Services, and the administration of your plan.

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) that is available within Your portal. 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 Provider 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 Claims Review Team at HRI. This can be done through the Messaging Center on Our member portal (https://portal.insuringsmiles.com/Account/Login), email (claims@insuringsmiles.com), or fax (812-424-2096).

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 Policy 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 Claims Review Team will make their decision and notify You in writing within 30 days of receiving Your request. Their notice of any Adverse Benefit Determination will: (a) inform You of the specific reasons for the denial; (b) list the pertinent Policy 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 Member 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 Members 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 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.

Fraud, Waste and Abuse

Health care fraud, waste, and abuse represent significant challenges that impact everyone - whether directly or indirectly. It is estimated that billions of dollars are lost each year to these issues, driving up health care costs and potentially increasing the expense of coverage for everyone.

Health care fraud involves the intentional misrepresentation, deception, or deliberate act of deceit with the purpose of receiving undue payment, either in part or in full.

Health care abuse, on the other hand, refers to actions or practices conducted with reckless disregard or that deviate from accepted business or medical standards, leading to unnecessary costs or inefficiencies within the system.

At HRI Dental & Vision, we remain committed to combating fraud, waste, and abuse to ensure the integrity of our services and the trust of those we serve. If you suspect Fraud, Waste or Abuse, please contact us:

- Call: 800-727-1444; or Email: compliance@insuringsmiles.com

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.

Notification to Insureds

HRI will notify You in writing by mail at Your last known address at least sixty (60) 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.

Misstatement of Age

If the age of any individual covered under the Policy has been misstated, there will be an adjustment of Premium for the Policy so that there will be paid to Us the Premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage will not be affected.

Incontestability

Except for non-payment of Premium or fraud, the insurance provided by the Policy or misinformation on the application cannot be contested after a period of two (2) years from the date of issue of such insurance. No statement made for the purpose of effecting insurance shall void this insurance or reduce its Benefits unless contained in a written instrument signed by You, a copy of which has been furnished to You or Your beneficiary.

After the Policy has been in force for two (2) years, We will not use any statements made in Your application to void the Policy, including diseases, physical injuries or other medical history not otherwise stated in the application. After You have been covered under the Policy for two (2) years, We will not use any statement made in Your application to defend a Claim.

Conformity with State Statutes

If any provision of the Policy 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.

Important Notice

If You (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint You have been unable to resolve with Your insurer You may contact the Department of Insurance by mail, telephone or email:

Ohio Department of Insurance
Consumer Services Division
50 W Town Street, Suite 300
Columbus, Ohio 43215
Consumer Hotline: 1-800-686-1526 / (614) 644-2658

Complaints can be filed electronically at https://insurance.ohio.gov/consumers.

Vision Benefits – What is Covered by My Vision Policy?

Benefits are payable for each Member as shown in the Summary of Benefits for expenses incurred while this insurance is in force.

In-Network Provider Benefits. The Member must pay any Copayment or any cost above the Allowance shown in the Summary of Benefits at the time the Covered Service is provided. Benefits will be paid to the In-Network Provider who will file a claim with the Company on behalf of the Member.

Out-of-Network Provider Benefits. The Member must pay the Out-of-Network Provider the full cost at the time the Covered Service is provided and file a claim with the Company, unless the Out-of-Network Provider allows assignment of benefits. The Company will pay the Out-of-Network benefits up to the maximum dollar amount shown in the Summary of Benefits.

When a Member receives services from a network vision Care Provider, the Member's co-insurance percentage will not exceed the percentage identified in the Summary of Vision Plan Benefits of this policy. However, if a Member receives services from a vision care Provider who is an Out-Of-Network vision care Provider, the Member's out-of-pocket costs may be greater than the Plan's co-insurance percentage if the out-of-network vision care Provider's fee exceeds the plan's allowable amount.

