REQUIRED OUTLINE OF COVERAGE
FOR
BLUEEXTRA
INDIVIDUAL SUPPLEMENTAL INSURANCE COVERAGE
DENTAL, VISION AND HEARING AID BENEFITS

BASIC POLICY

Issued by

QCC Insurance Company*
(Called the Company)

***a subsidiary of Independence Blue Cross – an independent licensee of the Blue Cross and Blue Shield Association**

A Pennsylvania Corporation
Located at:
1901 Market Street
Philadelphia, PA 19103

NOTICE OF RIGHT TO EXAMINE POLICY: The Policyholder may return this Policy within (10) days of its delivery if, after examination of the Policy, the Policyholder is not satisfied with it for any reason. This Policy may be returned to the Company, to the address shown above. The Policy shall be null and void from the beginning and no benefits will be payable under its terms. However, if benefits are paid for claims incurred by the Policyholder during this period, there shall be no full refund of the premium that was paid by the Policyholder.

When you enroll in this product and have dental, vision and/or hearing aid coverage under another medical plan, you may have duplicate coverage for these benefits and that the two benefit plans will not coordinate with each other.

OUTLINE OF COVERAGE

1. **Read your Policy Carefully –** This outline of coverage provides a very brief description of 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. **Supplemental Insurance Coverage –** Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

3. **A brief specific description of the benefits, including dollar amounts contained in this Policy:**

Subject to the Exclusions, conditions and limitations set forth in this Policy, a Covered Person is entitled to the benefits within the benefit section for Covered Services by a Provider or supplier, unless otherwise indicated in the amounts specified in the **Schedule of Benefits.**

WHEN TO USE A NETWORK PROVIDER

This program requires that you utilize your vision and dental benefit through a provider who participates in the Company's network of Participating Providers. To find a Participating Provider, visit our website at (www.ibxexpress.com, www.ibxmedicare.com) or call the toll-free number shown on the back of your ID card.

The dental benefit is administered by United Concordia Insurance (UCCI) and the vision benefit is administered by Davis Vision, independent companies. The Policy will not provide dental or vision benefits if you choose to use a Non-Participating Provider.

- The Covered Person will need to declare their Primary Dentist Office (PDO) on the application. If one is not selected, UCCI will select one based on availability and proximity to the Covered Person's address provided. You will be notified of the selection and will have the opportunity to change this assignment at any time by calling the Customer Service number listed on the back of your ID Card.

- Your Primary Dentist will provide your primary and preventive care, and, if necessary will arrange for referrals to a Participating Dental Specialist. Services provided by a Dental Specialist are covered only if you are referred by your Primary Dentist.

- A Covered Person may change the referred Dental Specialist to whom he or she has been referred by their Primary Dentist. To do so, the Covered Person would ask their Primary Dentist to refer another Participating Dental Specialist before the services are rendered.

- If a Covered Person uses the services of a Dental Specialist without having been referred by his or her Primary Dentist, he or she will not be eligible for benefits

Schedule of Benefits

As the Covered Person shown on this Policy, you will be entitled to the Covered Services as shown on the **Schedule of Benefits.** The Covered Services that are shown on the **Schedule of Benefits** will be eligible for vision and dental coverage's as long as they are performed directly by a Participating Provider. The Covered Services are subject to those provisions that are listed along with the limitations and exclusions as shown within this Policy.

The Schedule of Benefits will show:

- The Dental, Vision, Hearing Aid services that are covered;
- Any percentage or dollar amount that will be paid by the Policy;
- The Copayment amount the Covered Person will need to pay for a Covered Services or any allowance toward a benefit;
- Time limitations, such as 12 or 24 months;
- Hearing Aid frequency limitation;

Dental Schedule of Benefits

Dental Services

- Preventive Dental Covered Services provided by the Primary Dentist including cleaning and examinations once every six (6) months.

Dental Preventive

- The Preventive services for Oral Examination and Diagnosis, Single Bitewing x-rays, and Prophylaxis (teeth cleaning) will be covered once every six (6) months.

In the chart below:

1. The Copayment dollar amounts below represent the amount the Covered Person will be responsible to pay for that Covered Services.

