dental health OPTIONS® by Health Resources, Inc.

**Plan:** 7

**InsuringSmiles.com**
**HRI Payor ID: CX019**
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# PLAN COVERED SERVICES & LIMITATIONS

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D0120 | PERIODIC ORAL EVALUATION-ESTABLISHED PATIENT | 100 / 100 |
| D0140 | LIMITED ORAL EVALUATION-PROBLEM FOCUSED | 100 / 100 |
| D0145 | ORAL EVALUATION FOR A PATIENT UNDER 3 YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER | 100 / 100 |
| D0150 | COMPREHENSIVE ORAL EVALUATION-NEW OR ESTABLISHED PATIENT | 100 / 100 |
| D0180 | COMPREHENSIVE PERIODONTAL EVALUATION-NEW OR ESTABLISHED PATIENT | 100 / 100 |
| D0210 | INTRAORAL-COMPLETE SERIES OF RADIOGRAPHIC IMAGES | 100 / 100 |
| D0220 | INTRAORAL-PERIAPICAL FIRST RADIOGRAPHIC IMAGE | 100 / 100 |
| D0230 | INTRAORAL-PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE | 100 / 100 |
| D0240 | INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE | 100 / 100 |
| D0270 | BITEWING-SINGLE RADIOGRAPHIC IMAGE | 100 / 100 |
| D0272 | BITEWINGS-TWO RADIOGRAPHIC IMAGES | 100 / 100 |
| D0273 | BITEWINGS-THREE RADIOGRAPHIC IMAGES | 100 / 100 |
| D0274 | BITEWINGS-FOUR RADIOGRAPHIC IMAGES | 100 / 100 |
| D0277 | VERTICAL BITEWINGS-7 TO 8 RADIOGRAPHIC IMAGES | 100 / 100 |
| D0330 | PANORAMIC RADIOGRAPHIC IMAGE | 100 / 100 |
| D0460 | PULP VITALITY TESTS | 100 / 100 |
| D1110 | PROPHYLAXIS-ADULT | 100 / 100 |
| D1120 | PROPHYLAXIS-CHILD | 100 / 100 |
| D1206 | TOPICAL APPLICATION OF FLUORIDE VARNISH | 100 / 100 |
| D1208 | TOPICAL APPLICATION OF FLUORIDE-EXCLUDING VARNISH | 100 / 100 |
| D1351 | SEALANT-PER TOOTH (PERMANENT MOLAR TEETH) | 100 / 100 |
| D1510 | SPACE MAINTAINER-FIXED, UNILATERAL - PER QUADRANT | 80 / 80 |
| D1516 | SPACE MAINTAINER-FIXED-BILATERAL,MAXILLARY | 80 / 80 |
| D1517 | SPACE MAINTAINER-FIXED-BILATERAL,MANDIBULAR | 80 / 80 |
| D1526 | SPACE MAINTAINER-REMOVABLE-BILATERAL,MAXILLARY | 80 / 80 |
| D1527 | SPACE MAINTAINER-REMOVABLE-BILATERAL,MANDIBULAR | 80 / 80 |
| D1551 | RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER - MAXILLARY | 80 / 80 |
| D1552 | RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER - MANDIBULAR | 80 / 80 |
| D1553 | RE-CEMENT OR RE-BOND UNILATERAL SPACE MAINTAINER - PER QUADRANT | 80 / 80 |
| D1575 | DISTAL SHOE SPACE MAINTAINER - FIXED, UNILATERAL - PER QUADRANT | 80 / 80 |
| D2140 | AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT | 80 / 80 |
| D2150 | AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT | 80 / 80 |
| D2160 | AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT | 80 / 80 |
| D2161 | AMALGAM-FOUR OR MORE SURFACES, PRIMARY OR PERMANENT | 80 / 80 |
| D2330 | RESIN-BASED COMPOSITE-ONE SURFACE, ANTERIOR | 80 / 80 |
| D2331 | RESIN-BASED COMPOSITE-TWO SURFACES, ANTERIOR | 80 / 80 |

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D5630 | REPAIR OR REPLACE BROKEN CLASP-PER TOOTH | 80 / 80 |
| D5640 | REPLACE BROKEN TEETH-PER TOOTH | 80 / 80 |
| D5650 | ADD TOOTH TO EXISTING PARTIAL DENTURE | 80 / 80 |
| D5660 | ADD CLASP TO EXISTING PARTIAL DENTURE PER TOOTH | 80 / 80 |
| D5670 | REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY) | 80 / 80 |
| D5671 | REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR) | 80 / 80 |
| D5710 | REBASE COMPLETE MAXILLARY DENTURE | 50 / 50 |
| D5711 | REBASE COMPLETE MANDIBULAR DENTURE | 50 / 50 |
| D5720 | REBASE MAXILLARY PARTIAL DENTURE | 50 / 50 |
| D5721 | REBASE MANDIBULAR PARTIAL DENTURE | 50 / 50 |
| D5730 | RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE) | 50 / 50 |
| D5731 | RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE) | 50 / 50 |
| D5740 | RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE) | 50 / 50 |
| D5741 | RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE) | 50 / 50 |
| D5750 | RELINE COMPLETE MAXILLARY DENTURE (LABORATORY) | 50 / 50 |
| D5751 | RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY) | 50 / 50 |
| D5760 | RELINE MAXILLARY PARTIAL DENTURE (LABORATORY) | 50 / 50 |
| D5761 | RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY) | 50 / 50 |
| D5820 | INTERIM PARTIAL DENTURE (MAXILLARY) | 50 / 50 |
| D5821 | INTERIM PARTIAL DENTURE (MANDIBULAR) | 50 / 50 |
| D5850 | TISSUE CONDITIONING, MAXILLARY | 50 / 50 |
| D5851 | TISSUE CONDITIONING, MANDIBULAR | 50 / 50 |
| D5863 | OVERDENTURE-COMPLETE MAXILLARY | 50 / 50 |
| D5864 | OVERDENTURE-PARTIAL MAXILLARY | 50 / 50 |
| D5865 | OVERDENTURE-COMPLETE MANDIBULAR | 50 / 50 |
| D5866 | OVERDENTURE-PARTIAL MANDIBULAR | 50 / 50 |
| D6058 | ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN | 50 / 50 |
| D6059 | ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL) | 50 / 50 |
| D6060 | ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINANTLY BASE METAL) | 50 / 50 |
| D6061 | ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL) | 50 / 50 |
| D6062 | ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL) | 50 / 50 |
| D6063 | ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINANTLY BASE METAL) | 50 / 50 |
| D6064 | ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL) | 50 / 50 |
| D6065 | IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN | 50 / 50 |
| D6066 | IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS | 50 / 50 |
| D6067 | IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS | 50 / 50 |
| D6068 | ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD | 50 / 50 |
| D6069 | ABUTMENT SUPPORTED RETAINER FOR | 50 / 50 |

