UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA
1275 Milwaukee Avenue, Glenview, IL 60025
(800) 207-8050

SHORT-TERM HOME HEALTH CARE INSURANCE POLICY
OUTLINE OF COVERAGE

For Policy Form Series U2370-IL
With Optional Rider Forms RU15CA-IL(R), RU16ASH-IL, RU16ASB-IL, RU19RPDL, RU23CG-IL

CAUTION: The issuance of the Policy is based on your answers to the questions on your application. A copy of your application will be attached to the Policy. Any omission or wrong statements in your application may result in your loss of coverage. If, for any reason, any of your answers are incorrect, contact us within 30 days at the address shown above.

If you have any questions concerning this coverage, or if we can be of any assistance, please call us at 1-800-207-8050.

NOTICE TO BUYER
THE POLICY MAY NOT COVER ALL OF THE COSTS ASSOCIATED WITH SHORT-TERM HOME HEALTH CARE INCURRED BY THE BUYER DURING THE PERIOD OF COVERAGE. THIS IS A LIMITED POLICY. THE BUYER IS ADVISED TO REVIEW CAREFULLY ALL POLICY LIMITATIONS AND EXCEPTIONS.

POLICY DESIGNATION
The policy is an individual policy of insurance.

PURPOSE OF OUTLINE OF COVERAGE
This outline of coverage provides a very brief description of some of the important features of the Policy. This is not the insurance contract, but only a summary of coverage. Only the individual Policy contains governing contractual provisions. This means that the Policy sets forth in detail those rights and obligations applicable to both you and United National Life Insurance Company of America. It is very important, therefore, that you **READ YOUR POLICY CAREFULLY**.

GUARANTEED RENEWABLE
This means you have the right, subject to the terms of the Policy, to continue the Policy as long as you pay your premium on time. We cannot change any of the terms of the Policy on our own, except that, in the future, WE MAY INCREASE THE PREMIUM YOU PAY. We may change your premium by giving you advance written notice, as required by state law. We can only do this when we change the premiums for all policies like yours in the state where you live.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE
If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from us. Neither United National Life Insurance Company of America nor its agents represent Medicare, the federal government or any state government.

SHORT-TERM HOME HEALTH CARE INSURANCE
Policies of this category are designed to provide persons insured with limited or supplemental coverage.

The Policy provides coverage on an indemnity basis for Covered Home Health Care Services. All benefits are subject to the definitions, limitations and exclusions described in the Policy.

BENEFITS PROVIDED BY THE POLICY

Benefit Eligibility: To qualify for benefits, a Licensed Health Care Practitioner must provide us with written certification that: (i) you have a Cognitive Impairment or Functional Impairment, and (ii) Covered Home Health Care Services is/are needed pursuant to a Plan of Care.

BENEFIT ELIGIBILITY TERMS DEFINED:
Cognitive Impairment means a deterioration or loss in intellectual capacity resulting from Alzheimer's disease, dementia or other similar forms of permanent progressive disease that destroy memory and/or other important mental functions of a person such as thinking, sensing or reasoning and which requires Substantial Supervision to protect You from threats or actual harm to Your health and safety. Cognitive Impairment is evaluated and measured by clinical evidence and/or standardized tests that reliably measure impairment in one's: (1) short or long-term memory; (2) orientation as to people, places, or time; and/or (3) deductive or abstract reasoning.

Functional Impairment mean the inability to perform at least two (2) of the six (6) Activities of Daily Living, listed below, without Substantial Assistance.

Activities of Daily Living means the following six (6) basic activities of daily living:

1. **Continence:** The ability to maintain control of bowel or bladder function; or, if unable to maintain control of bowel or bladder function, the ability to perform associated care for a catheter or colostomy bag..
2. **Dressing:** The ability to put on or take off all items of clothing and, if applicable any necessary braces, fasteners or artificial limbs.
3. **Eating:** The ability to feed oneself by getting food into the body from a receptacle (e.g., plate, cup, table) or if fed by a feeding tube or intravenously, Your ability to properly use and maintain such feeding tube.
4. **Personal Hygiene:** The ability to clean oneself and perform grooming activities on oneself like shaving and brushing teeth.
5. **Toileting:** The ability to get to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
6. **Transferring:** The ability to move into or out of a bed, chair or wheelchair, or generally move from place to place, without assistance.