2. In the chart below, "N/C" means "Not Covered.

DESCRIPTION

Charge For Office Visit Not Requiring a Copayment	$5

CLINICAL ORAL EVALUATION

Periodic Oral Evaluation – established patient	$0
Limited Oral Evaluation – problem focused	$0
Oral Evaluation for a patient under three years of age and counseling with a primary caregiver patient	$0
Comprehensive Oral Evaluation – new or established patient	$0
Detailed and Extensive Oral Evaluation – problem focused by report	$0
Re-evaluation – limited, problem focused (established patient, not post-operative visit)	$0
Comprehensive periodontal evaluation – new or established patient	$0

RADIOGRAPHS/DIAGNOSTIC IMAGING (Including Interpretation)

Intraoral – complete series (including bitewings)	$15
Intraoral –periapical first film	$5
Intraoral – periapical each additional film	$3
Intraoral – occlusal film	$6
Extraoral – first film	N/C
Extraoral – each additional film	N/C
Bitewing – single film	$3
Bitewing – two films	$7
Bitewing – three films	$9
Bitewing – four films	$11
Vertical bitewings – 7 to 8 films	N/C
Panoramic film	$15
Cephalometric Film	N/C
Oral/facial photographic images	N/C
Pulp vitality tests	$10
Diagnostic casts	N/C

DENTAL PROPHYLAXIS

Prophylaxis – Adult	$10
Prophylaxis – Child	$10

TOPICAL FLUORIDE TREATMENT (Office Procedure)

Topical application of fluoride – child	N/C
Topical application of fluoride – adult	N/C
Topical fluoride varnish; therapeutic application for moderate to high risk caries patients	N/C

OTHER PREVENTIVE SERVICES

Nutritional counseling for control of dental disease	N/C
Oral hygiene instructions	N/C
Sealant – per tooth	N/C

SPACE MAINTENANCE (Passive Appliances)

Space maintainer – fixed – unilateral	N/C
Space maintainer - fixed – bilateral	N/C
Space maintainer - removable – unilateral	N/C
Space maintainer - removable – bilateral	N/C
Re-cementation of space maintainer	N/C
Removal of fixed space maintainer	N/C

AMALGAM RESTORATIONS (Including Polishing)

Amalgam – one surface, primary or permanent	$36
Amalgam - two surfaces, primary or permanent	$45
Amalgam - three surfaces, primary or permanent	$55
Amalgam - four or more surfaces, primary or permanent	$75

RESIN-BASED COMPOSITE RESTORATIONS – DIRECT

Resin – based composite – one surface, anterior	$65
Resin – based composite – two surfaces, anterior	$75
Resin – based composite – three surfaces, anterior	$85
Resin – based composite – four or more surfaces or involving incisal angle (anterior)	$95
Resin – based composite crown, anterior	N/C
Resin – based composite crown, one surface, posterior	$70
Resin – based composite crown, two surfaces, posterior	$85
Resin – based composite crown, three surfaces, posterior	$105
Resin – based composite crown, four or more surfaces, posterior	$115

INLAY/ONLAY RESTORATIONS

Inlay – metallic – one surface	N/C
Inlay – metallic – two surface	N/C
Inlay – metallic – three surfaces or more surfaces	N/C
Onlay – metallic – two surfaces	N/C
Onlay – metallic – three surfaces	N/C

INLAY/ONLAY RESTORATIONS (continued)

Onlay – metallic – four or more surfaces	N/C
Inlay – porcelain/ceramic – one surface	N/C
Inlay – porcelain/ceramic – two surfaces	N/C
Inlay – porcelain/ceramic – three or more surfaces	N/C
Onlay – porcelain/ceramic – two surfaces	N/C
Onlay – porcelain/ceramic – three surfaces	N/C
Onlay – porcelain/ceramic – four or more surfaces	N/C
Inlay – resin based composite – one surface	N/C
Inlay – resin based composite – two surfaces	N/C
Inlay – resin based composite – three or more surfaces	N/C
Onlay – resin based composite – two or more surfaces	N/C
Onlay– resin based composite – three surfaces	N/C
Onlay – resin based composite – four or more surfaces	N/C

CROWN – SINGLE RESTORATIONS ONLY

Crown - resin-based composite (indirect)	$225
Crown - 3/4 resin-based composite (indirect)	$600
Crown - resin high noble metal	$525
Crown - resin with predominantly base metal	$525
Crown - resin with noble metal	$525
Crown - porcelain/ceramic substrate	$700
Crown - porcelain fused to high noble metal	$650
Crown - porcelain fused to predominantly base metal	$625
Crown - porcelain fused to noble metal	$625
Crown - 3/4 cast high noble metal	$700
Crown - 3/4 cast predominantly base metal	$700
Crown - 3/4 cast noble metal	$700
Crown - 3/4 porcelain/ceramic	$700
Crown - full cast high noble metal	$650