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| D2332 | RESIN-BASED COMPOSITE-THREE SURFACES, ANTERIOR | 80 / 80 |
| D2335 | RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR) | 80 / 80 |
| D2390 | RESIN-BASED COMPOSITE CROWN, ANTERIOR (PRIMARY ONLY) | 80 / 80 |
| D2391 | RESIN-BASED COMPOSITE-ONE SURFACE, POSTERIOR | 80 / 80 |
| D2392 | RESIN-BASED COMPOSITE-TWO SURFACES, POSTERIOR | 80 / 80 |
| D2393 | RESIN-BASED COMPOSITE-THREE SURFACES, POSTERIOR | 80 / 80 |
| D2394 | RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES, POSTERIOR | 80 / 80 |
| D2520 | INLAY-METALLIC-TWO SURFACES | 50 / 50 |
| D2530 | INLAY-METALLIC-THREE OR MORE SURFACES | 50 / 50 |
| D2542 | ONLAY-METALLIC-TWO SURFACES | 50 / 50 |
| D2543 | ONLAY-METALLIC-THREE SURFACES | 50 / 50 |
| D2544 | ONLAY-METALLIC-FOUR OR MORE SURFACES | 50 / 50 |
| D2610 | INLAY-PORCELAIN/CERAMIC-ONE SURFACE | 50 / 50 |
| D2620 | INLAY-PORCELAIN/CERAMIC-TWO SURFACES | 50 / 50 |
| D2630 | INLAY-PORCELAIN/CERAMIC-THREE OR MORE SURFACES | 50 / 50 |
| D2642 | ONLAY-PORCELAIN/CERAMIC-TWO SURFACES | 50 / 50 |
| D2643 | ONLAY-PORCELAIN/CERAMIC-THREE SURFACES | 50 / 50 |
| D2644 | ONLAY-PORCELAIN/CERAMIC-FOUR OR MORE SURFACES | 50 / 50 |
| D2651 | INLAY-RESIN-BASED COMPOSITE-TWO SURFACES | 50 / 50 |
| D2652 | INLAY-RESIN-BASED COMPOSITE-THREE OR MORE SURFACES | 50 / 50 |
| D2663 | ONLAY-RESIN-BASED COMPOSITE-THREE SURFACES | 50 / 50 |
| D2664 | ONLAY-RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES | 50 / 50 |
| D2710 | CROWN-RESIN-BASED COMPOSITE (INDIRECT) | 50 / 50 |
| D2740 | CROWN-PORCELAIN/CERAMIC SUBSTRATE | 50 / 50 |
| D2750 | CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL | 50 / 50 |
| D2751 | CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL | 50 / 50 |
| D2752 | CROWN-PORCELAIN FUSED TO NOBLE METAL | 50 / 50 |
| D2753 | CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | 50 / 50 |
| D2780 | CROWN-3/4 CAST HIGH NOBLE METAL | 50 / 50 |
| D2781 | CROWN-3/4 CAST PREDOMINANTLY BASE METAL | 50 / 50 |
| D2782 | CROWN-3/4 CAST NOBLE METAL | 50 / 50 |
| D2783 | CROWN-3/4 PORCELAIN/CERAMIC | 50 / 50 |
| D2790 | CROWN-FULL CAST HIGH NOBLE METAL | 50 / 50 |
| D2791 | CROWN-FULL CAST PREDOMINANTLY BASE METAL | 50 / 50 |
| D2792 | CROWN-FULL CAST NOBLE METAL | 50 / 50 |
| D2794 | CROWN-TITANIUM AND TITANIUM ALLOYS | 50 / 50 |
| D2910 | RE-CEMENT OR RE-BOND INLAY, ONLAY, VENEER OR PARTIAL COVERAGE RESTORATION | 80 / 80 |
| D2915 | RE-CEMENT OR RE-BOND INDIRECTLY FABRICATED OR PREFABRICATED POST AND CORE | 80 / 80 |
| D2920 | RE-CEMENT OR RE-BOND CROWN | 80 / 80 |
| D2930 | PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH | 50 / 50 |
| D2931 | PREFABRICATED STAINLESS STEEL CROWN-PERMANENT TOOTH | 50 / 50 |
| D2933 | PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW (PRIMARY TOOTH) | 50 / 50 |
| D2934 | PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN-PRIMARY TOOTH | 50 / 50 |
| D2940 | PROTECTIVE RESTORATION | 80 / 80 |
| D2950 | CORE BUILDUP, INCLUDING ANY PINS WHEN REQUIRED | 50 / 50 |
| D2951 | PIN RETENTION, PER TOOTH, IN ADDITION TO | 80 / 80 |

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| | PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL) | |
| D6070 | ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINANTLY BASE METAL) | 50 / 50 |
| D6071 | ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL) | 50 / 50 |
| D6072 | ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL) | 50 / 50 |
| D6073 | ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINANTLY BASE METAL) | 50 / 50 |
| D6074 | ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL) | 50 / 50 |
| D6075 | IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD | 50 / 50 |
| D6076 | IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO HIGH NOBLE ALLOYS | 50 / 50 |
| D6077 | IMPLANT SUPPORTED RETAINER FOR METAL FPD - HIGH NOBLE ALLOYS | 50 / 50 |
| D6082 | IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS | 50 / 50 |
| D6083 | IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO NOBLE ALLOYS | 50 / 50 |
| D6084 | IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | 50 / 50 |
| D6086 | IMPLANT SUPPORTED CROWN - PREDOMINANTLY BASE ALLOYS | 50 / 50 |
| D6087 | IMPLANT SUPPORTED CROWN - NOBLE ALLOYS | 50 / 50 |
| D6088 | IMPLANT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS | 50 / 50 |
| D6092 | RE-CEMENT RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN | 80 / 80 |
| D6094 | ABUTMENT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS | 50 / 50 |
| D6097 | ABUTMENT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | 50 / 50 |
| D6098 | IMPLANT SUPPORTED RETAINER - PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS | 50 / 50 |
| D6099 | IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO NOBLE ALLOYS | 50 / 50 |
| D6110 | IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH-MAXILLARY | 50 / 50 |
| D6111 | IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH-MANDIBULAR | 50 / 50 |
| D6112 | IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH-MAXILLARY | 50 / 50 |
| D6113 | IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH-MANDIBULAR | 50 / 50 |
| D6114 | IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH-MAXILLARY | 50 / 50 |
| D6115 | IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH-MANDIBULAR | 50 / 50 |
| D6116 | IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH-MAXILLARY | 50 / 50 |
| D6117 | IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH-MANDIBULAR | 50 / 50 |
| D6120 | IMPLANT SUPPORTED RETAINER - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | 50 / 50 |
| D6194 | ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS | 50 / 50 |
| D6195 | ABUTMENT SUPPORTED RETAINER - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | 50 / 50 |
| D6210 | PONTIC-CAST HIGH NOBLE METAL | 50 / 50 |
| D6211 | PONTIC-CAST PREDOMINANTLY BASE METAL | 50 / 50 |
| D6212 | PONTIC-CAST NOBLE METAL | 50 / 50 |
| D6214 | PONTIC-TITANIUM AND TITANIUM ALLOYS | 50 / 50 |

