SCHEDULE OF BENEFITS

Dental Plan

Benefits for You and Your Dependents are listed below.

SUMMARY OF BENEFITS	
Deductibles Per Calendar Year: • Combined Basic Services, Major Services, And Orthodontic Services	**Individual** $50
Maximums: • Calendar Year Benefit Maximum, Including Preventive Services And Diagnostic Services, Basic Services, And Major Services • Lifetime Orthodontic Maximum ***Note: Maximums Do Not Apply To Essential Health Benefits. See The Glossary Of Terms Section Of This Plan For More Details.***	**Individual** $3,000 $1,500
Participation Percentage: • **Preventive Services And Diagnostic Services:** Routine Cleanings And Fluoride Treatments. Oral Exams And Bitewing And Full-Mouth X-Rays. Refer To Covered Expenses For Full Listing And Any Limitations. • **Basic Services:** Fillings, Endodontics, Periodontics, Oral Surgery, And Sealants. Refer To Covered Expenses For Full Listing And Any Limitations. • **Major Services:** Inlays, Onlays And Crowns, Bridges, Dentures, Implants. Refer To Covered Expenses For Full Listing And Any Limitations. • **Orthodontic Services:** Orthodontic Diagnosis, Treatment, And Appliances. Refer To Covered Expenses For Full Listing And Any Limitations.	**The Plan Pays** 100% 80% 50% 50%
Limitations and Exclusions: Refer To General Exclusions.	 Not Payable

PROVIDER NETWORK

This coverage provides for the use of a provider organization. Benefits are paid at the same level; however, Guardian Dental providers have agreed to provide certain discounts on covered services, reducing the Covered Person's out-of-pocket expenses.

The Plan does not limit a Covered Person's right to choose their own dental care at their own expense if a dental expense is not a Covered Expense under this Plan or is subject to a limitation or exclusion.

Provider Directory Information

Each covered Employee, COBRA participant, and Child or guardian of a Child who is considered an alternate recipient under a Qualified Medical Child Support Order will automatically be given or electronically provided a separate document, at no cost, that lists the participating network providers for this Plan. The Employee should share this document with other covered individuals in their household. If a covered spouse or Dependent wants a separate provider list, they may make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

To obtain more information on Guardian Dental providers, call the number on the back of the Plan's Identification card, or go to the following website:

www.umr.com

PRE-TREATMENT ESTIMATE OF BENEFITS

One of the advantages of this dental Plan is that it enables a Covered Person to see the amount payable by the Plan prior to having the Dentist begin any extensive treatment. Through this process, Covered Persons can prevent any misunderstandings as to what is covered by the Plan. A Covered Person can accurately estimate what they will owe the Dentist. This procedure is known as "Pre-Treatment Estimate of Benefits." Here is how the process works:

Usually, before beginning any extensive treatment, the Covered Person will be advised as to what the Dentist intends to do. This plan of action is referred to as the Treatment Plan. The Dentist will submit the Treatment Plan to UMR prior to performing the services. UMR will then notify the Covered Person and the Dentist, in advance, regarding what benefits are payable under this Plan, and how much the Covered Person will be responsible for paying.

Obtaining a Pre-Treatment Estimate of Benefits is recommended. This feature is not mandatory; however, dental care can be expensive. A Covered Person may want to have an idea of how much this Plan will pay before agreeing to have the treatment performed.

Note: The Pre-Treatment Estimate of Benefits is not a guarantee of payment and is valid for 12 months after the notice date. Benefits are payable if coverage is in effect on the date the services are performed (subject to all Plan provisions) and if the claim is submitted to the Plan within the timely filing period. If additional procedures are performed, the claim will be reviewed in its entirety.

COVERED EXPENSES

The Plan will pay for the following Covered Expenses Incurred by a Covered Person, subject to any Deductibles, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits, and to all other provisions as stated in this SPD. Benefits are based on the Usual and Customary charge, fee schedule, or Negotiated Rate. Any procedure that is not specifically listed as covered is excluded.

