Outline of coverage

Protection Series℠–

Dental, Vision and Hearing Insurance Plan

Policy Form CLIDH917 AR

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

Arkansas

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LIMITED BENEFIT DENTAL, VISION AND HEARING POLICY

OUTLINE OF COVERAGE FOR POLICY FORM: CLIDH917 AR

RETAIN THIS OUTLINE FOR YOUR RECORDS

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

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 us.

Limited Benefit Coverage: Policies of this type are designed to provide limited or supplemental insurance coverage to person(s) insured. This policy does not provide any benefits other than the coverage described below.

Coverage Provided by the Policy: Your policy provides benefits for (1) preventive, basic, and major dental services, and (2) vision and hearing services. All benefits are subject to any applicable Waiting Period, Policy Year Deductible, Policy Year Maximum Benefit, Exceptions and Limitations and all other provisions of the policy.

Policy Year Maximum Benefit Amount per Insured Person:

Maximum payable for all expenses during any one Policy Year	$1,000, $1,500 or $2,000
Maximum payable for Vision Expenses during any two Policy Years	$200
Maximum payable for Hearing Expenses during any one Policy Year	$500

Policy Year Deductible per Insured Person: There is a combined $100 Policy Year Deductible which is met by incurring Eligible Expenses for Dental Classes A, B and C, and Eligible Expenses for Vision and Hearing

Waiting Periods

Dental Class C Major Services	12 Months
Vision Expenses	6 Months
Hearing Expenses	12 Months

<u>DENTAL BENEFITS</u>

For Medically Necessary dental services provided by a Participating or Non-Participating Dentist, We will pay based on the contracted fee for service with the Preferred Provider Organization (PPO) for dental procedures and services after any required Policy Year Deductible amount, as shown above. You will be responsible for any applicable Coinsurance.

You will be responsible for charges by a Non-Participating Dentist in excess of the contracted fee for service charged by the PPO, in addition to any applicable Coinsurance and Policy Year Deductible.

Eligible Expenses are as follows:

Class A. Preventive Services Include:
Evaluations
Comprehensive or periodic oral evaluations: limited to two evaluations (including any initial exam) per Policy Year (separated by 6 months).

X-Rays
Bitewing films: Limited to 1 series consisting of no more than 4 films per Policy Year (unless complete series/panoramic x-ray benefit in Class B, Basic Services has been paid during the Policy Year).

Routine Dental Prophylaxis
Adult prophylaxis: limited to two treatments per Policy Year (separated by 6 months). Benefit includes scaling and polishing.

Class A benefits are paid as follows for services received from a Participating or Non-Participating Dentist:

	First Policy Year	**Second Policy Year**	**Each Policy Year Thereafter**
We pay, after Policy Year Deductible Is Met	60%	70%	80%

Class B. Basic Services Include:
Evaluations
1. Limited oral evaluation: limited to 1 evaluation per Policy Year and payable only if no other service (except x-rays) is rendered during the evaluation.
2. Diagnostic consultation: limited to 1 consultation (by a Dentist other than the one providing treatment) for each dental specialty per Policy Year and payable only if no other service (except x-rays) is rendered during the consultation.
3. Emergency palliative treatment: limited to 2 palliative treatments per Policy Year and payable only if no other service (except x-rays) is rendered.

X-Rays
1. Complete series/panoramic: limited to 1 panoramic film or complete series (including bitewing films) in any Policy Years (if paid during a Policy Year, replaces benefit for bitewing films in Class A, Preventive Services).
2. Periapical films: limited to 2 per Policy Year.

Basic Restorative Services
Insulating base and local anesthesia is considered an integral part of services provided.

Fillings:
1. Amalgam restoration: limited to 1 filling per tooth surface in any 2 Policy Years. Contiguous surfaces billed separately will be combined as one restorative procedure.
2. Composite resin (synthetic) restoration: limited to 1 filling per anterior tooth surface in any 2 Policy Years. Contiguous surfaces billed separately will be combined as one restorative procedure.
3. Pin retention: only in conjunction with amalgam or composite resin restorations and only 1 per tooth.

Basic Oral Surgery
Local anesthesia and routine follow-up care are considered an integral part of basic oral surgery.

Extractions
Extractions: non-surgical extraction, up to 4 teeth per Policy Year.

Periodontal Services
Local anesthesia and routine follow-up care are considered an integral part of services rendered.

Non-Surgical Services:
1. Periodontal scaling and root planing: As necessary for substantial bone and attachment loss evident on current periodontal charting and radiographs; limited to 1 treatment per quadrant in any 2 Policy Years.
2. Periodontal maintenance: limited to one treatment per Policy Year (replaces routine dental prophylaxis).

Class B benefits are paid as follows for services received from a Participating or Non Participating Dentist:

	First Policy Year	Second Policy Year	Each Policy Year Thereafter
We pay, after Policy Year Deductible Is Met	60%	70%	80%

Class C. Major Services Include:

Major Restorative Services

Laboratory fabricated restorations and crowns are covered only when needed because of extensive decay or fracture and only when the tooth cannot be restored with a direct placement restoration. Insulating base, temporization and associated gingival treatment are considered an integral part of services rendered.