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| | RESTORATION | |
| D2952 | POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED | 50 / 50 |
| D2954 | PREFABRICATED POST AND CORE IN ADDITION TO CROWN | 50 / 50 |
| D3220 | THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION)-REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION OF MEDICAMENT | 80 / 80 |
| D3230 | PULPAL THERAPY (RESORBABLE FILLING)-ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION) | 80 / 80 |
| D3240 | PULPAL THERAPY (RESORBABLE FILLING)-POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION) | 80 / 80 |
| D3310 | ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION) | 80 / 80 |
| D3320 | ENDODONTIC THERAPY, BICUSPID TOOTH (EXCLUDING FINAL RESTORATION) | 80 / 80 |
| D3330 | ENDODONTIC THERAPY, MOLAR (EXCLUDING FINAL RESTORATION) | 80 / 80 |
| D3351 | APEXIFICATION/RECALCIFICATION-INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC) | 80 / 80 |
| D3352 | APEXIFICATION/RECALCIFICATION-INTERIM MEDICATION REPLACEMENT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, PULP SPACE DISINFECTION, ETC) | 80 / 80 |
| D3353 | APEXIFICATION/RECALCIFICATION-FINAL VISIT (INCLUDES COMPLETED ROOT CANAL THERAPY-APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC) | 80 / 80 |
| D3410 | APICOECTOMY-ANTERIOR | 80 / 80 |
| D3421 | APICOECTOMY-BICUSPID (FIRST ROOT) | 80 / 80 |
| D3425 | APICOECTOMY - MOLAR (FIRST ROOT) | 80 / 80 |
| D3426 | APICOECTOMY (EACH ADDITIONAL ROOT) | 80 / 80 |
| D3430 | RETROGRADE FILLING-PER ROOT | 80 / 80 |
| D3450 | ROOT AMPUTATION-PER ROOT | 80 / 80 |
| D4210 | GINGIVECTOMY OR GINGIVOPLASTY-FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT | 80 / 80 |
| D4260 | OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE)-FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT | 80 / 80 |
| D4261 | OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE)-ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT | 80 / 80 |
| D4273 | AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURGICAL SITES) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT | 80 / 80 |
| D4275 | NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT (INCLUDING RECIPIENT SITE AND DONOR MATERIAL) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT | 80 / 80 |
| D4283 | AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURGICAL SITES)-EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE | 80 / 80 |
| D4285 | NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT SURGICAL SITE AND DONOR MATERIAL)-EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE | 80 / 80 |
| D4341 | PERIODONTAL SCALING AND ROOT PLANING-FOUR OR MORE TEETH PER QUADRANT (4 TEETH WITH 4+MM POCKETS) | 80 / 80 |
| D4346 | SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION - FULL MOUTH, AFTER ORAL EVALUATION | 80 / 80 |

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| D6240 | PONTIC-PORCELAIN FUSED TO HIGH NOBLE METAL | 50 / 50 |
| D6241 | PONTIC-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL | 50 / 50 |
| D6242 | PONTIC-PORCELAIN FUSED TO NOBLE METAL | 50 / 50 |
| D6243 | PONTIC - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | 50 / 50 |
| D6245 | PONTIC-PORCELAIN/CERAMIC | 50 / 50 |
| D6545 | RETAINER-CAST METAL FOR RESIN BONDED FIXED PROSTHESIS | 50 / 50 |
| D6548 | RETAINER-PORCELAIN/CERAMIC FOR RESIN BONDED FIXED PROSTHESIS | 50 / 50 |
| D6740 | RETAINER CROWN - PORCELAIN/CERAMIC | 50 / 50 |
| D6750 | RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL | 50 / 50 |
| D6751 | RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL | 50 / 50 |
| D6752 | RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL | 50 / 50 |
| D6753 | RETAINER CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | 50 / 50 |
| D6780 | RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL | 50 / 50 |
| D6781 | RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL | 50 / 50 |
| D6782 | RETAINER CROWN - 3/4 CAST NOBLE METAL | 50 / 50 |
| D6783 | RETAINER CROWN - 3/4 PORCELAIN/CERAMIC | 50 / 50 |
| D6784 | RETAINER CROWN 3/4 - TITANIUM AND TITANIUM ALLOYS | 50 / 50 |
| D6790 | RETAINER CROWN - FULL CAST HIGH NOBLE METAL | 50 / 50 |
| D6791 | RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL | 50 / 50 |
| D6792 | RETAINER CROWN - FULL CAST NOBLE METAL | 50 / 50 |
| D6794 | RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS | 50 / 50 |
| D6930 | RE-CEMENT OR RE-BOND FIXED PARTIAL DENTURE | 80 / 80 |
| D7111 | EXTRACTION, CORONAL REMNANTS-DECIDUOUS TOOTH | 80 / 80 |
| D7140 | EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL) | 80 / 80 |
| D7210 | SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED | 80 / 80 |
| D7220 | REMOVAL OF IMPACTED TOOTH-SOFT TISSUE | 80 / 80 |
| D7230 | REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY | 80 / 80 |
| D7240 | REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY | 80 / 80 |
| D7241 | REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS | 80 / 80 |
| D7250 | SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE) | 80 / 80 |
| D7251 | CORONECTOMY - INTENTIONAL PARTIAL TOOTH REMOVAL | 80 / 80 |
| D7270 | TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH | 80 / 80 |
| D7286 | INCISIONAL BIOPSY OF ORAL TISSUE-SOFT | 100 / 100 |
| D7310 | ALVEOLOPLASTY IN CONJUCTION WITH EXTRACTIONS-FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT | 80 / 80 |
| D7311 | ALVEOLOPLASTY IN CONJUCTION WITH EXTRACTIONS-ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT | 80 / 80 |
| D7320 | ALVEOLOPLASTY NOT IN CONJUCTION WITH EXTRACTIONS-FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT | 80 / 80 |
| D7321 | ALVEOLOPLASTY NOT IN CONJUCTION WITH EXTRACTIONS-ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT | 80 / 80 |

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| D4355 | FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS | 80 / 80 |
| D4910 | PERIODONTAL MAINTENANCE | 80 / 80 |
| D5110 | COMPLETE DENTURE-MAXILLARY | 50 / 50 |
| D5120 | COMPLETE DENTURE-MANDIBULAR | 50 / 50 |
| D5130 | IMMEDIATE DENTURE-MAXILLARY | 50 / 50 |
| D5140 | IMMEDIATE DENTURE-MANDIBULAR | 50 / 50 |
| D5211 | MAXILLARY PARTIAL DENTURE-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH) | 50 / 50 |
| D5212 | MANDIBULAR PARTIAL DENTURE-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH) | 50 / 50 |
| D5213 | MAXILLARY PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) | 50 / 50 |
| D5214 | MANDIBULAR PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) | 50 / 50 |
| D5221 | IMMEDIATE MAXILLARY PARTIAL DENTURE-RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) | 50 / 50 |
| D5222 | IMMEDIATE MANDIBULAR PARTIAL DENTURE-RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) | 50 / 50 |
| D5223 | IMMEDIATE MAXILLARY PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) | 50 / 50 |
| D5224 | IMMEDIATE MANDIBULAR PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) | 50 / 50 |
| D5225 | MAXILLARY PARTIAL DENTURE-FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH) | 50 / 50 |
| D5226 | MANDIBULAR PARTIAL DENTURE-FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH) | 50 / 50 |
| D5511 | REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR | 80 / 80 |
| D5512 | REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY | 80 / 80 |
| D5520 | REPLACE MISSING OR BROKEN TEETH-COMPLETE DENTURE (EACH TOOTH) | 80 / 80 |
| D5611 | REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR | 80 / 80 |
| D5612 | REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY | 80 / 80 |
| D5621 | REPAIR CAST PARTIAL FRAMEWORK, MANDIBULAR | 80 / 80 |
| D5622 | REPAIR CAST PARTIAL FRAMEWORK, MAXILLARY | 80 / 80 |
| D7340 | VESTIBULOPLASTY-RIDGE EXTENSION (SECONDARY EPITHELIALIZATION) | 80 / 80 |
| D7350 | VESTIBULOPLASTY-RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT AND MANAGEMENT OF HYPERTROPHIED AND HYPERPLASTIC TISSUE) | 80 / 80 |
| D7410 | EXCISION OF BENIGN LESION UP TO 1.25 CM | 80 / 80 |
| D7411 | EXCISION OF BENIGN LESION GREATER THAN 1.25 CM | 80 / 80 |
| D7450 | REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER UP TO 1.25 CM | 80 / 80 |
| D7451 | REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER GREATER THAN 1.25 CM | 80 / 80 |
| D7471 | REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE) | 80 / 80 |
| D7472 | REMOVAL OF TORUS PALATINUS | 80 / 80 |
| D7473 | REMOVAL OF TORUS MANDIBULARIS | 80 / 80 |
| D7510 | INCISION AND DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE | 80 / 80 |
| D7511 | INCISION AND DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE-COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES) | 80 / 80 |
| D7922 | PLACEMENT OF INTRA-SOCKET BIOLOGICAL DRESSING TO AID IN THE HEMOSTASIS OR CLOT STABILIZATION, PER SITE | 80 / 80 |
| D7960 | FRENULECTOMY | 80 / 80 |
| D7970 | EXCISION OF HYPERPLASTIC TISSUE-PER ARCH | 80 / 80 |
| D7971 | EXCISION OF PERICORONAL GINGIVA | 80 / 80 |
| D7980 | SIALOLITHOTOMY | 80 / 80 |
| D9110 | PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN-MINOR PROCEDURE | 100 / 100 |
| D9222 | DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES | 80 / 80 |
| D9223 | DEEP SEDATION/GENERAL ANESTHESIA – EACH SUBSEQUENT 15 MINUTE INCREMENT | 80 / 80 |
| D9230 | INHALATION OF NITROUS OXIDE/ANALGESIA, ANXIOLYSIS (PER VISIT) | 50 / 50 |
| D9239 | INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - FIRST 15 MINUTES | 80 / 80 |
| D9243 | INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA – EACH SUBSEQUENT 15 MINUTE INCREMENT | 80 / 80 |

