FreedomDental+ is a self-funded direct reimbursement combination plan that reimburses the Covered Person for medically necessary dental and vision expenses. Qualified members can choose to go to any dentist or vision specialist and receive any medically necessary procedure after their 30-day waiting period.

REIMBURSEMENT SCHEDULE

The Reimbursement Benefit is based on an aggregate total of accumulated expenses per Covered Person during the calendar year.

PER CALENDAR YEAR

Aggregated Expenses	Reimbursement Benefit *(per covered person)*
Up to $150.00	100%
$150.01 to $250.00	75%
$250.01 to $1,800.00	50%
$1,800.01 and up	0%

DENTAL

COVERED DENTAL SERVICES	Inclusions & Limitations
Class A: Preventive & Diagnostic Dental Procedures	
Routine oral exams	Includes cleaning and scaling of teeth. Limit of two visits per Covered Person each Calendar Year.
Bitewing x-ray	Two series per Calendar Year.
Full mouth or panoramic film	1 every three Calendar Years.
Fluoride treatment	Includes 1 treatment for Covered Persons under age 20 twice per Calendar Year.
Sealants	For Dependent Children under age 14 on the occlusal surface of a permanent tooth.
Other preventive and diagnostic dental x-rays	
Class B: Basic Dental Procedures	
Oral Surgery	Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts.
Periodontics (gum treatments)	
Endodontics (root canals)	
Extractions	Includes local anesthesia and routine post-operative care.
Relines and rebases to existing dentures	
Fillings, other than gold	Silicate, acrylic, and composite fillings are covered only for teeth in front of the first bicuspid.
General anesthetics	Upon demonstration of Medically Necessary.
Nitrous oxide	
Antibiotic drugs	
Space maintainers	Covered Dependent Children under age 15 to replace primary teeth and habit-breaking devices.
Emergency palliative treatment for pain	
X-ray and lab procedures for dental surgery	
Drugs that require a Dentist's prescription	Limited to medication given at the Dentist's office.
Consultations required by the attend Dentist	
Class C: Major Dental Procedures	
Installation of crowns	
Installing precision attachments for removable dentures	
Addition of clasp or rest to existing partial removable dentures	

COVERED DENTAL SERVICES	Inclusions & Limitations
Initial installation of fixed bridgework to replace one or more natural teeth	
Repair of crowns, bridgework and removable dentures	
Rebasing or relining of removable dentures	
Installing partial, full or removable dentures to replace one or more natural teeth	Limited to replace natural teeth pulled after coverage begins.
Replacing an existing removable partial or full denture or fixed bridgework or crowns	Adding teeth to an existing removable partial denture; or adding teeth, inlays, onlays, crowns or gold restorations to existing bridgework to replace newly extracted natural teeth. **However, this item will apply only if:** o The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable. o The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed. o The existing appliance cannot be repaired or restored to use. ▪ The replacement is needed because of the pulling of additional natural teeth or accidental injury to natural teeth while covered. ▪ The replacement is completed within 12 months of the extraction or accidental injury.
Addition of another tooth to a Covered Person's denture	If the Covered Person has a partial denture, and a natural tooth adjacent to that denture is pulled, the addition of another tooth to the Covered Person's denture is covered.

DENTAL EXCLUSIONS

- **Administrative costs.** *Administrative costs of completing claim forms or reports or for providing dental records.*
- **Dental care provided to correct any birth defect or developmental malformation that does not interfere with function.**
- **Broken appointments.** *Charges for broken or missed dental appointments.*
- **Cosmetic.** *Services or supplies that are primarily cosmetic in nature.*
- **Crowns.** *Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.*
- **Customized dental procedures.**
- **Fluoride.** *Take home fluoride solutions.*
- **Fluoride.** *Topical application of fluoride to the prepared portion of a tooth prior to placement of a final restoration and fluoride for use in prophylaxis paste and/or in restorative material is not covered.*
- **Hygiene.** *Oral hygiene, plaque control programs or dietary instructions.*
- **Local analgesics.**
- **Not Necessary.** *Services not necessary for the diagnosis, prevention or care of dental disease, defect or injury.*
- **Orthodontia.** *Orthodontic treatment and orthognathic surgery.*
- **Personalization.** *Personalization of dentures.*
- **Replacement.** *Replacement of lost or stolen appliances.*
- **Splinting.** *Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.*
- **TMJ.** *Care of craniofacial muscle disorders and temporomandibular disorders.*

VISION

COVERED VISION SERVICES	
Examinations	Routine examination services include examination of the outer and inner parts of the eye; evaluation of vision sharpness *(refraction);* binocular balance testing; routine tests of color vision, peripheral vision and intraocular pressure; and case history, recommendations and prescriptions.
Lenses	This benefit includes single, bifocal or trifocal lenses, including special features, such as: • Tinting or coating; • Fitting of eyeglass lenses to frames; and • Fitting contact lenses to the eyes. This benefit also covers contact lenses *(including disposable contact lenses)* that a Covered Person elects in place of eyeglasses *(eyeglass lenses or frames).*
Frames	This benefit includes parts of frames and fitting the frames to the face as described in the Vision Schedule of Benefits.

VISION EXCLUSIONS

- **Artificial eyes.**
- **Before coverage start date.** *Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.*
- **Health plan.** *Any charges that are covered under a health plan that reimburses a greater amount than this Plan.*
- **No prescription.** *Charges for lenses ordered without a prescription, including non-prescription safety glasses. Prescription safety glasses are covered.*
- **Orthoptics.** *Charges for orthoptics (eye muscle exercises) vision training or surgical treatment of the eye.*
- **Radial keratotomy** *or other eye surgery for improvement of visual acuity.*