WESTERN MUTUAL INSURANCE COMPANY

Dental Policy

Western Mutual Insurance Company

An Affiliate of Western Petroleum Marketers Association

PO Box 572450
Murray, UT 84157
(801) 263-8000 & (800) 748-5340
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DENTAL POLICY

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 will be covered under this policy subject to the exclusions and limitations set forth herein.

1. Routine oral examinations, including x-rays and prophylaxis (cleaning, scaling, and polishing). These services will not be covered 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 will be covered once each Calendar Year. This service is limited to children age eighteen (18) years or younger.

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. The initial installation of, or the addition to, dentures or fixed bridgework is covered. These services are only covered if: (i) the installation or addition is required due to the extraction of one or more natural teeth due to an Accidental Injury or a disease after the effective date of the Insured person's dental coverage; 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 is covered. These services are only covered 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 coverage; 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, is covered. This service is only covered if it is required as the result of structural change within the mouth and if it is 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 Policy for a period of two (2) years.

8. Repair of dentures or bridgework is covered. This Benefit does not include replacement, alteration, or relining.

9. Emergency palliative treatment is covered.

10. Fixed or removable space maintainers are covered for missing primary teeth if they are 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 are covered, 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 any 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 a dental disease, a defect, or an Accidental Injury to the teeth.

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

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

4. A condition or injury that resulted from an Accidental Injury or a 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 that are done 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: Any dental treatment or procedure that was started prior to the effective date of the patient's dental Insurance coverage.

12. Fees that exceed the reasonable or prevailing rate that is 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 Plan is an optional benefit that is in addition to the Major Medical Plan. In the event of a conflict between the medical Plan and the dental Plan, the Plan that provides the maximum coverage will apply.

2. Plan Year: The Plan Year is a Calendar Year (*i.e.*, January 1 through December 31).

3. In order for an Employee and his Dependents to participate in the Dental Plan, both of the following conditions must be satisfied.

   (a) An Employee and Dependent(s) must be enrolled in the Western Mutual Insurance Company Major Medical Plan.

   (b) An Employee and Dependent(s) must elect the Dental Benefit and pay all applicable premiums.

An Employee and his Dependent(s) may enroll in the Dental Plan by submitting a properly completed enrollment card at the time of the initial enrollment of the Employer. An Employee and his Dependent(s) may also enroll in the Dental Plan during a subsequent Open Enrollment Period by submitting a properly completed enrollment card.

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