Selecting a Vision Provider

HRI has created a robust network of vision providers. You can locate these providers by visiting the HRI vision website at: https://member.eyemedvisioncare.com/hri/en

Vision Service Exclusions

- No benefits will be paid for services or materials connected with or charges arising from:
- Medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures
- Refraction, when not provided as part of a Comprehensive Eye Examination;
- services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
- orthoptic or vision training, subnormal vision aids and any associated supplemental testing;
- Aniseikonia lenses;

- any Vision Examination or any corrective Vision Materials required by a Member as a condition of employment;
- occupational safety eyewear;
- solutions, cleaning products or frame cases;
- Non-Prescription Sunglasses;
- plano (non-prescription) lenses, except as included in the Non-Prescription Sunglasses benefit;
- plano (non-prescription) contact lenses;
- two pair of glasses in lieu of bifocals;
- electronic vision devices;
- services rendered after the date a Member ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Member are within 31 days from the date of such order;
- lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available;
- Services or materials rendered by a provider other than an ophthalmologist, optometrist, or optician acting within the scope of his or her license;
- Services rendered or materials ordered before the date coverage begins under the covered Policy;
- Discounts do not apply for benefits provided by other group benefit plans.
- In the event of a conflict or inconsistency between the Limitations and Exclusions listed above and the Limitations and Exclusions listed in the Covered Policy, the Limitations and Exclusions listed above shall take precedence.

Vision Service Limitations

Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Member to the Provider. Such fees, taxes or materials are not covered under the Policy.

Vision Freedom of Choice

A Member has the freedom to visit any vision care Provider of their choice. Out-Of-Network vision care Providers are under no obligation to file a Member's claim or accept contracted maximum allowable fees. Unless specified within the Summary of Vision Plan Benefits of this Policy, reimbursement for services to an Out-Of-Network vision care Provider will be paid based upon a maximum allowable scheduled amount. There may be a payment difference between the allowed reimbursement and the amount the vision care Provider charges for a particular service, which could result in greater out of pocket costs to a Member. This is referred to as Balance Billing. Therefore, services and out of pocket costs may be more than the percentages listed in Summary of Vision Plan Benefits. A Member may also be required to file their own vision claims and pay 100% for vision services at time of visit. Out-of-Network vision care Providers are under no obligation to file claims on a Member's behalf, accept allowable fees or assist with a Member's insurance benefits.

Questions and Assistance

Questions regarding Your Dental policy or coverage should be directed to:

HRI Claims Department

P.O. Box 659 Evansville, IN 47704-0659

800.727.1444 press 9

(7:30 am – 7:00 pm CST Monday through Friday)

Questions regarding Your Vision policy or coverage should be directed to:

EyeMed Vision Care Attn: Quality Assurance.

4000 Luxottica Place, Mason, OH 45040

844-961-2056

Fax: 1-513-492-3259

Out of Network Vision Claim submission address:

First American Administrators, Inc.

Attn: OON Claims

P.O. Box 8504; Mason, OH 45040-7111

To submit online: https://eyemedvisioncare.com/oon/EMV_OON_Form.pdf

Email form to: oonclaims@luxotticaretail.com

Glossary of Terms

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

Allowance: The benefit amount shown in the Summary of Benefits that is the maximum amount payable by the Company, subject to the expenses incurred. The Member is responsible for any amounts due above the Allowance. The Allowance cannot be used to satisfy a Copayment.

Balance Billing: Network Providers agree to accept the Network's contracted fees as payment in full. A participating Network Provider has agreed to not bill the patient for the difference between their Fee Charged and the contracted maximum allowable fee. This is referred to as "Balance Billing."

Benefits: The amounts that the Policy pays for Covered Services under Your dental Policy.

Benefit Frequency: The period of time in which a benefit is payable as shown in the Summary of Vision Benefits. The Benefit Frequency begins on [the later of the Member's Effective Date or last date services were provided to the Member] [Month Day]. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

Benefit Plan Year: The plan year. (See the Summary of Plan Benefits for Your Benefit Plan Year.)

Children or Child: Your natural Children, step Children, 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 You or Your Dentist 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.

Comprehensive Eye Examination: A general evaluation of the complete visual system. The examination includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields, basic sensorimotor examination and Refraction. It always includes initiation of diagnostic and treatment programs. It may include biomicroscopy, examination with cycloplegia or mydriasis and tonometry, as determined by the Provider. These services may be performed at different sessions but comprise only one Comprehensive Eye Examination.

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

Covered Services: Dental or Vision services for which a reimbursement is available under a Member's Policy, 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.

