

# Schedule of Benefits

**Employer:** Tradesmen International

**MSA:** MSA-100419  
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For: PPO Dental Plan

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

## Comprehensive Dental Plan (PPO)

### Schedule of Comprehensive Dental Benefits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year	Individual \$15	Individual \$100
<b>Deductible</b>	(applies to Major expenses only)	Family \$300

The Calendar Year **deductible** applies to all covered expenses.

Please refer to the listing of **covered expenses** and the percentage payable appearing below. The percentage the plan will pay varies by the type of expense.

PLAN PAYMENT PERCENTAGE	NETWORK PAYMENT PERCENTAGE	OUT-OF-NETWORK PAYMENT PERCENTAGE
Type A Expenses	100%	80%
Type B Expenses	90%	70%
Type C Expenses	70%	50%

#### Calendar Year Maximum Benefit

Calendar Year Maximum: \$1,500

The most the plan will pay for **covered expenses** incurred by any one covered person in a Calendar Year is called the Calendar Year Maximum Benefit.

The Calendar Year maximum benefit applies to **network** and **out-of-network covered** dental expenses combined. However, when your **covered expenses** totaling \$1,200 have been applied to your maximum, the plan will no longer pay benefits for any further **out-of-network** dental expenses that you or your dependents incur.

## Dental Emergency Maximum Benefit

Dental Emergency Maximum: \$75

The most the plan will pay for **covered expenses** incurred by a covered person for any one Dental Emergency is called the Dental Emergency Maximum.

## Expense Provisions

**The following provisions apply to your health expense plan.**

This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

**KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.**

## Deductible Provisions

**Covered expenses** applied to the **out-of-network provider deductibles** will be applied to satisfy the **network provider deductibles**. **Covered expenses** applied to the **network provider deductibles** will be applied to satisfy the **out-of-network provider deductibles**.

All **covered expenses** accumulate toward the **network provider and out-of-network provider deductibles** except for those **covered expenses** identified later in this *Schedule of Benefits*.

You and each of your covered dependents have separate **Calendar Year deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family **Calendar Year deductibles**.

## Network Provider and Other Health Care Calendar Year Deductible

### Individual

This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from a **network provider** and for **other health care** for which no benefits will be paid. This individual **Calendar Year deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual **Calendar Year deductible**, this Plan will begin to pay benefits for **covered expenses** that you incur from a **network provider** and for **other health care** for the rest of the Calendar Year.

### Family Deductible Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual **Calendar Year deductibles**, these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

The combined **covered expenses** that you and each of your covered dependents incur towards the individual **Calendar Year deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual **Calendar Year deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

## Out-of-Network Provider Calendar Year Deductible

### Individual

This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from an **out-of-network provider** for which no benefits will be paid. This individual **Calendar Year deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual **Calendar Year deductible**, this Plan will begin to pay benefits for **covered expenses** that you incur from an **out-of-network provider** for the rest of the Calendar Year .

### Family Deductible Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual **Calendar Year deductibles**, these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

The combined **covered expenses** that you and each of your covered dependents incur towards the individual **Calendar Year deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year , the individual **Calendar Year deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year .

### Payment Provisions

#### Payment Percentage

This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the “Plan Payment Percentage”. Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

### Maximum Benefit Provisions

#### Calendar Year Maximum Benefit

The most the plan will pay for covered expenses incurred by any one covered person in a Calendar Year is called the Calendar Year maximum benefit.

The Calendar Year maximum benefit applies to **network care** and **out-of-network care** expenses combined.

The Calendar Year maximum benefit applies to the medical, **prescription drug**, and dental expense coverage described in the Booklet.

## General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.