WESTERN MUTUAL
INSURANCE COMPANY

Dental Certificate

Western Mutual Insurance Company
An Affiliate of Western Petroleum Marketers Association

PO Box 572450
Murray, UT 84157
(801) 263-8000 & (800) 748-5340
Fax: (801) 263-1247

DENTAL CERTIFICATE

A. Schedule of Benefits:

Annual Maximum Dental Benefit Per Person $1,200

Diagnostic and Preventative Services	Restorative, Endodontic, and Periodontic Services	Prosthodontic Services
No Deductible	Calendar Year Deductible: $50 Per Person	
Plan Pays 100%	Plan Pays 80%	Plan Pays 50%

Orthodontic Services (No coverage during the first year)
Deductible $100 Per Person Plan Pays 50% Lifetime Orthodontic Maximum $1,000

B. Covered Services:

The following services are covered under this policy subject to the exclusions and limitations set forth herein:

1. Routine oral examinations include x-rays and prophylaxis (cleaning, scaling, and polishing), but not more frequently than every 180 days per insured.

2. Sealants for permanent molars for children age sixteen (16) or younger once per tooth every five (5) years.

3. Topical application of fluoride to the natural teeth limited to children age eighteen (18) years or younger once each Calendar Year.

4. Extractions; fillings (using silver amalgam, silicate, or plastic); crowns (as limited in the Exclusion section of this dental policy); endodontic treatment (including root canal therapy); periodontal treatment; oral surgery; general anesthesia (if deemed to be medically necessary); and oral drugs requiring a prescription by a Dentist or a Physician.

5. Initial installation of, or addition to, dentures or fixed bridgework, if: (i) such installation or addition is required due to the extraction after the effective date of the Insured person’s Dental Expense Benefit of one or more natural teeth due to Accidental Injury or disease; and (ii) such denture or bridgework includes the replacement of the extracted tooth and is completed within twelve (12) months of the date of the extraction except as listed under the Exclusion section of this policy.

6. Replacement or alteration of dentures or fixed bridgework if the change is (a) required due to an Accidental Injury requiring oral surgery or oral surgical treatment involving the removal of a tumor, cyst, or redundant tissue; (b) such event occurred after the effective date of the Insured person's Dental Expense Benefits; and (c) the replacement or alteration is completed within twelve (12) months after such event.

7. Replacement or alteration of a denture, bridge, or crown, if required as the result of structural change within the mouth and if made more than five (5) years after the installation of the denture, bridge, or crown. This benefit is not available until the Insured Person has been insured under the Dental Expense Benefit for a period of two (2) years.

8. Repair of dentures or bridgework (not including replacement, alteration, or relining).

9. Emergency palliative treatment.

10. Fixed or removable space maintainers for missing primary teeth if used to maintain the present position of the tooth but not to move the tooth (which may be covered under orthodontic benefits).

11. Charges incurred for the treatment of a diagnosed Illness of the jaw or joints (other than fracture, tumor, or cyst) and associated myofacial pain or equilibrium are eligible for benefits when covered orthodontic treatment is rendered.

12. Osseous implants, subject to the exclusions and limitations set forth herein.

IMPORTANT NOTICE: The Company requires pre-treatment x-rays for crowns, bridges, prosthetics, gold work, impacted extractions, implants, and periodontal surgery. For those services that require pre-treatment x-rays, the Company suggests that a pre-treatment plan be sent to the home office.

C. Definitions:

1. Accidental Injury: The sustaining of physical damage as the result of an unexpected occurrence caused by an external force, a foreign body, or corrosive chemical, that is independent of disease or bodily infirmity and for which the insured is not entitled to receive any benefits under any workman's compensation or occupational disease law. Physical damage resulting from normal movement of the mouth, including chewing, is not considered an Accidental Injury.

2. Diagnostic: Procedures to assist the dentist in evaluating the existing conditions to determine the required dental treatment.

3. Endodontics: Procedures for pulpal therapy and root canal filling.

4. Oral surgery: Procedures for extractions and other oral surgery including pre-operative care.

5. Orthodontics: Procedures for treatment of development, prevention, and correction of irregularities of the teeth and malocclusion, and with associated facial abnormalities.

