United National Life Insurance Company of America
1275 Milwaukee Avenue, Glenview, Illinois 60025 800-207-8050

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-SD
With Optional Benefit Rider Form RU21DCR-SD

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 up to 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, up to 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. Care, services, operations, procedures, supplies, injuries or diseases related to Your job paid under a state's workers' compensation law. If You enter into a settlement giving up Your right to recover future medical benefits under a workers' compensation law, the Policy will not pay those medical benefits that would have been payable in absence of that settlement.
5. Care, services, operations, procedures, or supplies provided by a Family Member, unless such Family Member is the only Dental Hygienist or Dentist in the area and acting within the scope of practice.

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; or
   b. Dental care of congenital or developmental malformation.
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 (except for Dependent Children covered under a Rider attached to the Policy) 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.

OPTIONAL BENEFIT RIDER COVERAGE(S): (Available for an additional premium)

DEPENDENT CHILD RIDER PROVIDING LIMITED DENTAL BENEFITS (FORM RU21DCR-SD)
Subject to the limitations stated below, We will pay up to the Dependent Children Calendar Year Maximum for the combined total of all Dependent Children 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 Dependent Children Dental Benefits are subject to:
1. The Policy and this Rider being in force;
2. The satisfaction of any Dependent Children Calendar Year Deductible;
3. The satisfaction of the Dependent Children Waiting Period, if any;
4. The Dependent Children Calendar Year Maximum;
5. The Dependent Children Insured Percent;
6. All other service limitations and timing restrictions shown in the Rider Schedule; and
7. The terms, conditions, definitions, provisions, limitations, and exclusions of the Policy and this Rider.

Dependent Children Calendar Year Deductible: $100

Dependent Children Insured Percent of Calendar Year Maximum: 80%

Dependent Children Calendar Year Maximum: ☐ $1,000, ☐ $2,000, ☐ $3,000; Same as Policy Calendar Year Maximum

The Dental Treatment, covered as Preventive Dental Care, Basic Dental Care, and Major Dental Care under this Rider, are those same services that are covered under the Policy, with the exception that one (1) visit, per Calendar Year, for fluoride treatment performed at a dental office is also covered under this Rider, subject to a maximum payment of $100 per visit.

EXCLUSIONS

Benefits, under this Rider, are subject to the same types of limitations, restrictions, and exclusions listed above for the Policy.

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 thirty-one (31) 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.

INITIAL PREMIUM: (Includes $20 Annual Policy Fee)

Limited Benefit Dental Policy: $_____

☐ Child Dental Benefit Rider $_____

TOTAL PREMIUM: $_____