Outline of coverage

Protection Series℠ –

Dental, Vision and Hearing Insurance Plan

Policy Form CLIDH917 KS

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

Kansas

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LIMITED BENEFIT DENTAL, VISION AND HEARING POLICY

OUTLINE OF COVERAGE FOR POLICY FORM: CLIDH917 KS

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. Refer to the Schedule of Benefits provided with your policy for details.

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

There is no pre-existing condition exclusion or limitation in the Policy.

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. related to Your job, to the extent You are covered or are required to be covered by the Worker's Compensation law. If You enter into a settlement giving up Your right to recover future medical benefits under a Workers' Compensation law, this policy will not pay those medical benefits that would have been payable in absence of that settlement. .
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:

The Policy Owner may cancel the Policy at any time by sending Us a written request to cancel. Upon cancellation, We will return the unearned portion of any premium paid in accordance with the laws in Your state of residence at the Policy Effective Date.

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.

Premium Calculation

Available Benefits:	**Benefits Selected:**	**Benefit Amount:**	**Premium Amount:**
Dental, Vision and Hearing	Dental, Vision and Hearing	○ $1,000	$
		○ $1,500	$
		○ $2,000	$
			Total Premium: $_______________

Name of Agent: ____________________________________ Date: _______________________

Signed by Continental Life Insurance Company of Brentwood, Tennessee Agent:

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