SCHEDULE OF DENTAL BENEFITS

PLAN YEAR DEDUCTIBLE	
TYPE I SERVICES	NONE
TYPE II, III AND ORTHODONTIC SERVICES*	$50 PER PERSON $100 PER FAMILY
BENEFIT PERCENTAGES	
TYPE I SERVICES	100% OF REASONABLE CHARGE
TYPE II SERVICES	80% OF REASONABLE CHARGE
TYPE III SERVICES	80% OF REASONABLE CHARGE
ORTHODONTIC SERVICES*	60% OF REASONABLE CHARGE
MAXIMUM BENEFIT PAYABLE PER PLAN YEAR	
TYPE I, II & III SERVICES COMBINED	$1,500 PER PERSON
MAXIMUM LIFETIME BENEFIT	
ORTHODONTIC SERVICES*	$1,000 PER PERSON

* Orthodontic Services are only provided to Eligible Dependent children to age 18.

SCHEDULE OF VISION BENEFITS

VISION EXAMINATION	$50
LENSES (Per Pair) and Frames	
SINGLE VISION	$300
BIFOCALS	$300
TRIFOCALS	$300
CONTACT LENSES (Per Pair)*	
NECESSARY	$300
COSMETIC	$100

(Contact lenses can be allowed in lieu of lenses and frames)

* Note: the amount for a single lens is 50% of the amounts shown for a pair of lenses.