CROWN – SINGLE RESTORATIONS ONLY (continued)

Crown - full cast predominantly base metal	$600
Crown - full cast noble metal	$600
Crown - titanium	$600
Provisional crown	N/C

OTHER RESTORATIVE SERVICES

Recement inlay, onlay or partial coverage restoration	N/C
Recement cast or prefabricated post and core	$75
Recement crown	$75
Prefabricated stainless steel crown - primary tooth	N/C
Prefabricated stainless steel crown - permanent tooth	$250
Prefabricated resin crown	$125
Prefabricated stainless steel crown with resin window	N/C
Prefabricated esthetic coated stainless steel crown - primary tooth	N/C
Protective restoration	$30
Core buildup (including any pins)	N/C
Pin retention - per tooth, in addition to restoration	$25
Post and core, in addition to crown, indirectly fabricated	$250
Each additional indirectly fabricated post - same tooth	$125
Prefabricated post and core, in addition to crown	$200
Post removal (not in conjunction with endodontic therapy)	N/C
Each additional prefabricated post - same tooth	$90
Labial veneer (resin laminate) - chairside	N/C
Labial veneer (resin laminate) - laboratory	N/C
Labial veneer (porcelain laminate) - laboratory	N/C
Temporary crown (fractured tooth)	$150
Additional procedures to construct new crown under existing partial denture framework	$100
Coping	$50

PULP CAPPING

Pulp cap - direct (excluding final restoration)	$25
Pulp cap - indirect (excluding final restoration)	$30

PULPOTOMY

Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$40
Pulpal debridement, primary and permanent teeth	N/C
Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	N/C

ENDODONTIC THERAPY ON PRIMARY TEETH

Pulpal therapy (resorbable filling) - anterior, primary tooth	N/C
Pulpal therapy (resorbable filling) - posterior, primary tooth	N/C

ENDODONTIC THERAPY
(Including treatment plan, clinical procedures and follow-up care)

Endodontic therapy, anterior tooth(excluding final restoration)	$275
Endodontic therapy, bicuspid tooth(excluding final restoration)	$320
Endodontic therapy, molar (excluding final restoration)	$425
Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$225

ENDODONTIC RETREATMENT

Retreatment of previous root canal therapy - anterior	N/C
Retreatment or previous root canal therapy - bicuspid	N/C
Retreatment previous root canal therapy - molar	N/C

APEXIFICATION/RECALCIFICATION PROCEDURES

Apexification/recalcification/pupal regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfections etc.)	N/C
Apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	N/C

APEXIFICATION/RECALCIFICATION PROCEDURES (continued)

Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	N/C
Pulpal regeneration – (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration	N/C

APICOETOMY/PERIRADICULAR SERVICES

Apicoetomy/periradicular surgery – anterior	N/C
Apicoectomy/periradicular surgery – bicuspid (first root)	N/C
Apicoectomy/periradicular surgery – molar (first root)	N/C
Apicoectomy/periradicular surgery – (each additional root)	N/C
Retrograde filling – per root	N/C
Root amputation – per root	N/C

OTHER ENDODONTIC PROCEDURE

Surgical procedure for isolation of tooth with rubber dam	N/C
Hemisection (including any root removal), not including root canal therapy	N/C
Canal preparation and fitting of performed dowel or post	$100

SURGICAL SERVICES (including usual postoperative care)

Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	N/C
Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	N/C
Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	N/C
Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	N/C
Apically positioned flap	N/C
Clinical crown lengthening - hard tissue	N/C
Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	N/C

SURGICAL SERVICES (including usual postoperative care) (continued)

Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	N/C
Bone replacement graft - first site in quadrant	N/C
Bone replacement graft - each additional site in quadrant	N/C
Guided tissue regeneration - resorbable barrier, per site	N/C
Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	N/C
Pedicle soft tissue graft procedure	N/C
Free soft tissue graft procedure (including donor site surgery)	N/C
Subepithelial connective tissue graft procedures, per tooth	N/C
Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	N/C
Soft tissue allograft	N/C
Combined connective tissue and double pedicle graft, per tooth	N/C