**PLAN GENERAL EXCLUSIONS, LIMITATIONS AND RESTRICTIONS**, including provider supporting documentation requirements

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

| ADA Range | Provider Rule |
|---|---|
| D0120, D0145 | Evaluations - Not eligible for more than two evaluations, of any procedure code combination, within any consecutive 12 month period. |
| D0140 | An evaluation limited to a specific oral health problem or complaint. The use of this procedure code is also appropriate in dental emergencies, trauma, acute infection, etc. Evaluations - Not eligible for more than two evaluations, of any procedure code combination, within any consecutive 12 month period. |
| D0150, D0180 | Eligible only once every 4 years. D0180 applies to age 14 and above. Charges will be disallowed if performed in conjunction with D4355. Evaluations - Not eligible for more than two evaluations, of any procedure code combination, within any consecutive 12 month period. |
| D0210 | A complete series includes bitewings. Eligible only once per 4 years. Not eligible if performed within 4 years of D0330. If D0210 is performed within 12 months of D0270, D0272, D0273, D0274 the allowable amount for D0210 will be reduced by the charges for D0270, D0272, D0273, D0274. Not eligible if performed within 12 months of D0277. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. |
| D0220, D0230 | Eligible for a maximum of 3 during a 12 month period. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. |
| D0240 | Eligible only once per arch per 12 months. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. |
| D0270, D0274 | “Bitewing” radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210 or D0277. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. “Bitewing” radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210 or D0277. |
| D0272, D0273 | Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. “Bitewing” radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210 or D0277. |
| D0277 | Not eligible if performed within 12 months of D0210 or D0274. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. |
| D0330 | Eligible only once per 4 years. Not eligible if performed within 4 years of D0210. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. |
| D0460 | Eligible for one charge per date of service. |
| D1110, D1120 | Not eligible if performed within 6 months of or same date of service as D1110, D1120, D4341 if four quadrants were treated, D4346, D4355, or D4910. Reimbursement for D1120 is limited to enrollees under the age of 14. |
| D1206, D1208 | Eligible only for children under 14 years of age and only once per 6 months. |
| D1351 | Eligible on permanent molar teeth (per tooth) only. Not eligible for replacement for a period of 5 years. Eligible only for children under 15 years of age. Not eligible for a restoration on the O, OB, or OL surfaces following the placement of a sealant on that surface or if a restoration involving the O surfaces has been performed for a period of 3 years. |
| D1510, D1515, D1516, D1517, D1525, D1526, D1527, D1575 | Eligible only for children under 13 years of age. Not eligible if performed within 3 years of D1510, D1515, D1520, D1525, or D1575. |
| D1550, D1551, D1552, D1553 | Not eligible within 12 months of the initial placement of the space maintainer. Eligible once per 12 months. |
| D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394 | Not eligible for the replacement of or an additional restoration on the same surface for a period of 3 years. Not eligible if performed within 3 years of placing a crown on the same tooth or a sealant on the same surface within 3 years. If two or more restorations are performed on the same tooth, on the same date of service, only the total number of unique surfaces will be considered. |
| D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2651, D2652, D2663, D2664, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794 | Not eligible for a replacement by any type of inlay, onlay, or crown for 7 years. A charge for a crown following the placement of a restoration is not eligible for a period of 3 years (a courtesy adjustment may be applied). Crowns, other than prefabricated steel crowns, are not eligible for primary teeth. Composite/resin inlays must be laboratory processed. |
| D2710 | Eligible on anterior teeth only. Not eligible for a replacement by any type of inlay, onlay, or crown for 7 years. A charge for a crown following the placement of a restoration is not eligible for a period of 3 years (a courtesy adjustment may be applied). Crowns, other than prefabricated steel crowns, are not eligible for primary teeth. Composite/resin inlays must be laboratory processed. |
| D2910, D2915, D2920, D6092 | Not eligible for the recementation of an inlay, onlay, or crown within 12 months of the original cementation. Eligible once per 12 months. |
| D2930, D2931, D2933, D2934 | Charges are subject to the same restrictions and conditions as D2520 through D2794. |

