

SUMMARY OF DENTAL BENEFITS

HRI DENTAL & VISION

HRI DENTAL &VISION

MBR-FLD-A-1.2619-34 11-25

READ YOUR POLICY CAREFULLY. This Summary of Benefits provides only a brief outline of some of the important features of your policy. This cover sheet is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. IT IS THEREFORE IMPORTANT THAT YOU READ YOUR POLICY.

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

Summary of Dental Plan Benefits

This Summary of Dental Plan Benefits is provided by HRI Dental & Vision (HRI), for some of the more frequently performed dental procedures. This Summary of Dental Plan Benefits should be read along with your Plan Book. Your Plan Book provides additional information about your HRI plan, including plan exclusions and limitations. If a statement in this Summary of Dental Plan Benefits conflicts with a statement in the Certificate, the statement in this Summary of Dental Plan Benefits applies to you and you should ignore the conflicting statement in the Certificate.

Group Name: University of Southern Indiana

Group Number: 941101113602

Benefit Plan Year: Jan 2026 – Jan 2027

Plan Annual Maximum (for all services except for Orthodontic)	**$1350.00**
Deductible (waived for preventive and diagnostic services)	**$0**
Out of Network Benefit	**Fee Schedule**

Diagnostic & Preventative	In*	Out**
Teeth Cleaning (Prophylaxis)	100%	100%
Fluoride - Topical Application or Varnish	100%	100%
X-Rays - Bitewings; Vertical, Periapical, Full Mouth	100%	100%
Sealants	100%	100%
Space Maintainer: Fixed & Removable	100%	100%

Restorative	In*	Out**
Fillings - Silver/amalgam or White/composite (Anterior and Posterior Teeth	50%	50%
Crowns, Inlays, Onlays, Veneers, Post, Core Buildup, Recementation and Repairs	50%	50%

Endodontics	In*	Out**
Root Canal Therapy: Anterior, Posterior & Retreatments - Includes Periapical X-Rays, Cultures, Follow-Up Care, Treatments and Pulpotomy	50%	50%
Apexification, Apicoectomy, Retrograde Fillings	50%	50%
Other Endodontic Procedures	50%	50%

Periodontics	In*	Out**
Scaling & Root Planing and Periodontal Maintenance	50%	50%
Surgical Periodontics Including Gingivectomy, Gingivoplasty, Gingival Flap, Osseous and Clinical Crown Lengthening	50%	50%

Prosthodontics	In*	Out**
Prosthodontic Services - Bridges, Partial, and Complete Dentures	50%	50%

Relining, Rebasing, Repairs, Replacement of Teeth and Adjustments	50%	50%

Implants	In*	Out**
Implant Services Including Placement and Abutments and Other Related Services	0%	0%

Oral Surgery	In*	Out**
Simple Extractions	50%	50%
Surgical Extractions Including Impactions, Alveoloplasty, Vestibuloplasty and Other Surgical Procedures	50%	50%

Adjunctive/Other Services	In*	Out**
Emergency Palliative Treatment	50%	50%
Anesthesia - General and IV Sedation	50%	50%
Anesthesia - Nitrous	50%	50%
Athletic Mouthguards	50%	50%
Occlusal Guards	50%	50%
Other Adjunctive	0%	0%
Teledentistry	100%	100%

Orthodontic Services	In*	Out**
Orthodontic Services (Braces) - Child (Through Age 25)	50%	50%
Orthodontic Services (Braces) - Adult	50%	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. Therefore, your benefit dollars will go further and your out of pocket costs will likely be less when you visit a network dentist.

****Out of Network** dentists are under no obligation to accept contracted fees. When dental services are received from a non-contracted dentist, the percentages in this column indicate the portion of HRI Dental & Vision's nonparticipating dentist fee schedule (allowed amount) that will be paid for those services. This fee schedule allowed amount may be less than the dentist's charge and you will be responsible for that dollar difference and your co-insurance percentage.

- Oral evaluations (all procedure codes, including evaluations performed by a general dentist or specialist) are payable 2 time(s) in 12 consecutive months. Comprehensive Oral evaluations are payable every 4 years.
- A routine teeth cleaning (prophylaxis) is payable 2 time(s) per consecutive 12 months 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 is payable 2 time(s) per consecutive 12 months for all members or dependents.
- Fluoride varnish treatment is payable 2 time(s) per consecutive 12 Months for dependents under the age of 14.
- Bitewing x-rays are payable to a maximum of 4 films in a 12-Months-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.
- A core buildup will not be payable if performed within 2 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.
- Replacement of crowns and implant crowns are payable per tooth every 60 months or 5 years.
- Root canal treatment includes periapical x-rays, cultures, follow up care, treatments, pulpotomy are payable 1 time(s) per 4 Years.
- Periodontal maintenance is payable 2 times per 12-Month period.
- Full mouth debridement is payable once per 12 Months.
- A periodontal scaling and root planing (4 or more active periodontal diseased and qualified teeth) is payable once in any 3 Years 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.

- ❖ Sealants are payable 1 time(s) per 5 Years for permanent molar teeth only and for all members or dependents under 15 years of age or all members.
- ❖ A restoration (amalgam or resin-based composite) is payable once in any 24 Month period per tooth for anterior and posterior teeth.
- ❖ Implant related services are payable once per tooth in any 7 year period.
- ❖ Replacement of dentures, partial dentures, and fixed bridges are payable once per 5 Years.
- ❖ Teledentistry - 1 time(s) per 12 month period.

Deductible - $0.00 deductible per member, per Benefit Plan Year. Limited to a maximum deductible of $0.00 per family, per Benefit Plan Year. The deductible is waived for diagnostic and preventive services such as, routine cleanings, x-rays, sealants, space maintainers, or orthodontic services.

Plan Annual Maximum - $1350.00 per member per Benefit Plan Year on all services except Orthodontic Services.

Benefit Year - Enrollees and their dependents are required to remain enrolled in the Plan for a period of 12 months (Benefit Plan Year).
An election to participate may be revoked or changed at any time if such change is the result of a qualifying event as defined under the Internal Revenue Code Section 125. Your Employer will offer a period of time preceding each Benefit Plan Year called "Open Enrollment" whereby you will have the opportunity to continue or change participation or drop dental coverage for the next Benefit Plan Year.

Orthodontic Rider – Orthodontic Services paid at 50%. Your dentist will submit a treatment plan to us based upon your projected course of time in treatment. When treatment begins, your Plan will provide a fixed monthly payment to your dentist over a 24 month period equivalent to your plan benefit.

Orthodontic Lifetime Maximum - $1200.00 per member per lifetime on Orthodontic Services.

Eligibility - The subscriber (you) is eligible for dental benefits when your employer or organization notifies us. Also eligible at your option are your legal spouse (or domestic partner) and your children who meet the dependent age requirements. New hire waiting periods are given by the employer group.

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.

Out of Network Reimbursement will be based on proprietary fee schedules.

Insurance products are marketed and administered by HRI Dental & Vision HRI's plans are insured by Health Resources, Inc. with network management provided by Health Resources, 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.

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