NON-SURGICAL PERIODONTAL SERVICES

Periodontal scaling and root planing - four or more teeth per quadrant	N/C
Periodontal scaling and root planing - one to three teeth per quadrant	N/C
Full mouth debridement to enable comprehensive evaluation and diagnosis	N/C

OTHER PERIODONTAL SERVICES

Periodontal maintenance	N/C
Unscheduled dressing change (by someone other than treating dentist)	N/C

COMPLETE DENTURES (including routine post-delivery care)

Complete denture - maxillary	$525
Complete denture - mandibular	$480
Immediate denture - maxillary	$540
Immediate denture - mandibular	$535

PARTIAL DENTURES (including routine post-delivery care)

Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$425
Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$425
Maxillary partial denture, case metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$650
Mandibular partial denture, case metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$650
Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$500
Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$500
Removal unilateral partial denture - one piece cast metal (including clasps and teeth)	$475

ADJUSTMENTS TO DENTURES

Adjust complete denture - maxillary	$50
Adjust complete denture - mandibular	$50
Adjust partial denture - maxillary	$50
Adjust partial denture - mandibular	$50

REPAIRS TO COMPLETE DENTURES

Repair broken complete denture base	$125
Replace missing or broken teeth - complete denture (each tooth)	$120

REPAIRS TO PARTIAL DENTURES

Repair resin denture base	$120
Repair cast framework	$125
Repair or replace broken clasp	$125
Replace broken teeth - per tooth	$100
Add tooth to existing partial denture	$100
Add clasp to existing partial denture	$125
Replace all teeth and acrylic on cast metal framework (maxillary)	$550

REPAIRS TO PARTIAL DENTURES (continued)

Replace all teeth and acrylic on cast metal framework (mandibular)	$500

DENTURE REBASE PROCEDURES

Rebase complete maxillary denture	N/C
Rebase complete mandibular denture	N/C
Rebase maxillary partial denture	N/C
Rebase mandibular partial denture	N/C

DENTURE RELINE PROCEDURES

Reline complete maxillary denture (chairside)	$200
Reline complete mandibular denture (chairside)	$200
Reline maxillary partial denture (chairside)	$150
Reline mandibular partial denture (chairside)	$150
Reline complete maxillary denture (laboratory)	$250
Reline complete mandibular denture (laboratory)	$250
Reline maxillary partial denture (laboratory)	$300
Reline mandibular partial denture (laboratory)	$250

INTERIUM PROSTHESIS

Interim complete denture (maxillary)	N/C
Interim complete denture (mandibular)	N/C
Interim partial denture (maxillary)	N/C
Interim partial denture (mandibular)	N/C

OTHER REMOVABLE PROSTHETIC SERVICES

Tissue conditioning, maxillary	N/C
Tissue conditioning, mandibular	N/C
Surgical stent	N/C
Fluoride gel carrier	N/C

FIXED PARTIAL DENTURE PONTICS

Pontic - indirect resin based composite	N/C
Pontic - cast high noble metal	$650
Pontic - cast predominantly base metal	$600
Pontic - cast noble metal	$650
Pontic - titanium	$600
Pontic - porcelain fused to high noble metal	$650
Pontic - porcelain fused to predominantly base metal	$650
Pontic - porcelain fused to noble metal	$650
Pontic - porcelain/ceramic	$650
Pontic - resin high noble metal	$600
Pontic - resin with predominantly base metal	$500
Pontic - resin with noble metal	$550

FIXED PARTIAL DENTURE RETAINERS – INLAYS/ONLAYS

Retainer - cast metal for resin bonded fixed prosthesis	N/C
Inlay - porcelain/ceramic, two surfaces	N/C
Inlay - porcelain/ceramic, three or more surfaces	N/C
Inlay - cast high noble metal, two surfaces	N/C
Inlay - cast high noble metal, three or more surfaces	N/C
Inlay - cast predominantly base metal, two surfaces	N/C
Inlay - cast predominantly base metal, three or more surfaces	N/C
Inlay - cast noble metal, two surfaces	N/C
Inlay - cast noble metal, three or more surfaces	N/C
Onlay - porcelain/ceramic, two surfaces	N/C
Onlay - porcelain/ceramic, three or more surfaces	N/C
Onlay - cast noble metal, two surfaces	N/C
Onlay - cast noble metal, three or more surfaces	N/C
Onlay - cast predominantly base metal, two surfaces	N/C
Onlay - cast predominantly base metal, three or more surfaces	N/C

