DENTAL + VISION

Dental+Vision is a direct reimbursement combination plan that pays for dental and vision expenses. With no waiting period, the tiered reimbursement structure begins at the first dollar and allows you to maximize your potential benefits. Choose to go to any dentist or vision specialist and receive any medically necessary procedure. Submit your claims for reimbursement to my.breckpoint.com.

EXAMPLES OF COVERED BENEFITS

- TEETH CLEANING
- ROOT CANAL
- FILLINGS
- DENTAL X-RAYS
- ANNUAL EYE EXAM
- FRAMES
- LENSES
- CONTACT LENSES

BENEFIT INFORMATION	
Network	Not applicable
Max Benefit Reimbursement	$1,000
Waiting Period	No waiting period
PROCEDURE COST	**REIMBURSEMENT**
UP TO $150.00	**100%**
$151.01 - $250.00	**75%**
$251.01 - $1,800.00	**50%**
$1,801.01 - up	**0%**

Benefits for Dental and Vision are combined.
*Benefit is based on an aggregate total of accumulated expenses per Covered Person during the calendar year.

DENTAL BENEFITS	PLAN PAYS
Dental Class I - Preventive & Diagnostic Care • Oral Exams • Routine Cleanings • Full Mouth X-rays • Bitewing X-Ray • Panoramic X-ray • Fluoride Application • Sealants • Histopathologic Exams	At Current Reimbursement Level
Dental Class II - Basic Restorative Care • Fillings • Periapical X-rays • Anesthetics • Space Maintainers • Emergency Care to Relieve Pain • Root Canal Therapy/Endodontics • Periodontal Scaling and Root Planing • Oral Surgery – Simple Extractions • Oral Surgery – all except simple Extractions • Surgical Extractions of Impacted Teeth	At Current Reimbursement Level
Dental Class III - Major Restorative Care • Crowns • Dentures • Bridges • Inlays/Onlays • Prosthesis Over Implant • Repairs to Bridges, Crowns and Inlays • Denture Adjustments and Repairs	At Current Reimbursement Level
VISION BENEFITS	**PLAN PAYS**
• Routine Examination Services • Lenses – including, single, bifocal or trifocal • Contact Lens • Frames	At Current Reimbursement Level

	Employee Only	Employee + Child(ren)	Employee + Spouse	Employee + Family
PRICING	**$31.50**	**$50.70**	**$56.30**	**$75.50**

DENTAL + VISION PLAN BENEFIT LIMITATIONS

Dental Procedure	Limitations	Dental Procedure	Limitations
Exams	Two per calendar year	**Prophylaxi** *(cleanings)*	Two per calendar year
Fluoride	1 per calendar year for people under 20	**Sealants**	One treatment per tooth every three years up to age 14
x-Rays *(routine)*	Bitewings: 2 per calendar year	**X-Rays** *(non-routine)*	Full mouth: 1 every 36 consecutive months., Panorex: 1 every 36 consecutive months
Crowns & Inlays	Replacement every 5 years	**Bridges**	Replacement every 5 years
Dentures & Partials	Replacement every 5 years	**Surgeries** *(ALL)*	Limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts.
Relines, Rebases	Covered if more than 6 months after installation	**Adjustments**	Covered if more than 6 months after installation
Repairs - Bridges	Reviewed if more than once	**Repairs - Dentures**	Reviewed if more than once
Prosthesis Over Implant	1 per 60 consecutive months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges	**Missing Tooth Limitation**	Teeth missing prior to coverage under the Dental Plan are not covered. Pretreatment review is available on a voluntary basis when extensive dental work in excess of $200 is proposed.
Space Maintainers	Limited to non-orthodontic treatment		
Vision Procedure	**Limitations**	**Vision Procedure**	**Limitations**
Complete Eye Exam	One per calendar year	**Frames**	One frame every two calendar years.
Frame-type Lenses	One per calendar year	**Contact Lens**	One per calendar year

Dental + Vision Benefit Exclusions:

- Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.
- Services that are deemed to be medical services.
- Services and supplies received from a hospital.
- Charges which the person is not legally required to pay.
- Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service.
- Experimental or investigational procedures and treatments.
- Any injury resulting from, or in the course of, any employment for wage or profit.
- Any sickness covered under any workers' compensation or similar law.
- Charges in excess of the reasonable and customary allowances.
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which would not have been made if the person had no insurance;
- For charges for unnecessary care, treatment or surgery;
- To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law.
- In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

Dental Specific Benefit Exclusions:

- Services performed primarily for cosmetic reasons.
- Replacement of a lost or stolen appliance.
- Replacement of a bridge or denture within five years following the date of its original installation.
- Replacement of a bridge or denture which can be made useable according to accepted dental standards.
- Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion.
- Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars.
- Bite registrations; precision or semi-precision attachments; splinting.
- Instruction for plaque control, oral hygiene and diet.
- Dental services that do not meet common dental standards.
- Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents)

Vision Specific Benefit Exclusions:

- Artificial eyes, if medically necessary, are covered under the Medical Plan.
- Charges for orthoptics (eye muscle exercises) vision training or surgical treatment of the eye.
- Charges for Radial keratotomy or other eye surgery for improvement of visual acuity or refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting.

This benefit summary highlights some of the benefits available under Plan Document and Summary Plan Description.