

DENTAL CARE

Preventive Dental Plan

No Pre-existing Condition Limitations

Choose Any Dentist: No Network Restrictions

No Waiting Periods

Completely Voluntary

\$25 Deductible Per Person Or Up To Three Family Members Per Year

Maximum Benefit Of \$750 Per Person Or \$1500 Per Family Per Year



OFFERED EXCLUSIVELY BY:

UNITED BENEFITS GROUP INC.

6705 East 81 st Street, Suite 190 Tulsa, Oklahoma 74133

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Underwritten By: Universal Fidelity Life Insurance Company
Duncan, Oklahoma

DENTAL CARE

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BENEFIT SCHEDULE

ADA Code	Description Of Dental Procedure	Allowable Amount	Co-insurance Percentage
DIAGNOSTIC			
D0120	Periodic Oral Evaluation	\$20	100%
D0150	Comprehensive Oral Evaluation	\$30	100%
D0220	Intraoral, Periapical, 1st film	\$11	100%
D0230	Intraoral, Periapical, Each Additional film	\$8	100%
D0270	Bitewing, Single	\$9	100%
D0272	Bitewing, Two	\$19	100%
D0274	Bitewing, Four	\$30	100%
D0330	Panoramic Film	\$70	100%
D0460	Pulp Vitality Test	\$23	100%
PREVENTIVE			
D1110	Cleaning, Adult	\$44	100%
D1120	Cleaning, Child	\$36	100%
D1201	Cleaning & Fluoride, Child	\$40	100%
D1203	Fluoride Treatment, Child	\$17	100%
RESTORATIVE			
D2110	1 Surface Amalgam, Primary	\$52	65%
D2120	2 Surface Amalgam, Primary	\$63	65%
D2130	3 Surface Amalgam, Primary	\$76	65%
D2131	4 or more Surface, Primary	\$98	65%
D2140	1 Surface Amalgam, Permanent	\$59	65%
D2150	2 Surface Amalgam, Permanent	\$73	65%
D2160	3 Surface Amalgam, Permanent	\$88	65%
D2161	4 or more Surface Amalgam, Permanent	\$115	65%
D2330	Composite 1 Surface, Anterior	\$72	65%
D2331	Composite 2 Surface, Anterior	\$88	65%
D2332	Composite 3 Surface, Anterior	\$109	65%
D2335	Composite 4 or more Surface or Incisal Angle, Anterior	\$139	65%
D2380	Composite 1 Surface, Posterior Primary	\$66	65%
D2381	Composite 2 Surface, Posterior Primary	\$80	65%
D2382	Composite 3 Surface, Posterior Primary	\$98	65%
D2385	Composite 1 Surface, Posterior Permanent	\$74	65%
D2386	Composite 2 Surface, Posterior Permanent	\$92	65%
D2387	Composite 3 Surface, Posterior Permanent	\$115	65%
D2388	Composite 4 or more Surface, Posterior Permanent	\$140	65%
D2721, D2781, D2791	Crown, Predominately Base Metal (Resin, 3/4 cast, full cast)	\$500	65%
D2951	Pin Retention, Per Tooth	\$35	65%

BENEFIT SCHEDULE (Continued)

ADA Code	Description Of Dental Procedure	Allowable Amount	Co-insurance Percentage
ENDODONTICS			
D3310	Root Canal Therapy, Antero	\$320	65%
D3320	Root Canal Therapy, Bicuspoid	\$390	65%
D3330	Root Canal Therapy, Molar	\$500	65%
PERIODONTAL			
D4260	Osseous Surgery (Per Quadrant)	\$300	65%
D4341	Scaling/Root Planning (Per Quadrant)	\$101	65%
D4355	Full Mouth Debridement	\$76	65%
D4910	Maintenance Procedures After Therapy	\$63	65%
ORAL SURGERY (Includes Local Anesthesia, Sutures, Routine Post-OP Care)			
D7110	Extraction, Single Tooth	\$74	65%
D7120	Extraction, Each Additional Tooth	\$68	65%
D7210	Surgical Removal – Erupted Tooth	\$112	65%
D7220	Surgical Removal – Impacted - Soft Tissue	\$160	65%
D7230	Surgical Removal – Impacted - Partially Bony	\$197	65%
D7240	Surgical Removal – Impacted - Completely Bony	\$235	65%
D7241	Surgical Removal – Impacted - Completely Bony & Complications	\$267	65%
D7250	Surgical Removal – Residual Tooh Roots	\$114	65%
GENERAL			
D9110	Emergency Treatment	\$42	65%