| | |
|---|---|
| D2940 | Not eligible for replacement by another protective restoration for a period of 3 years. Not eligible if performed in conjunction with endodontics, an amalgam/composite restoration, inlay, onlay, crown, or fixed prosthesis retainer prepared or cemented at the same appointment. Charges for definitive treatment are subject to an adjustment if performed within 12 months of D2940. |
| D2950 | Not eligible within 3 years of restoration and/or replacement within 7 years on the same tooth. Coverage for core buildups requires the submission of a duplicate, diagnostically acceptable, pre-operative radiographic image or intraoral photo that substantiates one of the following three criteria: 1) more than 50% of the tooth crown is missing due to fracture or decay; 2) less than 3 mm of sound tooth structure remaining around the gum line; 3) previous root canal filling completed except where a prior crown through which the access is made remains on the tooth. Charges not meeting established criteria will be disallowed. |
| D2951 | Charge is per tooth and limited to posterior teeth only. Additional pins will be disallowed. |
| D2952, D2954 | Not eligible if performed within 7 years of D2950, D2952, or D2954. Eligible once per 7 years per tooth. Not allowable without history of root canal therapy. |
| D3220 | Eligible for primary teeth only and only once per tooth. Charges are exclusive of the final restoration charge. |
| D3230, D3240 | Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. Separate fees for radiographs are disallowed. Charges are exclusive of the final restoration charge. Charges for "elective" root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment. |
| D3310, D3320, D3330 | Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. A single periapical will be considered however, fees for any additional radiographs will be disallowed. Charges are exclusive of the final restoration charge. Charges for "elective" root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment. |
| D3351, D3352, D3353 | Limited to children under 16 years of age. Eligible once per lifetime. Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. A single periapical will be considered however, fees for any additional radiographs will be disallowed. Charges are exclusive of the final restoration charge. Charges for "elective" root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment. |
| D3410, D3421, D3425, D3426, D3430, D3450 | Eligible once per lifetime. |
| D4210, D4260, D4261 | Eligible only once per area treated for a 5 year period. |
| D4273, D4275 | Two soft tissue grafts of any type are eligible per quadrant every 5 years. Teeth #24-25 are considered one site. Eligible only once per area treated for a 5 year period. |
| D4283, D4285 | Two soft tissue grafts of any type are eligible per quadrant every 5 years. Teeth #24-25 are considered one site. |
| D4341 | Eligible per quadrant (4 or more active periodontal diseased and qualified teeth). The enrollee must exhibit periodontal disease showing loss of clinical attachment and bone loss. Otherwise refer to D1110 and D4355. Not eligible on deciduous teeth. Not eligible for retreatment of any quadrant for 3 years. Charges require the submission of full mouth probe chart with six points per tooth probings AND diagnostic full mouth radiographs and/or vertical bitewings. Only two quadrants are considered on the same date of service, additional quadrants will be disallowed. Separate charges for local anesthetic are disallowed. A D1110 cannot be charged within 6 months if 4 quadrants of D4341/D4342 are performed. Charges not meeting established criteria will be disallowed. A pretreatment is suggested. Dental Review Team maintains discretionary authority regarding review requirements. |
| D4346 | Eligible only for enrollees over 15 years of age. Eligible once per 5 years. Not eligible within 6 months of or same date of service as D1110, D1120, D4341/D4342 (quadrant allottment may apply), D4355, or D4910. |
| D4355 | Eligible only for enrollees over 15 years of age. To be eligible, procedure must be performed before and not on the same date of service as D1110, D4341, D4342, D4346, or D4910, or more than 3 years has lapsed since D1110, D4341, D4342, D4346, D4355, or D4910 was performed. |
| D4910 | Not eligible if performed within 6 months of or same date of service as D1110, D1120, D4341, D4342, D4346 or D4355. Eligible once per 6 months. Eligible only for enrollees over 15 years of age. |
| D5110, D5120 | Not eligible for the replacement of a denture, including an immediate or partial denture, within 7 years. Separate charges for diagnostic casts (D0470) are disallowed. Charges for a conventional, removable partial dentures or a complete denture (D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, and D5226) are subject to an adjustment if performed within 5 years of an interim partial denture (D5820 & D5821) in the same arch or of any repairs, relines, rebases (D5510 through D5761). |
| D5130, D5140 | An immediate denture cannot be used to replace a complete denture. Other restrictions are the same as D5110 & D5120. |
| D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226 | Eligible every 7 years and are subject to the same conditions and restrictions listed for D5110 & D5120. Separate charges for diagnostic casts (D0470) are disallowed. The teeth replaced by the appliance must be identified on the claim form. |
| D5510, D5511, D5512, D5520, D5610, D5611, D5612, D5620, D5621, D5622, D5630, D5640, D5650, D5660 | Not eligible if the procedure is performed within 6 months of the date of delivery of the appliance. Eligible once per procedure code per 6 months. |
| D5670, D5671 | Eligible only once per 4 years per prosthesis. Not eligible if performed within 4 years of D5213 or D5214. Not eligible for charges for rebase, reline or repairs for 6 months. |
| D5710, D5711, D5720, D5721, D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761 | Not eligible within 6 months of the date of delivery of the appliance except when an immediate partial/denture is performed. Eligible for any of these procedures only once per 4 years per prosthesis. |
| D5820, D5821 | Charges for a conventional, removable partial dentures or a complete denture (D5110, D5120, D5130, D5140, D5211, D5212, D5213, |

**Visit Health Resources, Inc. Online 24 hours a day/7 days a week at InsuringSmiles.com**

**Contact Member Services**
**Health Resources, Inc.**
**(7:30 am – 5:00 pm CST Monday through Friday) 800.727.1444 press 9**
**P.O. Box 659, Evansville, IN 47704-0659**

# DENTAL ONLY CERTIFICATE OF INSURANCE

**TABLE OF CONTENTS**


Certificate of Coverage .......... 2
Eligibility .......... 3
Initial, Open, and Special Enrollment .......... 3
Receiving Dental Care-Selection of Your Network Dentist .......... 3
Plan Features .......... 4
General Exclusions .......... 5
Web Services .......... 6
Coordination of Benefits .......... 6
Arranging for Payment .......... 8
Appeal Procedures .......... 9
Notice of Privacy Practices .......... 9
Termination of Coverage .......... 11
Continuation Coverage (COBRA) .......... 11
ERISA .......... 12
Important Notice .......... 14
Definitions .......... 16
Schedule of Benefits .......... 18


Online materials serve as the primary source of information for groups, Members, dentists and advisers. Any printed documents that You may have is based on information at a certain point in time and may not be inclusive of all benefits, restrictions and limitations. All documents may also be requested by writing the Company at the address above.

**Affordable Care Act Pediatric Essential Health Benefit: This Certificate does not meet minimal essential coverage requirements for pediatric dental services as part of the Essential Health Benefits in accordance with the Affordable Care Act (ACA) provisions.**

## READ YOUR CERTIFICATE CAREFULLY!

**Welcome!**

Thank you for enrolling in Dental Health Options (DHO) by Health Resources Inc. (HRI)! Oral health is a vital part of overall health, and it is Our pleasure to be included in Your wellness culture. HRI collaborates with the dental profession to design dental plans that promote oral health care along the most cost-effective path. As any dental care professional will attest, the key to avoiding costly dental problems is prevention.

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

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

Our mission statement is, "To offer dental plans that help improve the dental health of the public." Since 1986, that is exactly what We have delivered to Our Members. We look forward to continuing that promise to Our customers.

Sincerely,
***Terry Bawel***
***President***

**CERTIFICATE OF COVERAGE**

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

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

- The Group Policy
- The Schedule of Benefits
- Riders
- Amendments

Specific selection of the Policy is stated on Your Member card and details of the covered benefits may be found in the Master Group Policy or in Your Certificate. If there is a conflict in the terms and conditions of the Certificate and the Master Group Policy, the terms of the Master Group Policy shall control the relationship of the parties. You may obtain a copy of the Master Group Policy from Your Employer by sending Your Employer a written request.

## ELIGIBILITY

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

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

### Initial Enrollment

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

### Open Enrollment

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

### Special Enrollment

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

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

### Qualified Medical Child Support Order (QMCSO)

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

### Extended Coverage for a Dependent Child

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

To request special enrollment or obtain more information, contact your Benefits Administrator or HRI member services at the address listed on page 1.

## RECEIVING DENTAL CARE – SELECTION OF YOUR DENTIST

Dentistry is a highly personal service. You may have any dental treatment performed as decided by You and Your dentist. The Master Group Policy does not dictate what treatment You receive. Only You and Your dentist can determine that. However, The Master Group Policy does determine what services are covered and by what type of dentist (In-Network vs. Out-of-Network). The Master Group Policy option selected by Your Employer pays for only those Covered Services under Your Dental Health Option Plan listed in this booklet within the Limitations and restrictions presented. You must personally pay for any service which is not covered or for any service that is covered but is subject to Limitations and restrictions. Your Claim will only be processed after completion of the dental service. If You are not sure whether a particular dental treatment is covered or how much You will be required to pay, You may request a Pre-Treatment Estimate from Your dentist. It is a free service offered by Your Master Group Policy.

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

The Master Group Policy 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 Dental Health Options and leased Networks included in Your Certificate.. Network Dentists provide the same excellent service at a contracted fee, resulting in savings for You and Your family.

Your Employer has selected the Master Group Policy option as well as Your Network option. You should verify the Network option selected by Your Employer prior to Your dental visit as it makes a difference in Your savings. Network Dentists are independent contractors and are not HRI employees.

**Network Plan Options:**

1. **In-Network Plan Option**

   HRI's best rates are reserved for in-network providers. It is an affordable, Network-only plan, offering strong cost savings and no Balance Billing to Members. Under this Network plan option, You must visit a dentist participating in the Network to receive Benefits. Benefits will be denied if You do not visit a Network Dentist. Remember, a Network Dentist is a dentist contracted with and participating in either the Dental Health Option or a leased Network. The Network includes more than 95,000 Network Dentists nationwide, including specialists, who have agreed to accept discounts on Your covered dental services. They have also agreed not to balance bill You for the difference between their Fee Charged and the contracted fee paid to them. Confirm if Your dentist is participating in the Network or consider if You are willing to change dental providers prior to enrolling for this dental plan. Remember, this is an In- Network only program. Visit the Find a Dentist link on [InsuringSmiles.com] to review a listing of Network Dentists' services.