POLICY BENEFITS BY PLAN SELECTION: Listed below are the benefits provided by the Policy. Benefit payment for each Covered Home Health Care Service is based upon the plan you select.

COVERED HOME HEALTH CARE SERVICES *(Check applicant's selection)*	**PLAN SELECTION** ☐ **Plan A**	☐ **Plan B**	☐ **Plan C**
NURSING CARE SERVICES			
Skilled Nursing Care /Daily Benefit	$75	$150	$200
General Nursing Care / Daily Benefit	$60	$120	$200
THERAPY AND MEDICAL SOCIAL SERVICES			
Physical / Daily Benefit	$75	$150	$200
Speech / Daily Benefit	$75	$150	$200
Occupational / Daily Benefit	$75	$150	$200
Enterostomal / Daily Benefit	$50	$100	$200
Respirational / Daily Benefit	$50	$100	$200
Chemotherapy Specialist / Daily Benefit	$60	$120	$200
Medical Social Services / Daily Benefit	$100	$200	$300
HOME HEALTH AIDE SERVICES			
Home Health Aide/Daily Benefit	$50	$100	$150
COMBINED MAXIMUM DAILY BENEFIT AMOUNT FOR COVERED HOME HEALTH CARE SERVICES			
Combined Maximum Daily Benefit Amount for ALL above Covered Home Health Care Services, not to exceed:	$150	$300	$450
PRESCRIPTION DRUG BENEFIT*			
Generic/per Prescription Drug	$10	$10	$10
Brand / per Prescription Drug	$25	$25	$25
Prescription Drug Policy Year Maximum	$300	$600	$900

*****The Prescription Drug benefit is not subject to the Pre-Existing Condition Limitation and is payable without regard to eligibility for Covered Home Health Care Services.

MAXIMUM BENEFIT PERIODS: The Maximum Benefit Period for all Covered Home Health Care Covered Services is 360 days.

PRE-EXISTING CONDITIONS LIMITATION:
The Policy is subject to a 6 month Pre-Existing Condition limitation. Pre-Existing Condition means a Sickness or Injury, disclosed or not disclosed on the Application, for which medical care, treatment, diagnosis or advice was received or recommended within the 6 month period immediately prior to the Policy's Effective Date OR a condition that, within the 6 months prior to the Policy's Effective Date, manifests itself in such a manner that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment. Treatment includes, but is not limited to, being prescribed drugs or taking Prescription Drugs. Any Loss due to a Pre-Existing Condition is not covered unless the Loss begins more than 6 months after the Policy's Effective Date.

LIMITATION ON BENEFITS:
1.) Benefits paid for Covered Home Health Care Services are subject to: (a) the Combined Daily Maximum Benefit Amount; and (b) the Maximum Benefit Period.

2.) We will not pay more than the Maximum Benefit Period, unless benefits are restored according to the Policy's Restoration of Benefits provision.

3.) The Daily Benefit Amount for each Covered Home Health Care Service is only payable for the date the specific service is provided.

4.) For benefits to be payable, Covered Home Health Care Services must occur while the Policy is in force.

5.) When multiple Covered Home Health Care Services are received on a single Day, We will count only one Day toward the Maximum Benefit Period.

RESTORATION OF BENEFITS:
The Maximum Benefit Period for Covered Home Health Care Services will be fully restored when:

1.) Covered Home Health Care Services are not received for a period of 180 consecutive days; and
2.) A Licensed Health Care Practitioner has provided written certification that you have sufficiently recovered enough to no longer qualify as having either (i) a Functional Impairment or (ii) Cognitive Impairment **and** have been advised that (i) you no longer require Covered Home Health Care or (ii) other nursing or home care services, whether or not such services are covered under the terms of the Policy.

