DENTAL AND VISION EXPENSE INSURANCE POLICY

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

THIS IS A LEGAL CONTRACT BETWEEN THE OWNER AND US.

This is a contract between You and The Order of United Commercial Travelers of America (UCT). We issue this Policy based on the application signed by You and the payment of premiums as stated on the Policy Schedule Page. We will pay the benefits subject to all the terms and conditions of this Policy. This Policy begins on the Date of Issue listed on the Policy Schedule Page. Payment of each premium as it comes due will continue coverage to the next premium due date.

The Order of United Commercial Travelers of America will pay the benefits of this Policy for an Insured Loss subject to the provisions and limitations of the Policy.

IMPORTANT NOTICE: The issuance of this Policy is based on the Insured’s answers to the questions on the application. A copy of the application is attached. Omissions or misstatements on the application could cause a claim to be denied or the Policy to be rescinded. If, for any reason the answers are incorrect, contact Us immediately at Our Home Office in Columbus, Ohio.

Thirty Day Right To Examine and Return Policy
Please read this Policy carefully. If, for any reason You are not satisfied, the Policy may be returned to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded.

Guaranteed Renewable for Life - Premium Subject to Change
This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as underwriting class, state and zip code of residence. You will be notified at least thirty (30) days prior to any change in the table of rates becoming effective.

Signed for the Society at Columbus, Ohio

Chief Executive Officer

NOTICE TO BUYER: This is NOT a Medicare Supplement Policy. If You are eligible for Medicare, review the Medicare Supplement Buyer’s Guide available from Us.

NON-PARTICIPATING
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State Variations May Apply
Policy Number: [12345678]  
Policy Effective Date: [July 1, 2010]

Insured Name: [John Doe]  
Issue Age: [45]

Owner Name (if Insured is a minor): [Jane Doe]

Mode At Issue:  
Modal Premium:

Policy Year Deductible: [$0 or $100]

Policy Year Maximum Benefit: [$1,000, $1,500, $2,000 or $2,500]

---------------------------------------------------------------

Premium

Plan 2  

Rider(s):

Hearing Expense Benefit Rider  

Total Premium  

$
Definitions

**Covered Expense or Covered Loss** refers to expenses incurred for Medically Necessary medical and dental services or supplies prescribed by a licensed medical professional. Covered Expenses may not be more than the Reasonable and Customary Charges for such services or supplies and will be deemed to be incurred on the date or dates such services or supplies are received by the Insured. Covered Expenses must be incurred while this Policy is in force.

**Dentist** refers to a person duly licensed and legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed, other than a member of the Insured's Immediate Family.

**Experimental or Investigational Procedure or Treatment** refers to the use of a treatment (drugs, devices and/or procedures) for a specific condition when all of the following are true:

1. the safety and effectiveness of a device is not proven; i.e. pre-market approval has not been granted (devices only);
2. benefits to at least one-third (1/3) of subjects are not documented in controlled clinical trials published in peer-reviewed English language medical journals; and
3. the treatment is not generally accepted medical practice as determined by review of peer-reviewed English language medical literature or authoritative medical journals or publications.


**Injury** means a bodily Injury which is the direct result of an accident and independent of all other causes that occurs after the Policy Effective Date and while this Policy is in force.

**Insured** refers to the person who is insured under this Policy. The Insured is as named in the application and shown on the Policy Schedule Page.

**Medically Necessary** means a service or supply that is required to diagnose or treat an Injury or Sickness and is:

1. prescribed by a Physician or other licensed medical professional;
2. consistent with the diagnosis and treatment of the Injury or Sickness;
3. in accordance with the generally accepted standards of medical practice; and
4. not solely for the convenience of You or the Physician or other licensed medical professional.

**Ophthalmologist** is a Physician duly licensed and legally entitled to practice ophthalmology at the time and in the state or jurisdiction in which services are performed, other than a member of the Insured's Immediate Family.

**Optometrist** is a Physician duly licensed and legally entitled to practice optometry at the time and in the state or jurisdiction in which services were performed, other than a member of the Insured's Immediate Family.

**Owner** refers to the person authorized to exercise the ownership rights under this Policy. The Owner is as named on the application or later endorsement. The Insured is the Owner unless the Insured is a minor.

**Physician** means any practitioner of the healing arts acting within the scope of his/her license, other than a member of the Insured's Immediate Family.

**Policy Effective Date** is the effective date of this Policy and is as shown on the Policy Schedule Page. The Policy Effective Date is not the date the application for coverage was signed.

**Policy Year** is a period of twelve months beginning each year on the month and day of the Policy Effective Date.

**Policy Year Deductible** refers to the dollar amount for which You are responsible during each Policy Year as shown on the Policy Schedule Page.

**Policy Year Maximum Benefit** is the maximum amount We will pay during any Policy Year as shown on the Policy Schedule Page.

**Pre-Existing Condition** means a condition for which symptoms existed prior to the Policy Effective Date that would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice or treatment was recommended by a Physician or received from a Physician.

**Preventative Dental Procedures** refer to Cleaning, Examination and X-ray.
Reasonable and Customary Charge refers to the normal and prevailing charge, fee, or expense for the service rendered or for the material furnished in the geographic area where rendered or furnished.

Sickness means illness or disease with first manifests itself after the Policy Effective Date and while this Policy is in force.

Written Notice to the Company means a request in writing on forms furnished by or acceptable to the Company. All correspondence should be sent to Our Home Office at P.O. Box 159019, Columbus, Ohio 43215.

We, Our, Us, Society, Company, UCT means The Order of United Commercial Travelers of America.

You, Your, Yours means the Insured named on the Policy Schedule Page.