General Overview:

This Plan provides dental benefits under several categories of dental services. Within each category, there are a number of subcategories of covered services.

PREVENTIVE SERVICES

- Cleanings (routine prophylaxis) - limited to four per calendar year.
- Topical fluoride treatments - Limited to two treatments per calendar year. A cleaning performed with a fluoride treatment is a separate dental service.

DIAGNOSTIC SERVICES

- Oral exams - limited to four per calendar year.
- Full-mouth X-rays - limited to one every 36 consecutive months, unless necessary due to an Injury, combined with panoramic / panorex X-rays.
- Panoramic / panorex X-rays - limited to one every 36 consecutive months, unless necessary due to an Injury, combined with full-mouth X-rays.
- Bitewing X-rays - limited to two visits per calendar year.
- X-rays – all other dental X-rays when Medically Necessary as part of the treatment of a Covered Expense.

BASIC SERVICES

- Restorative fillings – amalgam, silicate, acrylic, synthetic porcelain, and composite fillings.
- Preformed stainless steel crowns – limited to Dependent Children with deciduous primary teeth only.
- Endodontics – root canal treatments, root canal fillings, pulp vitality tests, and other related procedures.
- Periodontics – debridement and exams, and other related procedures necessary to treat a disease of the supporting tissues of the teeth. Periodontal splinting is not a covered expense.
- Periodontal maintenance.
- Occlusal guard (nightguard) - (only in conjunction with periodontal surgery or bruxism - limited to a maximum of $250, one every five years).
- Occlusal adjustment - (only in conjunction with periodontal surgery or bruxism - limited to four quadrants per Treatment Plan).

- Oral surgery – extractions and other oral surgery including preoperative and postoperative care.
- Local anesthesia.
- General anesthesia – when administered by a Dentist due to oral or dental surgery when Medically Necessary.
- Rebase procedures for denture or bridges. Not covered during the first six months after initial placement.
- Reline procedures for dentures or bridges. Not covered during the first six months after initial placement.
- Ancillary - emergency oral exams and palliative treatment for relief of dental pain.
- Sealants - limited to 1st and 2nd permanent molar teeth only once every 36 consecutive months. Not covered for primary teeth.
- Space maintainers - fixed appliances to maintain a space created by the premature loss of a primary tooth or teeth.

MAJOR SERVICES

- Inlays or onlays.
- Crowns.
- Implants and implant-related services.
- Installation of removable or fixed bridgework.
- Installation of partial and complete dentures, including six-month post-installation care.
- Gold restorations

Limitations for Major Restorative Services

Replacement of an inlay, onlay, or crown will be covered only if the appliance was installed at least five years prior to its replacement. This provision will not apply if replacement is due to an Accidental Injury that occurred while You were covered under this Plan. This provision will not apply if replacement is required due to the involvement of an additional tooth surface.

Replacement of a bridge or denture will be covered only if the appliance was installed at least five years prior to its replacement. This provision will not apply if:

- Replacement is Medically Necessary due to the placement of an initial opposing full denture;
- Replacement is Medically Necessary due to the extraction of additional natural teeth. Such extraction must leave the bridge or partial denture unserviceable;
- The bridge or denture is damaged beyond repair while in the oral cavity. The Injury must occur while You are covered under this Plan; or
- The existing denture is a temporary denture, placed while You were covered under this Plan. Replacement by a permanent denture must be required and performed within 12 months of the date the temporary denture was placed.

Expenses Incurred for implant removal are not covered.

Expenses Incurred for fixed bridges are not covered for Dependent Children under the age of 16. An allowance will be made for a partial denture.

Expenses Incurred for prosthodontic services performed on teeth other than permanent teeth are not covered.

Expenses Incurred at any time to replace a bridge or denture that meets, or can be made to meet, commonly held dental standards of functional acceptability are not covered.

The initial installation of a bridge or denture, replacing natural teeth that were extracted prior to Your effective date, is not covered. Such installation will be covered if Medically Necessary due to the loss or extraction of additional natural teeth after Your effective date.