Inlays / Onlays / Crowns (excludes core build up)

Inlay, onlay and crown replacements are payable only after 5 years from the date of initial insertion. Temporary inlays, temporary onlays and prefabricated crowns older than 1 year are considered a permanent appliance and are subject to the 5 year replacement limitation.

1. Crowns: acrylic with metal; porcelain; porcelain with metal; full cast of ¾ cast metal, other than stainless steel; cast post and core, in addition to crown but not a thimble coping; steel post and composite or amalgam core, in addition to crown; cast dowel pin, one-piece cast with crown, based on type of crown.
2. Prefabricated crowns: only for a permanent tooth fractured as a result of an accident limited to one prefabricated crown per lifetime of the tooth.
3. Labial veneers: covered as an alternate treatment to a crown when the tooth would have otherwise qualified for a crown.
4. Recementation: considered part of original service if done within 1 year of initial placement.

Endodontic Services

1. Root canal therapy (not covered, if pulp chamber was opened before coverage began): Non-vital, nerve-dead tooth; local anesthesia and routine follow-up care are considered an integral part of services rendered; limited to 1 root canal treatment per tooth in any 3 Policy Years.
2. Vital pulpotomy: limited to primary teeth only.
3. Apexification: therapeutic apical closure.
4. Apicoectomy and retrograde filling: as a separate procedure or in conjunction with other endodontic procedures; limited to 1 treatment per tooth in any 3 Policy Years.

Periodontal Services

Local anesthesia and routine follow-up care are considered an integral part of services rendered.

Surgical Services: limited to 1 periodontal surgical service per quadrant in any 3 Policy Years.

1. Gingivectomy: per quadrant; limited to less than 3 teeth.
2. Osseous surgery: Per quadrant; benefit includes all necessary associated surgical procedures.
3. Mucogingival surgery: pedicle soft tissue graft; gingival flap procedure; guided tissue regeneration; free soft tissue graft.
4. Bone replacement grafts: only when related to periodontal procedures.
5. Clinical crown lengthening: benefit includes all necessary associated surgical procedures.

Prosthodontic Services

1. Fixed bridges: each abutment and each pontic makes up a unit of a bridge. Temporary bridges older than 1 year are considered a permanent appliance.
2. Dentures: benefit includes all adjustments done by Dentist furnishing denture during first 6 months after installation. Temporary dentures older than 1 year are considered a permanent appliance.

Limited to services performed more than 12 months after initial insertion of appliance:

1. Denture rebase: limited to once per denture in any Policy Year.
2. Denture reline: limited to once per denture in any 2 Policy Years.
3. Tissue conditioning: limited to a maximum of 2 treatments per arch in any Policy Year.
4. Addition of teeth to partial dentures: limited to replacement of natural teeth lost under this Policy after 3 Policy Years.

5. Denture adjustments and repairs: adjustments; repairing acrylic dentures, no teeth damage; repairing acrylic dentures and replacing one or more broken teeth; repairing metal dentures to the extent and nature of damage and type of materials involved; replacing one or more broken teeth, no other damage.
6. Crown/bridge repair: limited to extent and nature of damage and type of materials involved.

Bridge or denture replacements available only after 8 years from the date of initial installation. No benefits are payable for replacement of third molars or a portion of a tooth lost due to root amputation or hemisection.

Missing Tooth
If an Insured has lost one or more teeth prior to the Effective Date, We will not pay for a prosthetic device that replaces such teeth unless the device also replaces one or more natural teeth lost or extracted while covered under this Policy. We will pay for fixed bridges or dentures to replace such missing teeth if teeth were extracted within 6 months of the Effective Date if this Policy immediately replaces a prior plan. Replacement of congenitally missing teeth is not covered under this Policy unless You are replacing a current fixed bridge or denture. This replacement is subject to contract replacement limits.

General Anesthesia:
General anesthesia: only when in conjunction with a covered complex oral surgery procedure.

Class C benefits are paid as follows for services received from a Participating or Non Participating Dentist:

	First Policy Year	**Second Policy Year**	**Each Policy Year Thereafter**
We pay, after Policy Year Deductible Is Met	0%	60%	60%

VISION BENEFITS

Vision Expenses
1. Visits to a Provider for a basic eye examination or eye refraction.
2. Expenses incurred for the cost of eyeglasses or contact lenses prescribed by the Provider.

Vision Benefits are paid as follows:

	First Policy Year	**Second Policy Year**	**Each Policy Year Thereafter**
We pay, after Policy Year Deductible Is Met	60%	70%	80%

HEARING BENEFITS

Hearing Expenses
1. Hearing examinations performed by a Provider or Audiologist,
2. The purchase of hearing aids prescribed by a Provider or Audiologist, including the cost of the hearing aid and any necessary repairs.