Benefit Provisions

PLAN 2 - After the Policy Year Deductible is satisfied, the Company will pay 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 fillings, non-routine X-rays and a maximum of (4) four simple extractions during the first Policy Year.

After the policy has been in force three (3) months, the Company will pay the first visit up to $125 for routine Dental Cleaning, Examination and X-ray. After the policy has been in force twelve (12) months, routine Dental Cleaning, Examination and X-ray are payable twice per year with up to $125/$75 alternating toward Preventative Dental Procedures. In the first policy year the amount payable up to the $125.00 benefit will be applicable. Beginning in the second policy year, the amount payable up to $125.00 will be applied to the first visit and up to $75 to the second visit. This benefit is not subject to the Policy Year Deductible; however, it is included in the Policy Year Maximum Benefit. Services performed by a licensed Dentist to include a routine examination, cleaning and x-ray.

After the policy has been in force twelve (12) months, We will pay the applicable percentage for dental services performed by a licensed Dentist to include bridges, crowns, full dentures or partials, “full mouth” extractions, and root canals.

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 twenty-four (24) month period.

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
AGENT USE ONLY - SAMPLE POLICY – State Variations May Apply

7. orthodontic treatment; or
8. implants; or
9. occlusal guards, adjustments; or
10. any expenses incurred for the diagnosis or treatment of temporomandibular joint disorder (TMJ); or
11. 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
12. charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures; or
13. prescription drugs; or
14. charges in excess of Reasonable and Customary Charges; or
15. treatment or diagnosis received while outside the United States of America or its territories; or
16. services for which you are not liable or for which no charge normally is made in the absence of insurance; or
17. loss that occurs while this Policy is not in force.

General Provisions

Entire Contract; Changes – This Policy, including the application, endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by one of the Company's officers and unless such approval shall be endorsed hereon or attached hereto. No agent or officer of any Local, Grand or Supreme Council has authority to change this Policy or to waive any of its provisions.

Time Limit On Certain Defenses (Contestable Period) – Statements in the application are considered representations, not warranties. Statements may be used to contest the validity of this Policy or in defense of a claim only if they are contained in an attached application or endorsement. The Company cannot contest this Policy after it has been in force two years during the Insured’s lifetime, from the Policy Effective Date.

Grace Period – A Grace Period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium. This Policy shall continue in force during any Grace Period.

Reinstatement – If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental injury as may be sustained after the date of reinstatement and loss due to any Sickness as may begin more than ten (10) days after that date. In all other respects, We and You shall have the same rights there under as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

Notice of Claim – We must receive written Notice of Claim within twenty (20) days after any Covered Loss occurs or begins. Notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on Your behalf to the Society at Our Home Office at 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

Claim Forms – When We get a Notice of Claim, We will send You forms for filing Proof of Loss. If We do not send the forms within fifteen (15) working days after receiving Written Notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within ninety (90) days after the date the loss began or occurred.

Proof of Loss – We must receive written Proof of Loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the Insured making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

Time of Payment of Claims – All benefits payable under this Policy will be payable immediately upon receipt of due Proof of Loss.

If We do not pay benefits upon receipt of due Proof of Loss, We shall have fifteen (15) working days to mail to You a letter or notice which states the reasons We have for not paying the claim, either in whole or in part, including an itemization of any documents or other information needed to process the claim or any portions thereof which have not been paid. Once all of the listed documents or other information needed to process the claim have been received, We shall then have
fifteen (15) working days to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

Payment of Claims – We will pay all benefits to You; benefits under this Policy are not subject to assignment. Any benefits unpaid at Your death will be paid to Your estate or Your designated beneficiary.

Legal Actions – No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written Proof of Loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written Proof of Loss is required to be furnished.

Misstatement Of Age or Sex – If the Insured's age or sex has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age and sex.

Unpaid Premium: Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Pro Rata Refund: If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after death occurs.

Cancellation By Insured – You may cancel this Policy at any time by Written Notice to the Company delivered or mailed to Us. Cancellation will be effective upon receipt of the Written Notice or on a later date as specified in the notice. In the event of cancellation of this Policy, We shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the date of the cancellation.

Insurance coverage will terminate automatically as of the premium due date if premium for this Policy is in default beyond the end of the Grace Period.

Conformity With State Statute – Any provision of the Policy which, on the Policy Effective Date, is in conflict with the laws of the state in which the Insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Clerical Error – Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof documenting any clerical errors must be supplied.

Maintenance of Solvency – UCT's constitution provides that in the event that its reserves as to all or any class of contracts of insurance issued by it become impaired, the Board of Governors may require that these shall be paid by each Owner of such contract of insurance to UCT an amount equal to such Owner's equitable portion of such deficiency as ascertained by the Board of Governors.

If payment of the amount required is not made by such Owner, then either or both of the following, at the election of the Owner, shall apply:

1. the amount shall stand as Indebtedness against the contract of insurance and shall bear interest at a rate not to exceed ten percent (10%) per annum; or
2. the Owner shall accept a proportionate reduction in benefits paid pursuant to the contract of insurance.

The Owner shall make such election by notifying the Board of Governors of his or her election on a form prescribed by the Board of Governors that shall be provided to each Owner. Failure to make such election shall result in a presumption that the Owner elects to accept a proportionate reduction in benefits paid pursuant to the contract of insurance.

The Owner hereby agrees that if they affirmatively elect to have the amount stand as Indebtedness against the contract of insurance, then UCT may offset the amount of such Indebtedness together with interest thereon against any payment of benefits under this contract of insurance.

Suspension or Expulsion – If the Owner should be expelled or suspended from the membership in the Society for any reason, except nonpayment of premium or within the Contestable Period for misrepresentation on the Owner’s application for membership, the Owner shall have the privilege of maintaining this Policy in force by continuing payment of the required premium.