Deductible: The amount a person and/or a family must pay toward Covered Services before HRI begins paying for those services under this Policy. 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 Your family who meets all the applicable Eligibility requirements, has been enrolled in the Policy and for whom the payment required has been received by HRI. Dependent Child may include Your biological child, stepchildren, adopted children, foster children, children subject to legal court or administrative order to provide health coverage. Coverage for adopted children is effective upon the earlier of the date of placement or the date of entry of an order granting custody.

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

Effective Date: The date this dental policy begins. The Effective Date is determined in accordance with Waiting Periods.

Eligible Persons: Eligible Persons include Your legal spouses, as defined by state and federal law, and Dependents. Dependent Children are eligible until they reach age 26. Dependent Child may include Your biological Children, step Children, adopted Children, foster Children, Children subject to legal guardianship, newborn Children, or any Child for whom You are the legal guardian or are required by a court or administrative order to provide dental coverage. Coverage for adopted Children is effective upon the earlier of: the date of placement or the date of entry of an order granting custody.

Exclusions: Services that are not covered under this Policy.

Explanation of Benefits (EOB): The statement received after a Claim is processed, detailing how Your Claim was processed, including identification of services rendered, fees, application of Policy Limitations, calculation of Policy 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.

Frequency Limitation: A limitation to how many times the Plan will pay for a particular treatment or procedure within a defined timeframe.

In-Network Provider: A Provider who has signed a Preferred Provider Agreement with the Plan. An In-Network provider is a Provider contracted with and participating in the your dental or vision network. Your network includes Providers nationwide, including specialists, who have agreed to accept discounts on Plan covered vision services. They have also agreed to not balance bill a Member for the difference between their fee charged and the contracted fee paid to them by the Plan.

Limitations: A list of conditions or circumstances that limit or exclude services from this Policy. Limitations may be related to time or frequency (the number of services permitted during a stated period).

Maximum Allowable Amount: The maximum amount of reimbursement this Policy 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 Policy and the patient. This amount is shown on the notice that accompanies payment of the Claim.

Medically Necessary Contact Lenses: That adequate functional vision correction cannot be achieved with spectacles but can be achieved with contact lenses. Conditions that qualify for Medically Necessary Contact Lenses are:

1. Anisometropia of 3D in meridian powers;
2. High Ametropia exceeding -12D or +12D in meridian powers;
3. Keratoconus when vision is not correctable to 20/25 in either eye or both eyes using standard spectacle lenses; or
4. vision impairments, other than Keratoconus, when vision can be improved by two lines on the visual acuity chart when compared to best corrected standard spectacle lenses.

Member: A person covered under the Plan.

Non-Prescription Sunglasses: Vision Materials that provide protection from Ultra Violet (UV) rays; are prefabricated (ready-to-wear); and are supplied by a Provider. Non-Prescription Sunglasses do not include lab-created lenses.

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

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.

Out-of-Network Provider: A Dentist or Vision Center 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 Policy maximums, services the Policy does not cover and Covered Services for which the patient is not eligible.

Policy: The legal contract between HRI and the Subscriber being insured. That is this document.

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

Preferred Provider Organization (PPO): A network of Providers (dental or vision) within the service areas that have signed an agreement with HRI.

Premiums: The money billed and paid to HRI for each month of dental coverage.

Pre-Treatment Estimate: A non-binding estimate of the Benefits available and Patient Responsibility for a proposed treatment plan after the application of Policy Limitations, restrictions, and Exclusions, remaining Plan Annual Maximum and determination of Covered Services.

Provider: A licensed healthcare professional or vision center who is operating within the scope of their license.

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

Refraction: A test performed by a Provider to determine the glasses or contact lens prescription due to a refractive error (for example, nearsightedness, farsightedness, astigmatism or presbyopia).

Retinal Imaging Examination: Photographing portion(s) of or the complete retina surface and structures.

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: The person who pays for and is the primary contact for the Policy.

Summary of Dental Plan Benefits: A description of the specific provisions of Your coverage. The Summary of Dental Plan Benefits is and should be read as a part of this Policy. This Policy supersedes any contrary provision of the Summary of Dental Plan Benefits.

Vision Materials: Those materials provided for visual health and welfare shown in the Summary of Benefits used to aid in the correction of vision, including, but not limited to, lenses, lens options, frames and contact lenses.

Waiting Period for Policy Eligibility and For Covered Services: The stated period of time that a Member must be enrolled in the Policy 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 also apply to specific/individual procedures.