2. **In-Network and Out-of-Network Plan Option**

   This option is a flexible plan that offers the payment of Benefits to either an In-Network Dentist or an Out-of-Network Dentist. You have the freedom to visit any dentist of Your choice. However, Your dentist choice can make a difference in the amount You pay. Choosing a dentist in the Network results in greater cost savings to You and less out of pocket costs. Any differences between the Network Dentist's actual charges and the contracted maximum allowed amount MAY NOT be balanced billed to You. The Network Dentist is required to adjust his/her bill for this difference. This is referred to as "no Balance Billing", so You benefit from Our negotiated savings. As an added convenience, when You visit a Network Dentist, the dentist files the Claim for You and the Company pays the dentist directly.

   Out-of-Network Dentists are under no obligation to file Claims on your behalf, assist with Your insurance benefits, or accept contracted fees. Unless otherwise specified, reimbursement for services not provided by a Network Dentist will be paid upon a scheduled table of allowances. There may be a payment difference between the allowed reimbursement and the amount the dentist charges for a particular service, which could result in greater out of pocket costs for You. This amount may be significant. This is referred to as Balance Billing. Therefore, services may not be covered at 100% and Your co- insurance may be a greater percentage of the dentist's fees if the charged fees exceed the allowable amount. You may also be required to file Your own dental Claims and pay 100% for Your dental services at time of visit.

## PLAN FEATURES

### Plan Annual Maximum Benefits/Plan Year

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

### Deductible

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

**Out of Pocket Deductible-**

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

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

**Benefit Deductible –**

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

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

**Waiting Period**

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

**Alternate Benefits**

There is often more than one service that can be used to appropriately treat a dental problem or disease. In determining the benefits payable on a claim, different materials and methods of treatment will be considered. If applicable, the amount payable will be limited to the Covered Expense for the least costly Service, which meets broadly accepted standards of dental care as determined by Us. A Member and his Dentist may decide on a more costly service or material than We have determined to be satisfactory for the treatment of the condition. In this case, the Plan will be a benefit toward the cost of the more expensive service or material, but the payment will be limited to the benefits payable for Covered Expenses for the least costly Covered Service.

**Unbundling**

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

**GENERAL EXCLUSIONS**

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

1. This Certificate will not pay for dental services that are not listed in the Plan Covered Services and Plan General Exclusions, Limitations and Restrictions attached to this Certificate.
2. This Certificate will not pay Claims for dental services rendered before the Effective Date or after coverage is terminated.
3. This Certificate will not pay Claims for dental services covered under non-dental insurance.
4. This Certificate will not pay Claims for charges made by hospitals.
5. This Certificate will not pay Claims for services performed primarily to rebuild occlusion or for full mouth reconstruction.
6. This Certificate will not pay Claims for Enrollees until HRI receives the appropriate contracted payment(s) for Premiums.
7. This Certificate will not pay Claims for services which are not completed.
8. This Certificate will not pay for duplicates, lost, or stolen prostheses, appliances, and/or radiographic images.
9. To be considered for payment, a Claim must be within one year from the date of service.

This includes submitted claims for which HRI has not received the 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. We may amend coverage, limitations to the Covered Services, General Exclusions, Annual Maximum, benefit payments or any other terms of this Certificate or the Master Group Policy upon thirty (30) days written notice to You and Your employer. This Certificate will pay for any Covered Services rendered prior to the Effective Date of the change. If there are any discrepancies as to coverage, limitations to Covered Services, General Exclusions, Annual Maximum or other provisions stated herein and as stated in the Master Group Policy, the provisions of the Master Group Policy will supersede those set forth herein.

**WEB SERVICES –** [InsuringSmiles.com]

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 option, renewal dates, dependent coverage, Claim status,
- Print Member Cards,
- Review benefit history,
- Download brochures and Certificates, and
- Acquire oral health and wellness tips.

**COORDINATION OF BENEFITS**

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

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

**Terms**

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

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

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

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

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

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

**Order of Benefit Determination Rules**

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

1. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

2. A Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

3. Each Plan determines its order of benefits using the first of the following rules that apply:
   a. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an

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

b. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent Child is covered by more than one Plan the order of benefits is determined as follows:
   (1) For a Dependent Child whose parents are married or are living together, whether or not they have ever been married:
      - The Plan of the parent whose birthday falls earlier in the [calendar] year is the Primary plan; or
      - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
   (2) For a Dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:
      (i) If a court decree states that one of the parents is responsible for the Dependent Child’s health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
      (ii) If a court decree states that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
      (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent Child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
      (iv) If there is no court decree allocating responsibility for the Dependent Child's health care expenses or health care coverage, the order of benefits for the child are as follows:
         - The Plan of the parent whose birthday falls earlier in the [calendar] year is the Primary plan; or
         - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
   (3) For a Dependent Child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

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

d. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a. can determine the order of benefits.

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

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

**Effect on the Benefits of this Plan**

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

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

other Closed panel plans.

**RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

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

**ARRANGING FOR PAYMENT**

**In-Network Dentists**

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

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

**Out-Of-Network Dentists**

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

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

Filing a Claim

Network Dentists are responsible for submitting claims to HRI on your behalf. Out-Of-Network Dentist may file the claim as a courtesy to their patients, but are under no obligation to do so. Submit claims to HRI to the address provided on page 1. The following information should be included on a standard ADA claim form:

a. Covered Employee's name, address, and identification number (SSN)
b. Patient's name, date of birth, and identification number (SSN)
c. Itemized bill including the ADA code, description of each charge, and date of service
d. Name and address of the Rendering Dentist
e. Rendering Dentist's Tax ID Number (W-9 Form)

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

**FACILITY OF PAYMENT**

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

**RIGHT OF RECOVERY**

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

## APPEAL PROCEDURES

### Informal Claims Appeal Procedure

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

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

First, You or Your dentist should contact HRI's Member Services Team listed on Page 1 of this Certificate and ask them to check the Claim to make sure it was correctly processed. If You contact Us in writing, please enclose a copy of Your Explanation of Benefits and describe the problem. HRI provides this opportunity for You to describe problems and submit information that might indicate that Your Claim was improperly denied and allow HRI to correct this error quickly.

### Formal Claims Appeal Procedure

Whether or not You have contacted HRI informally, as described above, to recheck the initial determination of Your Claim, You or Your authorized representative may submit Your Claim to a formal review through the Claims Appeal Procedure described here. To request a formal appeal of Your Claim, You must send Your request in writing to the Dental Claims Review Team to the address listed on page 1.

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

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

Attn: Consumer Services Division
Indiana Department of Insurance
311 W. Washington St., Ste 300
Indianapolis, IN 46204

Attn: Division of Consumer Protection
Kentucky Department of Insurance
PO Box 517
Frankfort, KY 40602-0517

## NOTICE OF PRIVACY PRACTICES

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

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

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

Our Privacy Principles:

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

confidentiality of information We obtain from You.
- We afford prospective and former customers the same protections as existing customers with the respect to the use of Confidential Information.

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

Confidential Information Collected:
- Confidential Information includes demographic data that can reasonably be used to identify You and that relates to Your past, present or future physical or mental health, the provision of health care to You, or the payment for that care.
- Confidential Information includes Your name, address, date of birth, marital status, sex, social security number, dental information, and Enrollee information, including information about Your transactions with Us, such as Claim history and Premium payments.

