



UCT® A Fraternal Benefit Society

THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA

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DENTAL, VISION AND HEARING EXPENSE INSURANCE POLICY

THIS IS A LIMITED BENEFIT POLICY WHICH ONLY PROVIDES BENEFITS FOR DENTAL, VISION AND HEARING EXPENSES. IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS, CONDITION OR INCAPACITY. THIS POLICY WILL NOT COVER ALL OF YOUR MEDICAL EXPENSES.

OUTLINE OF COVERAGE POLICY FORM DVH 0210

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

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and United Commercial Travelers of America. It is therefore important that you **READ YOUR POLICY CAREFULLY.**

Dental, Vision and Hearing only coverage is designed to provide you with coverage for certain losses for dental, vision and hearing **ONLY**, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

BENEFITS. After the Policy Year Deductible is satisfied, the following percentages of actual charges, not to exceed Reasonable and Customary Charges for Covered Expenses up to the Policy Year Maximum Benefit:

1. 60% in the first Policy Year;
2. 70% in the second Policy Year;
3. 80% in the third Policy Year; and
4. 90% thereafter.

Covered Expenses, subject to the Limitations and Exclusions, are:

Dental Benefits

We will pay the applicable percentage for dental services performed by a licensed Dentist, including one annual examination and cleaning, x-rays, fillings, prophylaxis, bridges, crowns, dentures and outpatient dental surgery prescribed as Medically Necessary.

After the Policy has been in force three (3) months, the Company will pay the cost of one (1) dental cleaning up to a maximum benefit of \$75 each Policy Year. This benefit is not subject to the Policy Year Deductible; however, it is included in the Policy Year Maximum Benefit.

We will NOT pay any benefits during the first six (6) months following the Policy Effective Date for root canals.

We will NOT pay benefits during the first Policy Year for the following items and/or services:

Bridges, crowns, full dentures or partials, any work relating to replacement of natural teeth which were missing on the Policy Effective Date, "full mouth" extractions or fluoride treatments;

Hearing Benefits

We will pay the applicable percentage for hearing examinations performed by a Physician or Audiologist, including the cost of the hearing aid and any necessary repairs.

We will NOT pay benefits during the first Policy Year for existing hearing aids.

Vision Benefits

We will pay the applicable percentage for visits to a Physician for a basic eye examination or eye refraction, including the cost of eyeglasses or contact lenses prescribed by the Physician, up to a maximum benefit of \$150 in any one (1) Policy Year.

We will NOT pay any benefits during the first six (6) months following the Policy Effective Date for existing eyeglasses or contact lens (including the renewal or changing of prescriptions).

Limitations and Exclusions

This Policy has a Policy Year Deductible as shown on the Policy Schedule Page. Once the Policy Year Deductible has been met, benefits are limited to the Policy Year Maximum Benefit as shown on the Policy Schedule Page.

We will NOT pay benefits for:

1. any loss resulting from war, declared or undeclared; or
2. any intentionally self-inflicted Injury; or
3. any loss resulting from the commission of or the attempt to commit an assault or felony; or
4. any loss resulting from engaging in any illegal activity or occupation; or
5. any services that are not recommended by a Physician or other licensed medical professional; or
6. any Experimental or Investigational Procedure or Treatment; or
7. orthodontic treatment; or
8. any expenses incurred for the diagnosis or treatment of temporomandibular joint disorder (TMJ); or
9. expenses incurred for surgical procedures (other than outpatient dental surgery) performed on an inpatient or outpatient basis (including any surgical procedure performed for the treatment of cataracts); or
10. charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures; or
11. prescription drugs; or
12. charges in excess of Reasonable and Customary Charges; or
13. treatment or diagnosis received while outside the United States of America or its territories; or
14. services for which you are not liable or for which no charge normally is made in the absence of insurance; or
15. loss that occurs while this Policy is not in force.

RENEWABILITY. The policy is guaranteed renewable for life. We will renew the policy each time you send us a premium. It must be paid on or before the date it is due or during the 31 days that follow.

PREMIUM CHANGE. We may change the premium rates for the policy. The change will be based on a new table of rates. We can only change the premium if we change it for all policies like yours in your class and in the same state where your policy was issued.