DENTAL EXCLUSIONS AND LIMITATIONS

The Plan does not pay for expenses Incurred for the following, even if deemed to be Medically Necessary, unless otherwise stated below. The Plan does not apply exclusions to treatment listed in this SPD as covered dental benefits based upon the source of the Injury when the Plan has information that the Injury is due to a medical condition (including both physical and mental health conditions) or domestic violence.

1. **Acts of War:** Illness or Injury caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

2. **Appointments Missed:** Appointments the Covered Person did not attend.

3. **Athletic Mouth Guards.**

4. **Before Effective Date and After Termination:** Services, supplies, or expenses Incurred before coverage begins or after coverage ends under this Plan.

5. **Cosmetic:** Services or treatment for cosmetic purposes as determined by the Plan, including, but not limited to bleaching. This exclusion does not apply to Accidental Dental Injury or to orthodontic services.

6. **Denture Duplication.**

7. **Duplicate Services and Charges or Inappropriate Billing** including the preparation of medical or dental reports and itemized bills.

8. **Excess Charges:** Charges or the portion thereof that are in excess of the Usual and Customary charge, the Negotiated Rate, or the fee schedule.

9. **Experimental or Investigational, or Unproven:** Services, supplies, medicines, treatment, facilities, or equipment that the Plan determines are Experimental, Investigational, or Unproven, including administrative services associated with Experimental, Investigational, or Unproven treatment.

10. **Fractures:** Treatment of fractures not including teeth or alveolar processes.

11. **Interest and Legal Fees**.

12. **Medications,** whether prescription or over-the-counter, other than those administered while in the Dentist's office as part of treatment. See the Prescription Drug Benefits section.

13. **Military:** A military-related Illness of or Injury to a Covered Person on active military duty, unless payment is legally required.

14. **Multiple Surgical and Periodontal Procedures** in the same area. Benefits will be limited to the most extensive and inclusive procedure.

15. **Myofunctional Therapy.**

16. **Not Medically Necessary:** Services, supplies, treatment, facilities, or equipment that the Plan determines are not Medically Necessary.

17. **Orthodontic Services,** unless covered elsewhere in this document.

18. **Orthognathic Surgery,** unless covered elsewhere in this document.

19. **Preventive Control Programs** including oral hygiene instruction; plaque control; dietary planning; lab tests; anaerobic culture, except in connection with periodontal disease; sensitivity testing; and bite registrations.

20. **Professionally Recognized Standards:** Procedures that are not necessary and that do not meet professionally-recognized standards of care.

21. **Programs** for oral hygiene or plaque control.

22. **Replacement** of lost, missing, or stolen appliances regardless of any other provision of this Plan.

23. **Services At No Charge or Cost:** Services for which the Covered Person would not be obligated to pay in the absence of this Plan or that are available to the Covered Person at no cost, or for which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.

24. **Services Not Furnished By a Dentist or Dental Hygienist** who is acting under a Dentist's supervision and direction, except for X-rays ordered by a Dentist.

25. **Services Provided By a Close Relative.** See the Glossary of Terms section of this SPD for a definition of "Close Relative."

26. **Splints** unless necessary as the result of an Accidental Injury.

27. **Supplies** for plaque control or oral hygiene that can be purchased over-the-counter.

28. **Treatment of Disturbances** of the temporomandibular joint, craniomandibular dysfunctions, myofascial pain syndrome, or any other disorder of the joint linking the jaw to the skull and the associated muscles. This exclusion also pertains to temporomandibular joint radiographs.

29. **Workers' Compensation:** Dental health services for which other coverage is required by federal, state, or local law to be bought or provided through other arrangements. This includes coverage required by workers' compensation or similar legislation. This exclusion does not apply to employers that are not required by law to buy or provide, through other arrangements, workers' compensation insurance for employees, owners, and/or partners.

Benefits not specifically included in the Covered Expenses section of this document are considered excluded.