Information Disclosed:
- We may provide Confidential Information to You in order to supply You with information about Your Benefits, or if You request to inspect Your Confidential Information.
- We may provide Your Confidential Information to health care providers and to Our business associates who request Confidential Information for payment-related activities and for health care operations.
- We may provide Your Confidential Information to someone who has the legal right to act on Your behalf.
- We may provide Confidential Information to the extent necessary to comply with laws related to Workers' Compensation or similar programs.
- We may provide Confidential Information without Your written permission for matters in the public interest such as public health and safety activities or averting a serious threat to the health or safety of others.
- We may provide Confidential Information that We collect to third-parties involved in the underwriting, processing, servicing and marketing of Your HRI insurance products. We will not provide this information to any other third party for purposes other than set forth above unless We have a written agreement that requires such third party to protect the confidentiality of this information or Your written authorization.
- The law or the courts may require Us to provide Confidential Information to persons or agencies involved in regulatory, enforcement, or civil or criminal judicial activities.
- When We provide Your Confidential Information to any third party, We will provide only a limited data set, or if needed, the minimal amount of information that We deem is necessary.
- We do not disclose any Confidential Information about Our customers to anyone except as permitted or required by law.
- We must obtain Your written authorization for any disclosures of Your Confidential Information for purposes other than those listed above, including disclosures of psychotherapy notes or for marketing purposes.
- We are prohibited from using or disclosing genetic information of an individual for underwriting purposes.

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

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

- Individual Enrollees who believe that the way we communicate decisions related to payment and Benefits may endanger their Confidential Information may request that We communicate with them using a reasonable alternative means or location.

Duties:
- HRI 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 at the corporate address listed on Page 1 of this Certificate.

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 if You file a complaint with Us or with the U.S. Department of Health and Human Services.

**Termination of Coverage**
Your dental coverage may be automatically terminated:
- When Your employer advises HRI to terminate Your coverage;
- When Your employer fails to pay timely Premium payments or fees to HRI; or
- For any other reason stated in the Policy.

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

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

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

An Enrolled Employee will become a Qualified Beneficiary if coverage under the Master Group Policy ends as a result of either the following:
- Hours of employment are reduced, or
- Employment ends for any reason other than gross misconduct by the Enrolled Employee.

An Enrolled Spouse will become a Qualified Beneficiary if coverage under the Master Group Policy ends as a result of the following:
- The Enrolled Employee dies;
- The Enrolled Employee's hours of employment are reduced;
- The Enrolled Employee's employment ends for any reason other than his/her gross misconduct;
- The Enrolled Employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or

- The Enrolled Employee becomes divorced or legally separated from his/her Enrolled Spouse

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

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

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

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

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

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

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

Questions concerning Your Certificate, the Master Group Policy or Your COBRA continuation coverage rights should be addressed to Your Plan Administrator or contacts identified below. For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area (EBSA Regional Office: Cincinnati Regional Office, 1885 Dixie Highway, Ste 210, Ft. Wright, KY 41011-2664, Tel 859.578.4680/Fax 859.578.4688) or visit the EBSA website at www.dol.gov/ebsa.

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

**ERISA**
As a participant in a Dental Health Option, You may be entitled to certain rights and protections under ERISA. You should check with Your employer to determine whether ERISA applies in Your situation.

If You are covered by ERISA, then You may:
- Obtain the Plan Administrator's name, address, and telephone number from Your employer.
- Examine (without charge) at the Plan Administrator's office and at certain other locations, all plan documents, including the group insurance contracts, and copies of all documents filed by the Plan Administrator with the Internal Revenue Service such as annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.
- Receive a Summary Annual Report (SAR), Summary Plan Description (SPD) and a Summary of Material Modifications

(SMM).

- Receive a written explanation if Your Claim for Benefits has been denied. You have the right to request a review of any such denial. If Your Claim is still denied, You may sue for Your Benefits.
- File suit in Federal court if materials You requested aren't received within thirty (30) days (unless the materials weren't sent because of matters beyond the administrator's control), or if You feel Benefits have been improperly denied, or if You have been discriminated against exercising Your rights under ERISA. If You are successful, the court may require the administrator to provide the materials You requested and pay up to $110 a day until You receive them. The court will decide who should pay the court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your Claim frivolous.

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

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

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

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

**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 at the address noted on Page 1 or given it to Our agent. If You visit an Out-of-Network Dentist, You may personally be responsible for submitting Claims directly to HRI.

**Claim Forms**
Your dentist will file Your claim or provide You with the forms necessary to file the claim. If Your dentist does not provide these forms within fifteen (15) days, You may send Us a written statement to satisfy this requirement. This statement should include enough information to identify You as well as the nature and extent of the Claim. It should be sent to Us within the time stated in the Proof of Loss provision.

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

**Proof of Loss**
We must receive written proof of loss within ninety (90) days of a Claim. If it is not possible for proof to be provided 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.

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.

**Misstatement of Age**
For Indiana residents: 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.

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

**Incontestability**
FOR KENTUCKY RESIDENTS: Except for non-payment of Premium, the insurance provided by the Policy cannot be contested after a period of three (3) 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 the Policyholder or the Member a copy of which has been furnished to such Member or to such person or his beneficiary.

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

FOR INDIANA RESIDENTS: Except for non-payment of Premium, the insurance provided by the Policy 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 the Policyholder or the Member a copy of which has been furnished to such Member or to such person or his beneficiary.

After the Policy has been in force for two (2) years, We will not use any statements made in the application of the Employer to void the Policy. After You have been covered under the Policy for two (2) years, We will not use any statement made in Your enrollment form to defend a Claim.

**Conformity with State Statutes**
If any provisions of the Plan is contrary to any law to which it is subject, such provision will be amended to conform to the minimum extent necessary to satisfy legal requirements.

**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.

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

**MEMBER CARD**
The Dental Health Options Member Card is intended to provide a general summary of information that is specific to the Member and the Employer Group.

## Important Notice

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

Claims Department
Health Resources Inc.
P.O. Box 659
Evansville, IN 47704-0659
800.727.1444 press 9
(7:30 am – 5:00 pm CST Monday through Friday)

For Indiana residents, if You need the assistance of the governmental agency that regulates insurance or if You have a complaint which You have been unable to resolve with Your insurer, You may contact the Department of Insurance by mail, telephone, or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204-2787
Consumer Hotline: 1-800-622-4461 / (317) 232-2395
Complaints can be filed electronically at www.in.gov/idoi.

## Definitions

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| **Adverse Determination** | Any denial, reduction or termination, or a failure to provide or to make payment (in whole or part) of the benefit sought. |
| **Allowable Amount/Expense** | The maximum amount of reimbursement the Plan will pay for covered dental services provided by a Dentist to a Member and which meets Our definitions of a Covered Service. The maximum allowable/expense is determined by a) the lesser fee of the primary or secondary insurance carrier as it applies to network participation, associated agreed discounts and patient responsibility or b) the fee considered for the global service. For network Dentists, this is the dollar amount that the attending Dentist has agreed to accept as payment in full for the plan and the patient. This amount is shown on the notice that accompanies payment of the claim. . |
| **Balance Billing:** | Network Dentists agree to accept the network's contracted fees as payment in full. A participating network Dentist has agreed to not bill the patient for the difference between his fee charged and the contracted maximum allowable fee. This is referred to as "balance billing" and is not enforceable for Out-Of-Network Dentist as they are under no obligation to limit their fees. |
| **Benefits:** | The amounts that the Plan pays for Covered Services under a Member's dental Plan. |
| **Claim/Claim Form**: | Standard statement of dental services performed that is submitted by a Dentist or Member to request payment from the Payor. Network dentists always file claim forms on behalf of members and accept payment directly from the Payor. Claim forms are also used to request a pre-treatment estimate. |
| **Coinsurance:** | The Member's share, expressed as a fixed percentage, of the covered dental service. |
| **Coordination of Benefits (COB):** | A process that carriers use to determine the order of payment and amount each carrier will pay when a person receives dental services that are covered by more than one benefit plan. COB ensures that no more than 100 percent of the lowest allowable charges for services are paid when a member has coverage under two or more benefits plans (dual coverage) — for example, a child who is covered by both parents' plans. |
| **Covered Services:** | Dental care services for which a reimbursement is available under a Member's plan contract, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation. |
| **Custodial Parent** | The parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the plan year excluding any temporary visitation. |
| **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. |
| **Dependent Child** | Health Resources Inc. will acknowledge each individual employer's definition for dependent(s) as long as the definition is compliant with the guidelines set forth by the U.S. Department of Health & Human Services, State and other Federal regulatory entities associated with health care regulations and oversight. Dependent children are subject to the employer group's dependent age limitation which must be no less than age 26.<br><br>Dependent child may include the Enrolled Employee's biological children, stepchildren, adopted children, foster children, children subject to legal guardianship, newborn children, or any child for whom the Member is the legal guardian or is required by a court or administrative order to provide health coverage. Coverage for adopted children is effective upon the earlier of: the date of placement 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. |
| **Effective Date:** | The date a dental benefits policy begins. Effective date may also be used to describe the date that benefits begin for a Member. The Effective Date is determined in accordance with waiting periods and employment terms enforced by the employer group and applicable State and Federal regulatory entities. |