Hearing Benefits are paid as follows:

	First Policy Year	**Second Policy Year**	**Each Policy Year Thereafter**
We pay, after Policy Year Deductible Is Met	0%	70%	80%

Exclusions and Limitations
Your Policy does not cover any expense not considered an Eligible Expense.

We will NOT pay benefits for:
1. Items, treatments or services:
   a. not listed as an Eligible Expense in the Schedule of Benefits;
   b. not prescribed by or performed by or under the direct supervision of a Dentist or a Provider;
   c. not Medically Necessary;
   d. any Experimental of Investigational procedure or treatment; or

   e. performed by a member of Your Immediate Family.
2. Charges in excess of the Reasonable and Customary Charge;
3. Treatment resulting from:
   a. Your participation in a war or an act of war, declared or undeclared;
   b. Your attempt to commit, or committing, an assault or felony;
   c. Your unlawful participation in a riot, rebellion, or insurrection; or
   d. an intentional self-inflicted injury while sane or insane.
4. Services furnished primarily for cosmetic reasons, including, but not limited to:
   a. specialized techniques, characterizing and personalizing prosthetic devices;
   b. making facings on prosthetic devices for any tooth in back of the second bicuspid;
   c. replacements of restorations performed for cosmetic reasons; or
   d. charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures.
5. Orthodontic treatment; implantology and related services; implants and all related procedures, including removal of implants;
6. Charges for any appliance or service that is used to:
   a. change vertical dimension;
   b. restore or maintain occlusion;
   c. splint or stabilize teeth for periodontal reasons; or
   d. treat disturbances of the temporomandibular joint (TMJ), unless mandated by state law.
7. Charges for any service performed as a result of abrasion, attrition, bruxism, erosion or abfraction.
8. Occlusal, athletic, or night guards.
9. Preventive root canal therapy.
10. Full mouth debridement.
11. Charges for any services that are considered to be an integral part of another service, such as pulp capping.
12. Surgical trays, or sutures.
13. Ridge preservation, augmentation, bone grafts and regeneration procedures performed in edentulous sites.
14. Overdentures or precision attachments.
15. Space maintainers and sealants for an insured over the age of 16.
16. Preparation and fitting of preformed dowel or post for root canal tooth; pulp cap either directly or indirectly.
17. Duplicate or temporary devices, appliances, and services except as listed as an Eligible Expense.
18. Replacing a lost, stolen or missing appliance or prosthetic device.
19. Application of chemotherapeutic agents.
20. Oral hygiene instruction, plaque control, diet instruction or infection control.
21. Charges for sterilization of equipment; disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies.
22. Treatment or diagnosis received while outside the territorial limits of the United States.
23. Treatment which is:
    a. due to an on-the-job or job-related illness or injury; or
    b. a condition for which benefits are payable by Workers' Compensation or similar laws, whether or not benefits are claimed.
24. Treatment for which no charge is made or for which You are not legally obligated to pay, including, but not limited to, treatment (or charges made) by:
    a. Your employer, labor union or similar group, in its dental or medical department or clinic;
    b. a facility owned or run by any government body; or
    c. any public program, except Medicaid, paid for or sponsored by any government body.
25. Telephone consultations, charges for failure to keep a scheduled appointment, X-ray copy fees, or charges for completion of a claim form.
26. Ancillary charges, including, but not limited to, hospital, ambulatory surgical center or similar facility; or use of Provider office space.
27. Impacted wisdom teeth.
28. Prescription drugs.
29. Any surgical procedure performed in the treatment of cataracts.
30. Loss that occurs while this Policy is not in force.

Benefits are limited as follows:

1. In the event You transfer from the care of one Dentist or Provider to that of another during the course of treatment, or if more than one Dentist or Provider performs services for one Eligible Expense, We shall only be liable for an amount, not to exceed the charges that would be typically incurred, had one Dentist or Provider performed the services.

2. In all cases involving Eligible Expenses in which the Dentist or Provider and You select a more expensive course of treatment than is customarily provided by the medical or dental profession, payment under the Policy will be based on the charge allowed for the procedure with the lesser charge.

Guaranteed Renewable: You have the right to renew this Policy for consecutive terms by paying the required premium by the end of each Grace Period subject to the Policy Termination provisions.

Policy Termination:

Your Policy will terminate at 12:01 a.m. local time in Your state of residence on the earliest of the following dates:

1. The date We receive Your written request to cancel Your Policy or on the specific date requested by You;
2. The Premium Due Date, if sufficient premium has not been paid by the end of the Grace Period;
3. For a Child, on the date they no longer meet the eligibility requirements of a Child under this Policy;
4. For a Domestic Partner, on the date they no longer meet the eligibility requirements of a Domestic Partner under this Policy;
5. For a Spouse, on the date of a valid decree of divorce; or
6. The date of death of the Policy Owner.

Premiums: Premiums for the Policy may change. Any change in premium will apply to all Insured Persons with Your same Policy type based on the state of issue of Your Policy. Any change in premium may occur on the premium due date following at least 30 days advance written notice of such premium change to You.