Mail Claims to:

Universal Fidelity Life Insurance Company
P.O. Box 16708
Jackson, MS 39236
(888) 888-2519

Administrative Office:

Universal Fidelity Life Insurance Company
407 Briarwood Drive, Suite 201
Jackson, Mississippi 39206

Universal Fidelity Life Insurance Company

DENTAL BENEFITS COVERAGE

REQUIRED OUTLINE OF COVERAGE- POLICY FORM UF-SCHED-DENTAL

1. 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 your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

2. The policy is designed to provide you with Dental coverage only. Coverage is provided for the benefits outlined in Paragraph 3. The benefits described in Paragraph 3 may be limited by Paragraph 4. **THIS POLICY IS NOT A MEDI-CARE SUPPLEMENT POLICY.**

3. BENEFITS. Only listed procedures are covered. \$25.00 calendar year deductible for each Insured; up to maximum of 3 calendar year deductibles per policy. Maximum calendar year benefit for each Insured is \$750.00, not to exceed maximum calendar year benefit per policy of \$1500. **DIAGNOSTIC & PREVENTIVE procedures paid at 100% of Allowable Amount or actual expense incurred, whichever is less. All other procedures are paid at 65% of Allowable Amount or actual expense incurred whichever is less. (SEE BENEFIT SCHEDULE FOR LISTING)**

4. LIMITATIONS AND EXCLUSIONS – READ CAREFULLY. The Outline of Coverage includes a complete list of dental procedures for which benefits are payable. No benefits are payable for any procedure or expense which is not listed. Benefits are not payable for: (a) dental care for which payment would not be required if there were no insurance; (b) dental care provided only for the purpose of improving appearance (cosmetic dentistry); (c) dental care below American Dental Association standards; (d) charges for appointment, not kept, office calls if no other service is performed or charges for completion of claim forms; (e) charges related to dental care payable under any Worker's Compensation Law or similar legislation; (f) service begun before or provided prior to the Effective Date or services provided after termination of insurance; (g) services as a result of injuries due to commission or attempt to commit a felony, or engaging in an illegal occupation or participating in a riot, rebellion or insurrection; (h) services provided or paid for by a governmental program or law unless the Insured is legally obligated to pay; (i) treatment received outside the U.S. if an Insured traveled to the location to receive treatment. Spouse's coverage terminates following divorce unless conversion privilege is exercised. Dependent children and/or dependent grandchildren, named on the application, are covered until the earlier of age 22 or marriage.

5. RENEWABILITY. This policy is renewable at the option of the Company. Premium rates are subject to change. There is a grace period of 31 days in which to pay premiums after the initial premium; unless, the Company mails notice to the Insured of its intention to non-renew at least 30 days before the premium due date.

DISCLOSURE OF LIMITED AGENT AUTHORITY

Your application was taken by a soliciting agent whose authority is limited only to providing you with an outline of coverage and an application, assisting you, if necessary, in filling out the application and then transmitting your application and initial premium to the home office. Your agent does not have the authority to waive a complete answer to any question on your application, or to approve insurability, nor the authority to waive any rights of the company and you will not be insured until a policy is actually issued by the company. The making of an application and the payment of an initial premium does not guarantee your insurability and does not mean that you are insured by the company.