POLICY EXCLUSIONS:
The Policy will not pay benefits for Loss under the following circumstances:

1.) For the provision of services due to Injury or Sickness arising out of war or any act of war, declared or undeclared while serving in the military services or any auxiliary unit attached thereto;
2.) For the provision of services due to Injury or Sickness caused, or aggravated by, intentionally self-inflicted injuries, or attempted suicide while sane or insane;
3.) For the provision of services due to participation in a felony, riot or insurrection;
4.) For the provision of services due to Injury or Sickness arising out of or in the course of employment or which is compensable under any workers' compensation or occupational disease act or law; or motor vehicle no-fault law;
5.) For the provision of services by a member of Your Immediate Family unless: (a) he or she is employed by the Home Health Care Agency; (b) the Home Health Care Agency receives payment for the services; and (c) he or she receives no compensation other than the normal compensation for employees of the Home Health Care Agency;
6.) For the provision of services not included in Your Plan of Care;
7.) For the provision of services which would not routinely be paid in the absence of insurance;
8.) For the provision of services received outside the United States or its possessions;
9.) For the provision of services arising out of Your taking of alcohol, or Your voluntary use of any drug, narcotic or other controlled substance, unless taken as prescribed by a Doctor; or
10). For the provision of services incurred prior to the Policy Effective Date, or on or subsequent to its termination or expiration date.

OPTIONAL RIDERS

CRITICAL ACCIDENT BENEFIT RIDER – FORM RU15CA-IL(R)

Maximum Benefit Amount per Accident: ☐ $5,000 ☐ $10,000
Waiting Period: 30 days

This Rider pays limited benefits for the following types of Injuries: hip and knee dislocation; fractures; and knee ligament and meniscus tears. To be eligible for benefits, you must receive Medically Necessary services in an Emergency Room or Urgent Care Facility to treat such Injuries within 48 hours of a covered Accident. Benefit payment is subject to a 30 day Waiting Period. Benefits are a paid as a percentage of the Maximum Benefit Amount per Accident:

Covered Injury	Percentage of Maximum Benefit Amount Per Accident That Will be Payable
Dislocation, hip	20%
Dislocation, knee	10%
Fracture, hip or skull	25%
Fracture, all other	5%
Tear, knee ligament or meniscus	10%

If more than one Fracture, Dislocation and / or Knee Ligament / Meniscus Tear is sustained as a result of a covered Injury, only one benefit is payable. The benefit payable will be that of the highest benefit amount associated with the sustained Fracture, Dislocation, or Knee Ligament/Meniscus Tear.

A Loss of Life Benefit is payable in the event of death as a result of Injuries sustained in a covered Accident. The Loss of Life Benefit is equal to the Maximum Benefit Amount Per Accident.

CRITICAL ACCIDENT BENEFIT RIDER EXCLUSIONS: This rider does not provide benefits for:

1.) Treatment, services or supplies which:
   a.) Are not prescribed by a doctor to treat an injury.
   b.) Are determined to be experimental / investigational in nature.
   c.) Are received without charge or legal obligation to pay.
   d.) Are received from persons employed or retained by any family member.
   e.) Are provided outside of an emergency room or urgent care facility.
2.) Fracture of fingers, toes, ribs or coccyx.
3.) Intentionally self-inflicted injury, violating or attempting to violate any duly enacted law.
4.) Injury being exposed to war or any act of war, declared or not, or participating in or contracting with the armed forces (including coast guard) of any country or international authority.
5.) Cosmetic surgery, except for reconstructive surgery on an injured part of the body.
6.) Dental treatment.
7.) Treatment of sickness, disease or degenerative process, including degenerative joint disease and/or non-traumatic arthritis. We also will not pay benefits for any related medical treatments or diagnostic procedures.
8.) Treatment of vegetation or ptomaine poisoning or bacterial infections, except pyogenic infections due to accidental open cuts; or accidental ingestion of contaminated substances.
9.) Suicide or attempted suicide while sane; or self-destruction or an attempt to self-destroy while insane.
10.) Injury resulting from being legally intoxicated as defined and determined by the laws of the state in which the injury where the loss or cause of the loss was incurred; or being under the influence of any illegal drugs or narcotic unless administered on the advice and as directed by a doctor.
11.) Injuries arising out of or in the course of employment and which is payable or covered under any workers' compensation or occupational disease act or law.
12.) Injuries incurred more than 40 miles outside the territorial limits of the United States or Canada, unless such loss is incurred while you are on a trip of not more than 60 days.

RETURN OF PREMIUM UPON DEATH BENEFIT RIDER – FORM RU19RPDL

This rider pays a return of premium benefit in the event of your death. The actual amount of premium that will be returned, if any, will equal:

1. The sum of all premiums you paid for the policy, including premiums paid for this rider and any other benefit riders attached to the policy (unless expressly excluded), while this rider is in force (except for any application and annual policy fees.) The sum of all premiums is without interest accumulation. MINUS
2. The sum of all benefits paid or then payable under the policy, including benefits paid or then payable under any attached benefit riders while the rider was in force.

