

LIMITED BENEFIT DENTAL INSURANCE POLICY

BENEFITS PROVIDED BY THE POLICY ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

OUTLINE OF COVERAGE
For Policy Form U21DN-NC

KEEP THIS OUTLINE OF COVERAGE FOR YOUR RECORDS

THIS IS NOT A MEDICARE SUPPLEMENT INSURANCE POLICY. If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from the Company.

THIS IS AN OUTLINE OF COVERAGE FOR A LIMITED DENTAL BENEFIT POLICY AND OPTIONAL BENEFIT RIDER COVERAGE - READ YOUR POLICY AND RIDER(S) CAREFULLY. This Outline of Coverage provides a very brief description of the important features of the Policy and any attached Riders. This is not the insurance contract and only the actual Policy provisions will control. Your Policy sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY AND ANY RIDERS CAREFULLY!

LIMITED BENEFIT DENTAL INSURANCE POLICY

Subject to the limitations stated below, We will pay not to exceed the Calendar Year Maximum Benefit for the combined total of all Covered Expenses incurred as a result of Dental Treatment provided by a Dentist for Preventive Dental Care, Basic Dental Care, and Major Dental Care.

Payments for Dental Benefits are subject to:

1. Your Policy being in force;
2. The satisfaction of any applicable Calendar Year Deductible;
3. The satisfaction of any applicable Waiting Period;
4. The Calendar Year Maximum;
5. The Insured Percent;
6. All other service limitations and timing restrictions shown in the Policy Schedule; and
7. The terms, conditions, definitions, provisions, limitations, and exclusions of this Policy.

Payments for preventive dental examinations and/or cleanings are not subject to an Insured Percent, but are instead subject to a maximum of \$100 per visit, 2 visits per Calendar Year.

Calendar Year Deductible: \$100

Insured Percent of the Selected Calendar Year Maximum: 80%

Calendar Year Maximum Selected: ☐ \$1,000, ☐ \$2,000, ☐ \$3,000

GENERAL EXCLUSIONS

Benefits will not be paid for dental expenses arising from or in connection with:

1. Care, services, operations, procedures, or supplies not furnished by a Dentist, except:
 - a. That performed by a Dental Hygienist under the supervision of a Dentist; and/or
 - b. X-rays ordered by a Dentist.
2. Care, services, operations, procedures, or supplies which are:
 - a. Not defined as Dental Treatment in this Policy;
 - b. Experimental/Investigational in nature;
 - c. Received while outside the territorial limits of the United States;
 - d. Started prior to the Effective Date of this Policy or any attached riders; or
 - e. Started during any Waiting Period applicable to such care, service, operation, procedure, or supply.
3. Care, services, operations, or procedures due to Injury, unless such care, services, operations, or procedures begin and are completed while this Policy or any attached riders are in effect.
4. Services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers compensation insurance carrier according to a final adjudication under the North Carolina Workers Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers Compensation Act.
5. Care, services, operations, procedures, or supplies provided by a Family Member.
6. Care, services, operations, procedures, or supplies for which there would be no charge in the absence of insurance.

7. Care, services, operations, procedures, or supplies furnished to You for:
 - a. Cosmetic purposes, unless needed as a result of Injury. Facing on crowns, on pontics, posterior to the second bicuspid shall always be considered cosmetic
8. Implants or care, services, operations, procedures, or supplies provided in preparation for implants.
9. Appliances, replacement of lost or stolen appliances, replacement of orthodontic retainers, athletic mouthguards, precision or semi-precision attachments, denture duplication or sealants.
10. Abutment replacements or the placement or replacement of crowns attached to existing abutments.
11. Oral hygiene instructions; plaque control, acid etch, fluoride treatments or prescriptions for take-home fluoride.
12. Overdentures and associated procedures.
13. Care, services, operations, procedures, or supplies not completed by the end of the month in which insurance terminates.
14. Orthodontic related expense.
15. Bone grafts and/or socket grafts.

POLICY GUARANTEED RENEWABLE FOR LIFE. You may keep the Policy in force during Your lifetime by paying the renewal premium at the intervals available to You at time of renewal. To keep Your coverage in force, You must pay the renewal premium by its due date or during the Policy's thirty-one (31) Day Grace Period. We cannot cancel or refuse to renew the Policy or place any restrictions on it if You pay Your premiums on time.

PREMIUMS SUBJECT TO CHANGE. We may change the premium rates for the Policy by giving You at least forty-five (45) Days advance written notice of any change in the premium. We can only change the premium if We change it for all Policies like Yours in Your state on a class basis. We will not change Your premium more than once in a twelve (12) month period.

INITIAL PREMIUM: (Includes \$20 Annual Policy Fee)

Limited Benefit Dental Policy: \$ _____

TOTAL PREMIUM: \$ _____