Dental Policy

(with amendment #'s 1 and 2 incorporated)

WMI Mutual Insurance Company

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Salt Lake City, UT 84157
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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 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: Any dental treatment or procedure started prior to the effective date of the patient's Dental Insurance coverage. For any policy issued to an employer domiciled in the state of Idaho, the treatment or procedure must have been started within six (6) months immediately prior to the effective date in order to be considered a preexisting condition.

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 WMI 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. 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. Dependents: The following individuals are eligible Dependents of the Policy.

   (a) The lawful spouse of an Insured Employee;

   (b) The Insured Employee's (or the Insured Employee's Spouse's) Child(ren), under age twenty-six (26); and

   (c) An unmarried Child who has reached the limiting age for termination of coverage, who is incapable of self-sustaining employment by reason of intellectual Disability or physical Disability, who became so incapable prior to attainment of the limiting age, and who is chiefly dependent upon the Employee for support and maintenance. Proof of such Disability must be submitted within thirty-one (31) days of such Dependent's attainment of the limiting age. The Company may require at reasonable intervals during the two (2) years following the Child's attainment of the limiting age subsequent proof of his incapacity. After the two (2) year period, subsequent proof may not be required more than once each year.

5. Special Enrollees: The following individuals are eligible to enroll in the Plan outside the Open Enrollment period, provided that a properly completed written enrollment card is submitted to the Company within thirty-one (31) days of eligibility (or within sixty (60) days of eligibility if otherwise specified). Coverage will be effective on the first day of the first calendar month following the date that the enrollment materials are received by the Company.

   (a) Employees and/or Dependents who declined participation in the Plan when they were first eligible because they maintained other health insurance and have since involuntarily lost the other coverage. If the other coverage is provided under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), the Employee may only enroll after the COBRA coverage has been involuntarily exhausted. If the other coverage was provided under Medicaid or SCHIP, and coverage has been terminated due to a loss of eligibility, coverage through this Plan must be requested within sixty (60) days after the termination.

   (b) Employees who marry or acquire a Child through birth, adoption, or placement for the purpose of adoption. The Employee must enroll within the first sixty (60) days of eligibility.

   (c) Eligible Dependents of Insured Employees acquired due to marriage, birth, adoption, or placement for the purpose of adoption, are subject to the following eligibility rules:

      (i) A spouse may enroll in the Plan at the time of marriage or when a Child is born, adopted or placed for the purpose of adoption. Enrollment must be within sixty (60) days of eligibility.

      (ii) Newborn children and adopted newborn children placed for adoption within sixty (60) days of the adopted child's birth are automatically covered from and after the moment of birth for a period of sixty (60) days.

Coverage for adopted children placed more than sixty (60) days after the birth of the adopted child shall be from and after the date the child is placed. In order for the coverage of a newborn or adopted Child to continue beyond the sixty (60) day period, a completed enrollment form must be received by the Company within sixty (60) days from the date of birth or placement for adoption, and the appropriate premium (if any) must be received by the Company within thirty-one (31) days of the date the monthly premium invoice is received by the Employer and a notice of premium (if any) is provided to the Insured by the Employer.

For the purposes of this subsection, "Child" means an individual who has not attained age eighteen (18) years as of the date of the adoption or placement for adoption. For the purposes of this section, "placed" shall mean physical placement in the care of the adoptive Insured, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive Insured signs an agreement for adoption of such Child and signs an agreement assuming financial responsibility for such Child. Coverage includes that for congenital anomalies. For purposes of this section, "congenital anomaly" shall mean a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. The term "significant deviation" means a deviation which impairs the function of the body and includes, but is not limited to, the conditions of cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be congenital anomalies. Coverage continues until the first to occur of the following events:

1. The date the Child is removed permanently from that placement and the legal obligation terminates; or

2. The date the Insured rescinds, in writing, the agreement of adoption or agreement assuming financial responsibility.

6. All statements made by the Policyholder or by the Insured Employees and their Dependents shall, in the absence of fraud, be deemed representations and not warranties. No statement made by an Insured Employee or his Dependents shall affect the insurance or be used in defense to a claim hereunder unless such statement is formalized in writing and a copy of the instrument containing such statement is, or has been furnished to such Employee or to his beneficiary.

7. Grace Period: A grace period of thirty-one (31) days will be allowed for payment of any premium due, unless the Policyholder gives written notice of discontinuance prior to the premium due date.

8. Termination of Policy: This Plan is guaranteed renewable at the option of the Employer as long as premiums are paid and participation requirements are met. WMI Mutual Insurance reserves the right to amend the Policy, upon

sixty (60) days written notice to the Policyholder, or by mutual consent of the parties. This Plan may be non-renewed or it may be discontinued if any of the following apply.

(a) The Employer fails to pay the premiums.

(b) The Employer has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact under the terms of the coverage.

(c) The Employer has failed to comply with the contribution or the participation rules of the Plan.

(d) The Company ceases to offer coverage in accordance with applicable state law.

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