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

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

Summary of Dental Plan Benefits

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

Group Name: Greene County Court House

Group Number: 919906142010

Benefit Plan Year: Apr 2024 – Apr 2025

Plan Annual Maximum (for all services except for Orthodontic)	**$1000.00**
Deductible (waived for preventive and diagnostic services)	**$0**
Out of Network Benefit	**Fee Schedule**

Diagnostic & Preventative	In*	Out**
Exams: Periodic, Limited, Comprehensive	100%	0%
Teeth Cleaning (Prophylaxis)	100%	0%
Fluoride - Topical Application or Varnish	100%	0%
X-Rays - Bitewings; Vertical, Periapical, Full Mouth	100%	0%
Sealants	100%	0%
Space Maintainer: Fixed & Removable	100%	0%

Restorative	In*	Out**
Fillings - Silver/amalgam or White/composite (Anterior and Posterior Teeth	50%	0%
Crowns, Inlays, Onlays, Veneers, Post, Core Buildup, Recementation and Repairs	50%	0%

Endodontics	In*	Out**
Root Canal Therapy: Anterior, Posterior & Retreatments - Includes Periapical X-Rays, Cultures, Follow-Up Care, Treatments and Pulpotomy	50%	0%
Apexification, Apicoectomy, Retrograde Fillings	50%	0%
Other Endodontic Procedures	50%	0%

Periodontics	In*	Out**
Scaling & Root Planing and Periodontal Maintenance	50%	0%
Surgical Periodontics Including Gingivectomy, Gingivoplasty, Gingival Flap, Osseous and Clinical Crown Lengthening	50%	0%

Prosthodontics	In*	Out**
Prosthodontic Services - Bridges, Partial, and Complete Dentures	50%	0%
Relining, Rebasing, Repairs, Replacement of Teeth and Adjustments	50%	0%

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

Oral Surgery	In*	Out**
Simple Extractions	50%	0%
Surgical Extractions Including Impactions, Alveoloplasty, Vestibuloplasty and Other Surgical Procedures	50%	0%

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

Orthodontic Services	In*	Out**
Orthodontic Services (Braces) - Child (Through Age 18)	50%	0%
Orthodontic Services (Braces) - Adult	0%	0%

***In Network** dentists have agreed to accept contracted maximum allowable fees on covered dental services. Your co-insurance percentage is based on that contracted fee. Therefore, your benefit dollars will go further and your out of pocket costs will likely be less when you visit a network dentist.

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

- ❖ Oral evaluations (all procedure codes, including evaluations performed by a general dentist or specialist) are payable 2 time(s) in 12 consecutive months. Comprehensive Oral evaluations are payable every 4 years.
- ❖ A routine teeth cleaning (prophylaxis) is payable 2 time(s) per consecutive 12 months regardless of the dentist's specialty, unless performed within 6 months of periodontal scalings and root planing, periodontal full mouth debridement, or periodontal maintenance.
- ❖ A core buildup will not be payable if performed within 2 years of restoration and/or replacement within 7 years on the same tooth. Coverage for a core buildup requires the submission of a duplicate, diagnostically acceptable, pre-operative radiographic image or intraoral photo.
- ❖ Replacement of crowns and implant crowns are payable per tooth every 60 months or 5 years.
- ❖ Root canal treatment includes periapical x-rays, cultures, follow up care, treatments, pulpotomy are payable 1 time(s) per 4 Years.