ACCIDENT AND SICKNESS HOSPITALIZATION BENEFIT RIDER - FORM RU16ASH-IL

Accident and Sickness Hospitalization Benefit: ☐ $100 ☐ $200 ☐ $300 / per day
Maximum Benefit Period: ☐ 3 ☐ 6 / days
Waiting Period for Covered Sickness: 30 Days

This rider pays an Accident and Sickness Hospitalization Benefit for:

1. A Loss incurred as a result of a covered Injury, which was initially treated in an Emergency Room or Outpatient Facility within 48 hours after the covered Injury occurred, and with admittance to a Hospital immediately following.
2. A Loss as a result of a covered Sickness. Benefits are payable only when:
   a. Incurred while the Policy and Rider are in force;
   b. The Waiting Period, if any, has been satisfied; and
   c. Not otherwise excluded from coverage under the Policy and Rider.

We will pay the Accident and Sickness Hospitalization Benefit Amount for each day of Hospital Confinement due to a covered Accident or Sickness. Benefits are not payable beyond the Maximum Benefit Period of Hospital Confinement for any One Period of Hospital Confinement.

The first Hospital Confinement Day for the Accident and Sickness Hospitalization Benefit Amount is payable upon a Hospital Confinement of at least 24 consecutive hours by reason of a covered Injury or Sickness, for which benefits are payable and there is a charge for room and board.

Any one continuous period of hospitalization which begins while the Rider is in force, won't be affected by the Policy or Rider terminating.

ACCIDENT AND SICKNESS HOSPITALIZATION BENEFIT RIDER EXCLUSIONS:

This rider does not provide benefits for Loss as a result of:

1.) Intentionally self-inflicted injury, violating or attempting to violate any duly enacted law.
2.) Injury being exposed to war or any act of war, declared or not, or participating in or contracting with the armed forces (including coast guard) of any country or international authority.
3.) Injury received while traveling or operating, learning to operate, serving as a crewmember on, or jumping or falling from any aircraft including those, which are not motor-driven.
4.) Suicide or attempted suicide while sane; or self-destruction or an attempt to self-destroy while insane.
5.) Injury resulting from being legally intoxicated or under the influence of alcohol as defined by the laws of the state in which the injury occurs; or being under the influence of any illegal drugs or narcotic unless administered on the advice and as directed by a doctor.
6.) Injury to the spine, or the cervical, thoracic spinal, dorsal, sacro-iliac, or lumbar regions unless loss begins not less than 6 months after the covered person's effective date of coverage.
7.) Repetitive motion injuries, strains, all types of hernia, tendinitis, bursitis and heat exhaustion not related to a specific injury.
8.) Injuries arising out of or in the course of employment and which is payable or covered under any workers' compensation or occupational disease act or law.
9.) Injuries incurred more than forty (40) miles outside the territorial limits of the United States or Canada, unless such loss is incurred while the covered person is on a trip of not more than sixty (60) days.
10.) Pregnancy, except for complications of pregnancy; or hospital confinement due to giving birth within the first nine (9) months after the effective date of coverage under this rider as a result of a normal pregnancy, including cesarean.

AMBULANCE SERVICE BENEFIT RIDER - FORM RU16ASB-IL

This rider pays an Ambulance Service Benefit of $200 if a licensed ground ambulance service transports you to or from a medical facility. The ambulance service must be Medically Necessary. This Benefit is payable no more than 4 times per Calendar Year and is subject to a lifetime maximum benefit of $2,500.

AMBULANCE SERVICE BENEFIT RIDER EXCLUSIONS

This rider does not pay benefits for:

1.) Services which are not Medically Necessary.
2.) Services which are received without charge or legal obligation to pay.
3.) Services which would not routinely be paid in the absence of insurance.
4.) Services received outside the United States.
5.) Loss as a result of war, or any action of war, declared or undeclared; service in the armed forces of any country.
6.) Loss incurred as a result of participating in a felony or riot or insurrection.
7.) Loss incurred as a result of suicide or intentionally self-inflicted injury while sane or insane.
8.) Injury or sickness arising out of or in the course of employment or which is compensable under any workers' compensation or occupational disease act or law.
9.) Injury due to being legally intoxicated, as defined by the jurisdiction in which an accident occurs.
10.) Loss due to voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a doctor.