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| **Eligibility:** | The circumstances or conditions determined by your Employer that define who and when a person may qualify to enroll in a plan and/or a specific category of Covered Services. These circumstances or conditions may include length of employment, job status, length of time a Member has been covered under the plan, dependency, child and student age limits. |
| **Eligible Member:** | An Eligible Member who has met the eligibility requirements set forth by the Enrolled Employee's Employer. |
| **Exclusions:** | Services that are not covered under the Employer Group Dental Insurance Plan. |
| **Explanation of Benefits (EOB):** | The statement received after a claim is processed, detailing how Your claim was processed, including identification of services rendered, fees, application of plan Limitations, calculation of Plan payment, and the amount for which you are responsible. |
| **Fee Charged:** | The amount that the Dentist bills and is entered on a claim as the charge for a specific |
| **Lifetime Maximum:** | The cumulative dollar amount that a plan will pay for dental care incurred by an individual Member for the life of the Member. Lifetime maximums usually apply to specific services such as orthodontic treatment. |
| **Limitations:** | A list of conditions or circumstances that limit or exclude services from Plan coverage. Limitations may be related to time or frequency (the number of services permitted during a stated period) |
| **Master Group Policy:** | The written agreement between HRI and an Employer Group. |
| **Plan Annual Maximum Benefit:** | The total maximum dollar amount the Employer Group Dental Health Option Plan will pay toward the cost of dental care incurred by an individual Member in a Plan Year. |
| **Member:** | A person covered under the Employer Group Dental Health Option Plan. There are two subsets of Members: The Primary Member who is the Employer Group Member under whom the family is enrolled, and the enrolled family members including spouse, domestic partner and eligible children. |
| **Network Dentist:** | A dentist who contracts with HRI or leased network carrier and agrees to accept contracted fees as payment in full and abide by certain administrative guidelines. |
| **Network:** | A panel of Dentists that contractually agree to provide treatment according to administrative guidelines, including limits to the fees accepted as payment in full. |
| **Open Enrollment:** | A period (usually a two-week or one-month period during the year) when qualified individuals (eligible employees) can enroll in or change their choice of coverage in group benefits plans. |
| **Out-Of-Network** | A dentist who does not contract with HRI to participate in the network and the associated administrative guidelines including claim submission requirements and maximum allowable fee capitations. |
| **Patient Responsibility:** | The portion of a Dentist's fee that a Member must pay for dental services, including deductible, coinsurance, any amount over plan maximums, services the plan does not cover and covered services for which the patient is not eligible. |
| **Plan Administrator:** | The Employer/Sponsor of the Plan or such third party hired by the Employer/Sponsor who performs certain activities for the Plan. |
| **Pre-Authorization:** | A requirement that recommended treatment must first be approved by the Plan before the treatment is rendered in order for the Plan to pay benefits for those Covered Services. |
| **Premiums:** | The money billed and paid to HRI for each month of dental coverage. Payment must be made by an Employer group in order for claims to be paid. |
| **Pre-Treatment Estimate:** | A non-binding estimate of the benefits available and patient responsibility for a proposed treatment plan after the application of Plan Limitations, restrictions, and exclusions, remaining plan annual maximum and determination of Covered Services. |
| **Qualifying Event:** | Change in marital status, change in the number of dependents, or change in employment status. |
| **Resin/ Composite:** | Tooth-colored filling material. Although cosmetically superior, it is less durable than other materials. |
| **Waiting period:** | Waiting periods are designated by an Employer Group. If an Employer Group establishes a plan waiting period, it is the stated period of time that a Member must be enrolled in the Plan before being eligible for benefits or for a specific category of benefits. |

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| | D5214, D5225, and D5226) are subject to an adjustment if performed within 5 years of an interim partial denture (D5820 & D5821) in the same arch. |
| D5850, D5851 | Eligible for two tissue conditioning charges within 6 months of delivery of immediate partial/denture only. |
| D5863, D5864, D5865, D5866 | Charges are subject to the conditions listed for D5110/D5120 and D5213/D5214. |
| D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6194, D6195 | Charges are subject to the same definitions and restrictions listed for D2710 thru D2794 and D6210 thru D6974. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch. |
| D6110, D6111, D6112, D6113, D6114, D6115, D6116, D6117 | Charges are subject to the same definitions and restrictions listed for D5110 thru D5866. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch. |
| D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6545, D6548, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794 | Charges are subject to the same definitions and restrictions listed for D2520 thru D2794. Each unit of a fixed partial denture must be identified on the claim. Not eligible for pontics to replace third molars. All fix prosthodontic services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch. Not eligible for replacement of a removable partial denture by a fixed partial denture within 7 years of the original placement. |
| D6930 | Not eligible within 12 months of the original cementation. Eligible only once per 12 months per fixed partial denture. |
| D7210, D7250 | Surgical extractions: use when either (1) removal of bone and/or (2) sectioning of tooth, including elevation of mucoperiosteal flap if indicated, is necessary. Surgical extraction charges include alveoloplasty. Primary teeth, teeth 7-10 and 23-26 require the submission of a duplicate, diagnostically acceptable, pre-operative periapicial and/or panoramic radiograph with claim submission. Charges not meeting established criteria will be disallowed. |
| D7286 | Charges will be disallowed in performed in conjunction with D3410, D3421, D3425, D3426, or D3427. |
| D7310, D7311 | Charges are subject to review if performed in conjunction with D7210 thru D7250. Charges not meeting generally accepted standards of care will be disallowed (see D7210 thru D7250). |
| D7340, D7350 | Charges filed in conjunction with implant services will be disallowed. |
| D7473 | Eligible once per arch per lifetime. |
| D7510 | Charges filed in conjunction with definitive treatment will be disallowed. |
| D7922 | Not eligible for more than a combination of two D7922 or D9110 per 12 month period. Charges filed in conjunction with definitive treatment will be disallowed. |
| D7960 | Charges are subject to review if performed in conjunction with definitive treatment. Charges not meeting generally accepted standards of care will be disallowed. |
| D7971 | Charges filed in conjunction with definitive restorative treatment will be disallowed. |
| D9110 | Not eligible for more than two palliative (emergency) treatments per 12 month period. Charges filed in conjunction with definitive treatment will be disallowed. |
| D9222, D9223, D9239, D9243 | Limited to a total of 30 minutes per date of service. |
| D9230 | Eligible once per date of service. |