FIXED PARTIAL DENTURE RETAINERS – INLAYS/ONLAYS (continued)

Onlay - cast noble metal, two surfaces	N/C
Onlay - cast noble metal, three or more surfaces	N/C
Inlay - titanium	N/C
Onlay - titanium	N/C

FIXED PARTIAL DENTAL RETAINERS – CROWNS

Crown - indirect resin based composite	N/C
Crown - resin with high noble metal	$600
Crown - resin with predominantly base metal	$500
Crown - resin with noble metal	$550
Crown - porcelain/ceramic	$650
Crown - porcelain fused to high noble metal	$650
Crown - porcelain fused to predominantly base metal	$600
Crown - porcelain fused to noble metal	$650
Crown - 3/4 cast high noble metal	$550
Crown - 3/4 cast predominantly base metal	$550
Crown - 3/4 cast noble metal	$550
Crown - 3/4 porcelain/ceramic	$550
Crown - full cast high noble metal	$650
Crown - full cast predominantly base metal	$600
Crown - full cast noble metal	$650
Crown - titanium	$600

OTHER FIXED PARTIAL DENTURE SERVICES

Connector bar	N/C
Recement fixed partial bridge	$100
Stress breaker	N/C
Precision attachment	N/C
Post and core in addition to fixed partial denture retainer, indirectly fabricated	$225

OTHER FIXED PARTIAL DENTURE SERVICES (continued)

Prefabricated post and core in addition to fixed partial denture retainer	$200
Core build up for retainer, including any pins	N/C
Coping - metal	N/C
Each additional indirectly fabricated post - same tooth	$100
Each additional prefabricated post - same tooth	$90

EXTRACTIONS
(includes local anesthesia, suturing, if needed and routine Postoperative Care)

Extraction, coronal remnants - deciduous tooth	$45
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$45

SURGICAL EXTRACTIONS
(includes local anesthesia, suturing, if needed and routine Postoperative Care)

Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.	N/C
Removal of impacted tooth - soft tissue	N/C
Surgical removal of residual tooth roots (cutting procedure)	N/C

OTHER SURGICAL PROCEDURES

Tooth reimplantation and/or stabilization of accidently evulsed or displaced tooth	N/C
Surgical access of an unrupted tooth	N/C
Placement of device to facilitate eruption of impacted tooth	N/C
Brush biopsy - transepithelial sample collection	N/C
Transseptal fiberotomy/supra crestal fiberotomy, by Report	N/C

ALVEOLOPLASTY – Surgical Preparation of ridge for dentures

Alveoplasty in conjunction with extractions – four or more teeth or tooth spaces	N/C
Alveoplasty not in conjunction with extractions – four or more teeth or tooth spaces	N/C
Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	N/C

VESTIBULOPLASTY

Vestibuloplasty, ridge extension (secondary epithelialization)	N/C

SURGICAL INCISION

Incision and drainage of abscess - intraoral soft tissue	$65
Incision and drainage of abscess - intraoral soft tissue - complicated	$80

REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS

Occlusal orthotic device, by report	N/C

OTHER REPAIR PROCEDURES

Frenulectomy – also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	N/C
Frenuloplasty	N/C
Excision of pericoronal gingiva	N/C

COMPREHENSIVE ORTHODONTIC TREATMENT

Comprehensive orthodontic treatment of adolescent dentition	N/C
Comprehensive orthodontic treatment of adult dentition	N/C

UNCLASSIFIED TREATMENT

Palliative (emergency) treatment of dental pain - minor procedures	$40

ANESTHESIA

Local anesthesia in conjunction with operative or surgical procedures.	$0

PROFESSIONAL CONSULTATION

Consultation (diagnostic service provided by dentist or physician other than requesting dentist or physician)	N/C

PROFESSIONAL VISITS

Office visit for observation (during regularly scheduled hours) – no other services performed	$5
Office visit, after regularly scheduled hours	$50
Case presentation, detailed and extensive treatment planning	$50

MISCELLANEOUS SERVICES

Occlusal guard, by report	N/C
Occlusion analysis - mounted case	N/C
Occlusal adjustment - limited	N/C
Occlusal adjustment - complete	N/C
Unspecified adjunctive procedure, by report	$0

Vision Schedule of Benefits

In the chart below:

The Copayment or allowance amounts below represent the Covered Person's responsibility for that Covered Service:

	In-Network Only
Benefit	
Eye Exam (includes dilation)	Every 12 Months
Glasses – Lenses	Every 12 Months
Glasses – Frame	Every 24 Months
Contact Lenses (in lieu of Glasses)	Every 12 Months
Eyeglass Frame Benefit **	
Non-Collection Frame Allowance	Allowance: up to $100
Davis Vision Frame Collection (in lieu of allowance)	Included
Eyeglass Lens Benefit	
All ranges of prescriptions and sizes	Included
Choice of glass or plastic	Included
Oversize Lenses	Included
Fashion and gradient tinting of plastic lenses	Included
Scratch-Resistant Coating	Single Vision: $15 Multifocal: $25
Polycarbonate Lenses	$0 or $30
Ultraviolet Coating	$12
Standard Anti-Reflective (AR) Coating	$33
Standard progress lenses	Included
Premium Progressives	Not Available
Polarized Lenses	$60
Contact Lens Allowance (in lieu of glasses) ***	
Towards evaluation, fitting, follow up and materials	Allowance: up to $100

**** Frames other than Davis Vision's Designer or Premier Collection will be paid up to a maximum of $100. The balance, if any, is the Covered Person's responsibility.**

***** Contact Lenses will be paid up to a maximum of $100. The balance, if any, is the Covered Person's responsibility.**

Hearing Aid Schedule of Benefit

In the Chart below:

1. The dollar amounts shown below will be the reimbursement the Covered Person will receive for Covered Expenses for a Hearing Aid benefit.

Hearing Aid	Up to $500 for Hearing Aids (up to two aids), every three years.

4. **description of any policy provisions which exclude, eliminate, restrict, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above:**

Dental Exclusions

- for any liability for any services started prior to a Covered Person's effective date of coverage;
- which are not prescribed or performed by or under the direct supervision of a Primary Dentist Office, except in cases where a Dental Emergency Care is required;
- which are not Dental Necessary as defined in the Definitions section;
- which are cosmetic in nature, including but not limited to, charges for personalization or characterization of prosthetic appliances;
- which do not meet accepted standards of American dental practices;
- for labial veneers and laminates when done for cosmetic purposes. However, when performed for restorative purposes, labial veneers and laminates are covered under the same conditions and to the same extent that amalgam and composite restorations are covered;
- for duplicate devices, appliances and services;
- for temporary devices, appliances, and services that are integral to the overall procedure;
- related to the diagnosis and treatment of temporomandibular joint dysfunctions;
- for implantology and related services;
- performed in a facility by a Dentist who is compensated by a facility for similar Covered Services performed by patients;
- to alter vertical dimension or restore or maintain the occulusion. Such procedures include, but are not limited to, equilibration, periodontal, splinting, full mouth rehabilitation, restoration of tooth structure lost from attrition and restoration for misalignment of the teeth;
- for local anesthesia when billed separately by the Dentist;
- for gold foil restorations;
- with the exception of a Dental Emergency Care, if you have a previous unresolved Copayment balance that has been outstanding for sixty (60) or more

days, unless special payment arrangements have been made with the Dentist office;

- for prescription medications or nitrous oxide;
- for general anesthesia or IV sedation;
- in a hospital unless Dental Necessary or required for covered Dental Emergency Care;
- which are necessary due to a lack of patient cooperation or failure of the patient to follow a professionally prescribed Plan of Treatment;
- for periodontal splinting and any related procedures;
- for treatment of congenital malformations, including but not limited to , cleft palate, anodontia and mandibular prognathism;
- for dental prosthetic devices including dentures, bridges, crowns, inlays and onlays and fitting thereof, which prescribed (i.e. ordered from the laboratory) while the patient was not covered under the Policy but which were inserted more than thirty (30) days after the termination date of coverage;
- for replacement of a lost or stolen prosthetic device (such as dentures) or the replacement or repair of orthodontic braces;
- for the treatment of orthodontic conditions;
- for orthognathic surgery to cover non-traumatic jaw deformity.