CAREGIVER SUPPORT BENEFIT RIDER – FORM RU23CG-IL

This rider pays a fixed indemnity benefit when Covered Home Care services are provided to you, due to a Functional Disability, by an informal Caregiver.

Before the Caregiver Benefit Amount will be payable under this rider:

1. A Licensed Health Care Practitioner must certify that the Covered Home Care services are needed because you have a Functional Disability or are Functionally Disabled as defined within this rider;
2. You must undergo, and complete, an Assessment with a Qualified Caregiver Support Provider;
3. We must receive a copy of the Tailored Caregiver Plan of Care developed as a result of the Assessment; and
4. You must be receiving Covered Home Care.

Assessment means the process by which a Qualified Caregiver Support Provider, in cooperation with a Caregiver, develops a Tailored Caregiver Plan of Care that the Caregiver must comply with while performing your Covered Home Care.

Caregiver means a member of your Immediate Family, or other person, who, on a day-to-day basis, provides at least one (1) hour of Covered Home Care directly to you in your Home. A Caregiver does not include a person who qualifies as a Home Health Care Practitioner, as defined by the Short-Term Home Health Care Benefit Rider, if such rider is attached to your Policy.

Covered Home Care means medical and non-medical services and/or treatments (as described below) provided to you, in strict accordance with a Tailored Caregiver Plan of Care, by a Caregiver in your Home. Medical and non-medical services and treatments include nursing care, physical therapy, occupational therapy, speech therapy, nutritionist services, meal preparation, laundry, light housekeeping, shopping for food, medications or medical supplies, and transportation to and from appointments. Covered Home Care is incurred on the date the service and/or treatment is provided. Covered Home Care must occur while this rider is in force. Any service and/or treatment provided prior to the Effective Date of this rider, or after this rider has terminated, is not Covered Home Care.

Functionally Disabled/Functional Disability means an Insured who is:

1. Unable to perform at least 2 Activities of Daily Living without human assistance or supervision; or
2. Requires Substantial Supervision to protect such individual from threats to one's health and/or safety due to Cognitive Impairment.

Qualified Caregiver Support Provider means an entity who utilizes a caregiver support platform that has been reviewed, and determined to be an evidence-based program, by the U.S. Department of Health and Human Services.

BENEFITS PROVIDED BY THE CAREGIVER RIDER

Caregiver Benefit Amount: $ 3,500

Caregiver Benefit Lifetime Maximum: $ 7,000

LIMITATIONS ON CAREGIVER BENEFITS

In addition to exceptions contained within the Policy, we will not pay the Caregiver Benefit Amount under this rider for:

1. Services or treatments provided prior to the Effective Date of this rider;
2. Services or treatments provided after the termination of this rider;
3. Services or treatments provided outside a Period of Care;
4. Services or treatments provided by an individual for which benefits have been paid under your policy or any other rider attached to your Policy;
5. Services or treatments which are inconsistent with, or not included within, the Tailored Caregiver Plan of Care;
6. Services or treatments provided during Days in which you do not receive at least one (1) hour of Covered Home Health Care;
7. Services or treatments which are the result of a pre-existing condition in accordance with the Policy's provisions relating to pre-existing conditions; or
8. Services or treatments resulting from an Assessment completed by a Qualified Caregiver Support Provider that is (1) owned, or operated, by a member of your Immediate Family or (2) a business entity that you or your Immediate Family have a financial interest in or business relationship with.

INITIAL PREMIUM

COVERAGE DESCRIPTION	PREMIUM
Short-Term Home Health Care Policy *(Check box for Plan selected)* ☐ Plan A ☐ Plan B ☐ Plan C	$_____
Accident and Sickness Hospitalization Benefit Rider	$_____
Ambulance Service Benefit Rider	$_____
Critical Accident Benefit Rider	$_____
Return of Premium Upon Death Benefit Rider	$_____
Caregiver Support Benefit Rider	$_____
Policy Fee:	$ 20.00
TOTAL PREMIUM:	$_____