6. Periodontics: Procedures for treatment of the tissues supporting the teeth.

7. Preventive: Prophylaxis, topical application of fluoride solutions, space maintainers.

8. Prosthodontics: Procedures for construction of bridges, partial and complete dentures, crowns, jackets, onlays and inlays. These procedures will be covered under the prosthodontic benefit, subject to the exclusions and limitations herein, when teeth cannot be restored with conventional filling materials.

9. Restorative: Provides amalgam, synthetic porcelain, and plastic restorations for treatment of carious lesions. Crowns and jackets will be provided as a "Prosthodontics Benefit" when teeth cannot be restored with the above materials.

D. Exclusions and Limitations: Covered dental charges shall not include expenses for services, supplies, or treatment for the following:

1. Services, supplies, or treatment which were not prescribed as necessary by a dentist or physician in connection with dental disease, defect, or Accidental Injury to teeth.

2. Crowns, fixed bridges, partial dentures, full dentures, and osseous implants are **ineligible for benefits during the first six (6) months of coverage** under the Dental Plan. This exclusion includes preparatory dental work in conjunction with these services.

3. Charges for local anesthesia or analgesic used for treatment other than the removal of bone-impacted teeth, cysts, or tumors.

4. A condition or injury which resulted from an Accidental Injury or disease arising out of or in the course of employment.

5. Installation, replacement, alteration of, or additions to dentures or fixed bridgework except as provided in "Covered Services."

6. Replacement of osseous implants and crowns (unless the existing implant or crown was placed at least five (5) years previously). Osseous implant replacements and crown replacements are limited to a maximum of two (2) per lifetime.

7. Loss or theft of dentures or bridgework.

8. Orthodontic services during the first year of coverage.

9. Dentistry for cosmetic purposes. This exclusion includes, but is not limited to, treatment for the alteration or extraction and replacement of sound teeth to change appearance including procedures to affect the color of the teeth.

10. Services for temporary fillings, temporary crowns, or temporary bridges that are billed in addition to the permanent filling, crown, or bridges.

11. Preexisting conditions **are ineligible for benefits during the first twelve (12) months of coverage (eighteen (18) months for a late enrollee)**. A treatment or procedure which was started or recommended within six (6) months immediately prior to the Enrollment Date is considered to be a preexisting condition. There is no credit for Creditable Coverage towards the satisfaction of the preexisting condition limitation period.

12. Fees that exceed the reasonable or prevailing rate customarily used in the area of service.

13. Fluoride treatment of a patient who is over 18 years of age.

14. Services which were not actually rendered.

15. Oral hygiene; dietary or plaque control programs; or other education programs.

16. Mouth guards.

17. Myofunctional therapy.

E. Major Medical Plan Provisions: Except as specifically modified herein, all provisions of the Major Medical Plan, except the benefits provisions, apply to this Supplemental Dental Benefit Plan.

F. General Provisions:

1. The dental benefits as described in this supplement will be in addition to any benefits provided by the Western Mutual Insurance Company Major Medical Plan. Should any conflict manifest itself between the medical base plan on which enrollees are covered and the Supplemental Dental Plan, the benefit that provides the maximum coverage will apply.

2. Plan Year: This plan is based on a calendar year (*i.e.*, January 1 through December 31).

3. Participation in this Plan: To participate in the Dental Plan: (a) an Employee and Dependent(s) must be enrolled on the Western Mutual Insurance Company Major Medical Plan; and (b) all Eligible Employees of the Employer group and insured Dependents must elect the dental benefit and pay premiums therefor. Enrollment

in the Dental Plan is accomplished by submitting a properly completed enrollment card at the time of the Employer's initial enrollment or any subsequent Open Enrollment Period.

4. Any newborn Child of any covered person is automatically covered, with no waiting or elimination period, from the moment of birth for a period of thirty-one (31) days. Coverage for a newborn Child includes immediate accident and sickness coverage, from and after the moment of birth. An adopted Child of any covered person is automatically covered from the date the Child is placed for the purpose of adoption and will continue unless the placement is disrupted prior to legal adoption. Coverage at the time of placement includes the necessary care and treatment of medical conditions existing prior to the date of placement. If the payment of a specific premium is required to provide coverage for a newborn or adopted Child, the Insured Employee must enroll the eligible Child within thirty-one (31) days from the date of birth or placement for adoption and must pay all applicable premium within the thirty-one (31) day period, in order for the coverage of a newborn Child or a Child placed for the purpose of adoption to extend beyond the thirty-one (31) day period.

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