Outline of Coverage

Protection Series℠–

Dental, Vision and Hearing Plus Insurance Plan

Policy Form CLIDVH20 TX

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

Texas

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CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE

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LIMITED BENEFIT DENTAL, VISION AND HEARING POLICY

OUTLINE OF COVERAGE FOR POLICY FORM: CLIDVH20 TX

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 designed to provide you with limited dental, vision and hearing insurance coverage but it provides benefit amounts which are less than those prescribed by the insurance regulatory authority of your state as minimum benefit amounts for this type of coverage. Coverage is provided for the benefits outlined in paragraph (3). The benefits described in paragraph (3) may be limited by paragraph (4).

Coverage Provided by the Policy: Your policy provides benefits for (1) preventive, basic, and major dental services, and(2) Orthodontia, and (3) vision and hearing services. All benefits are subject to any applicable Waiting Period, Policy Year Deductible, Policy Year Maximum Benefit.

Policy Year Maximum Benefit Amount per Insured Person:

Maximum payable for all Eligible Expenses during any one Policy Year	$1,000-5,000 in $500 increments
Maximum payable for Vision Expenses during any two Policy Years	$200
Maximum payable for Hearing Expenses during any one Policy Year	$500

Lifetime Maximum Benefit Amount per Insured Person

Lifetime Maximum Benefit Amount per Insured Person Orthodontia	$1,500
Lifetime Maximum Benefit Amount per Insured Person Implant Services	$1,500

Policy Year Deductible per Insured Person: There is a combined 0-$150 Policy Year Deductible which is met by incurring Eligible Expenses for Dental Classes A, B and C, and Eligible Expenses for Orthodontia and Eligible Expenses for Vision and Hearing

Waiting Periods

Dental Class C Major Services	1-12 Months
Orthodontia	1-12 months
Vision Expenses	1-6 Months
Hearing Expenses	1-12 Months

Dental Benefits

Class A Benefits	**First Policy Year**	**Second Policy Year**	**Each Policy Year Thereafter**
We pay, after Policy Year Deductible Is Met	100%	100%	100%
Class B Benefits			
We pay, after Policy Year After Deductible Is Met	65%	80%	80%

Class C Benefits			
We pay, after Policy Year After Deductible Is Met	20%	50%	50%
Orthodontia Benefits			
Initial Treatment: Orthodontic Examination We pay, after Policy Year Deductible Is Met	N/A 0-30%	50%	50%
Initial Treatment: Placement of Braces or Appliances We pay, after Policy Year Deductible Is Met	N/A 0-30%	50%	50%
Continuing Treatment for Braces or Appliances We pay, after Policy Year Deductible Is Met	N/A $0-$100	$50-$300	$50-$300

Vision Benefits	**First Policy Year**	**Second Policy Year**	**Each Policy Year Thereafter**
We pay, after Policy Year Deductible Is Met	65%	80%	80%

Hearing Benefits	**First Policy Year**	**Second Policy Year**	**Each Policy Year Thereafter**
We pay, after Policy Year Deductible Is Met	N/A	80%	80%

Plans may be offered with or without a Contracted Provider Organization for dental expenses. Please refer to your Policy for details.

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. performed by a member of Your Immediate Family except for Eligible Expenses provided by a licensed Dentist.
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;
6. implantology and related services; implants and all related procedures, including removal of implants; 7. 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.
8.Charges for any service performed as a result of abrasion, attrition, bruxism, erosion or abfraction.
9. Occlusal, athletic, or night guards.
10.Preventive root canal therapy. 11.Full mouth debridement.
12.Charges for any services that are considered to be an integral part of another service, such as pulp capping.
13.Surgical trays, or sutures.
14.Ridge preservation, augmentation, bone grafts and regeneration procedures performed in edentulous sites.
15.Overdentures or precision attachments.
16.Space maintainers and sealants for an insured over the age of 16.
17.Preparation and fitting of preformed dowel or post for root canal tooth; pulp cap either directly or indirectly.
18.Duplicate or temporary devices, appliances, and services except as listed as an Eligible Expense.
19.Replacing a lost, stolen or missing appliance or prosthetic device.
20.Application of chemotherapeutic agents.
21.Oral hygiene instruction, plaque control, diet instruction or infection control.
22.Charges for sterilization of equipment; disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies.
23.Treatment or diagnosis received while outside the territorial limits of the United States. 24.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.
25.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.
26.Telephone consultations, charges for failure to keep a scheduled appointment, X-ray copy fees, or charges for completion of a claim form.
27.Ancillary charges, including, but not limited to, hospital, ambulatory surgical center or similar facility; or use of Provider office space.
28.Impacted wisdom teeth.
29.Prescription drugs.
30.Any surgical procedure performed in the treatment of cataracts. 31.Loss that occurs while the 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 the Policy for consecutive terms by paying the required premium by the end of each Grace Period subject to the Policy Termination provisions.

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.

Grace Period: A grace period of 31 days from Your Premium Due Date will be allowed for late payment of premium. During such Grace Period, the Policy will not lapse as long as You pay Your full premium by the end of the Grace Period.

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 Policy terminates the last day of the Grace Period if the premium is unpaid. Termination will be after 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 the Policy;
5. For a Spouse, on the date of a valid decree of divorce; or 6.
The date of death of the Policy Owner.

Payment Modes

Annual.....Annual x 1
Semi-annual.....Annual x .52
Quarterly.....Annual x .265
Monthly.....Annual x .08333
Bi-Monthly ..... Annual x 0.0417
Weekly .....Annual x 0.0192
Bi-Weekly..... Annual x 0.0385