SCHEDULE OF BENEFITS
Benefit Plan 002

Benefits for You and Your Dependents are listed below

This coverage provides for the use of an Exclusive Provider Organization (EPO). Certain Benefits are paid at different levels if the service is not provide a Participating Provider.

SUMMARY OF BENEFITS	EPO PROVIDER (In-Network)	Non-EPO Provider (Out-of-Network
Co-Pay Per Tooth Or Unit: • Crowns, Inlays, And Fixed Prosthodontics	$25	No Benefit
Maximus: • Calendar Year Benefit Maximum, Including Preventative Services and Diagnostic Services, Basic Services, Major Services, And Orthodontic Services, Dependent Children Only	**Individual** $2,000	No Benefit
Participation Percentage:	**This Plan Pays**	
• **Preventative Services and Diagnostic Services:** Routine Cleanings And Fluoride Treatments. Oral Exams And Full-Mouth X-Rays. Refer To Covered Expenses For Any Limitations	100%	No Benefits
• **Basic Services:** Fillings, Endodontics, Periodontics (Scaling And Root Planing Only), And Oral Surgery. Refer to Covered Expenses For any Limitations.	100%	No Benefits
Periodontics (Except Scaling and Root Planing). Refer To Covered Expenses for Any Limitations.	80%	No Benefits
• **Major Services:** Inlays, Onlays And Crowns, Bridges, Dentures. Refer To Covered Expenses for Any Limitation.	100%	No Benefits
• **Orthodontics Services:** Orthodontic Diagnosis, Treatment, And Appliances. Refer To Covered Expenses For Any Limitations.	80%	No Benefits
Limitations And Exclusions: Refer To General Exclusions	Not Payable	Not Payable