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

Dental and Vision Policy U17DV
Provides Limited Benefits for Certain Dental and Vision Treatment and Child Rider RU17CR
Guaranteed Renewable; Premiums May Be Changed By Class

OUTLINE OF COVERAGE
KEEP THIS OUTLINE OF COVERAGE FOR YOUR RECORDS

THIS INSURANCE AND OPTIONAL RIDER(S) PROVIDE LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

THIS IS NOT A MEDICARE SUPPLEMENT INSURANCE. 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 AND VISION BENEFIT POLICY [AND ADDITIONAL 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!

THIS DENTAL AND VISION POLICY PROVIDES LIMITED BENEFITS DURING THE FIRST 12 MONTHS AFTER THE RIDER EFFECTIVE DATE. PLEASE READ THE POLICY CAREFULLY.

DENTAL AND VISION BENEFIT POLICY
We will pay up to the Dental and Vision Benefit Calendar Year Maximum Benefit for visits for defined dental and vision treatment for the services and supplies shown. After the Calendar Year Deductible, if any, is satisfied, We will pay the Insured Percent of covered expenses up to the Calendar Year Maximum Benefit.

Policy Deductible Amount: $100
Insured Percent of the Selected Calendar Year Maximum – may vary by Type of Service: 80%
Dental and Vision Benefit Policy Calendar Year Maximum Benefit Selected:
□ $1,000, □ $1,500, □ $2,000

Dental and Vision benefits are subject to the:
1. Calendar Year Deductible Amount;
2. Waiting Period;
3. Calendar Year Maximum Benefit;
4. Insured Percent of covered expenses; and
5. Terms, definitions, provisions, limitations, and exclusions of the Policy.

The Insured Percent of covered expenses does not apply to Dental Evaluations, Cleanings or Eye Examination/Refraction services.

This Policy pays benefits for: (a) certain preventive dental care; and (b) certain non-preventive dental and vision care: Certain Preventive Dental Care is covered after 3 months, and subject to the selected Calendar Year Maximum Benefit of $75 per visit.

An annual eye examination or eye refraction is covered, after 3 months, with a Calendar Year Maximum Benefit of: $50

Basic Dental services provided after 6 months include fillings, non-surgical tooth extractions and problem focused x-rays. Additional Major Dental services are provided after 12 months.

Coverage for prescription eyeglasses or contact lenses is provided, after 6 months, up to an annual maximum of: $200.

EXCLUSIONS FOR DENTAL AND VISION BENEFITS

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

1. A service not furnished by a Dentist, except:
   a. That performed by a Dental Hygienist under the supervision of a Dentist; and
   b. X-rays ordered by a Dentist.
2. Treatment, services, procedures or supplies which are:
   a. Not defined as Dental Treatment in this Policy;
   b. Experimental/Investigational in nature;
   c. Covered by Workers Compensation Services;
   d. Started prior to the Effective Date of this Policy.
   e. Started during any Waiting Period applicable to that Service.
3. Services, injuries or diseases related to Your job to the extent You are covered or are required to be covered by the 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.
4. Treatment by a Family Member;
5. Services or supplies for which there would be no charge in the absence of insurance;
6. A service 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.
7. Implants or services provided in preparation for implants; replacement of lost or stolen appliances, replacement of orthodontic retainers, athletic mouthguards, precision or semi-precision attachments; denture duplication; or sealants.
8. Oral hygiene instructions; plaque control; acid etch; fluoride treatments (except for Dependent Children covered under a Policy Rider) or prescription for take-home fluoride.
9. Overdentures and associated procedures.
10. Services not completed by the end of the month in which insurance terminates.
11. Orthodontic related expense.
12. Bone grafts and/or socket grafts.

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

1. Treatment, services or supplies which are:
   a. Experimental/Investigational in nature;
   b. Received without charge or legal obligation to pay; or
   c. Provided by any Family Member.
2. Conditions 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;
3. Services and supplies in connection with special procedures such as: orthoptics (vision training or therapy) and subnormal vision aids;
4. Non-prescription (plano) eyewear;
5. Medical or surgical treatments of the eyes; or
6. Eye examinations required by an employer as a condition of employment.

OPTIONAL BENEFIT RIDER:

Child Rider for Dental and Vision Benefits: Provides the same benefits, limitations and exclusions as the Policy. An annual fluoride treatment is also provided.

Policy Deductible Amount: $100
Insured Percent of the Selected Calendar Year Maximum: 80%
Dental and Vision Child Rider Calendar Year Maximum Benefit Selected: □ $1,000, □ $1,500, □ $2,000

This Rider pays benefits for: (a) certain Preventive Dental Care; and (b) certain non-preventive Dental and Vision care:

Certain Preventive Dental Care is covered after 3 months, and subject to the selected Calendar Year Maximum Benefit of $75 per visit.

An Annual Eye Examination or Eye Refraction is covered, after 3 months, with a Calendar Year Maximum Benefit of: $50

Basic Dental Services provided after 3 months include fillings, non-surgical tooth extraction and problem focused x-rays. Additional Major Dental services are provided after 12 months.

Coverage for prescription eyeglasses or contact lenses is provided, after 6 months, up to an annual maximum of: $200.

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. You must pay the renewal premium by its due date or during the policy's 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 this Policy by giving You at least 31 days advance written notice of any change in the renewal 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:
Limited Benefit Dental and Vision Policy: **$**_____