Vision Exclusions

- for services or supplies not recommended by a Participating Provider;
- for any lenses which do not require a prescription;
- for periodic vision examinations, except as provided for in the Schedule of Benefits;
- for Sunglasses, safety eyeglasses, safety googles, other than shown on the Schedule of Benefits
- for eye examinations required by an Employer as a condition of employment;
- for services or materials provided in connection with special procedures such as orthoptics and visual training or in connection with medical or surgical treatment.
- for drugs or any other medications

- for lenses which do not provide vision correction;
- for charges for the replacement of lost or stolen lenses or frames within 24 months of service
- for sickness or injury covered by a workers' compensation act or other similar legislation;
- incurred as a direct or indirect result of war (declared or undeclared);
- incurred as a result of an intentionally self-inflicted injury or injury sustained while committing a crime;
- for services or supplies furnished to a Covered Person before the effective date of the Policy or after the date a Covered Person's Policy ends.
- for services or supplies which are not generally accepted in the United States as being necessary and appropriate for the treatment of a patient's sickness or injury;
- for any medical treatment rendered outside the United States or Canada;
- for services rendered by practitioners who do not meet the definition of Provider.
- for any expenses covered by any union welfare plan or governmental program or a plan required by law;
- for medically necessary contact lenses prescribed for a Covered Person for which prior approval was not obtained from the Company;
- for comprehensive low vision evaluations, subsequent follow-up visits following such evaluations or low vision aids for which prior approval was not obtained by the Company.
- for medical attention or surgical treatment of the eye;

Hearing Aid Exclusions

- For Hearing Aids ordered before the Covered Person became eligible for coverage or after the termination of this Policy coverage;
- charges for Hearing Aids that do not meet professionally accepted standards of practice, including charges for any such services or supplies that are experimental/investigative in nature;
- replacement of Hearing Aids that are lost, broken or stolen unless at the time of such replacement the Covered Person is otherwise eligible under the frequency limitation shown in the Schedule of Benefits;

- replacement parts, including replacement batteries, for the repairs of Hearing Aids.

5. **A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.**

ELIGIBILITY

The Covered Person that will be eligible for benefits under this Policy will be the individual Policyholder that has completed the application for coverage.

GEOGRAPHIC SERVICE AREA

The Covered Person must continue to reside in the geographic area served by the Company. Should the Covered Person change his or her residence to a geographic area outside the area served by the Company, or are absent from the area for more than 6 consecutive months, the Covered Person will no longer be eligible for benefits under this policy.

POLICY PREMIUM RATE AND REVISION

The Policy premium rate that applies to this Policy at any given time are those on file with and approved by the Pennsylvania Insurance Department. The rates are based as a Table of Rates, which the Company has the right to revise, but can only change these premium rates if we raise the premium rates for all policies like your Policy. The Company will make no changes to your premium rate because of claims made under this Policy. The Company, subject to the approval of the Insurance Department of the Commonwealth of Pennsylvania may alter or revise this Policy by endorsement or notice of change issued by the Company and modify the applicable Policy premium rates. The premium rates may be changed as of January 1st during any year in which this Policy remains in effect, provided that written notice of such a rate change shall be given by the Company not later than (30) days prior to January 1st. We will provide at least a 30 day advance notice of any change in Premium.

POLICY TERM AND RENEWAL

The Term of this Policy is for one year beginning at 12:01 AM on the Effective Date shown on the Policy Schedule. This Policy will renew from year to year if the full premium is paid on a monthly basis as shown on the Policy Schedule. We will provide at least a 30 day advance notice of any change in Premium. The Policyholder may elect to renew the Policy on their Renewal Date. The Policyholder may also change their Dental, Vision or Hearing Aid benefit plans at renewal by notifying the Company. If a change of benefits is made, the Company will supply the Policyholder with replacement Schedules of Benefits which will depict the product choice you have selected. Any change in premium will be included in your next bill. There will be no evidence of insurability that will be required to change either a Dental, Vision or Hearing Aid benefit at renewal.

If you elect to not renew, you will not be permitted to apply for a new BlueExtra Dental, Vision, and Hearing Aid Policy with the Company for one year from your renewal date. No benefit will be paid for expenses incurred during any period for time for which the premium has not been paid, subject to the Grace Period.

GRACE PERIOD

This Policy has a grace period of 31 days. This means that if a payment is not made on or before the date it is due, it may be paid during the grace period. During the grace period, the Coverage will stay in force, but no benefits will be paid for services incurred subsequent to the Coverage's then current paid date. If the appropriate payment is not received at the end of the thirty-one (31) day period, this Policy automatically terminates as of the then current paid date.

REINSTATEMENT

If this Policy is terminated solely due to nonpayment of premium, coverage will be reinstated if the Policyholder, within sixty (60) days from the date of termination, tenders and the Company receives payment of the premium required for reinstatement. In connection with this reinstatement within 60 days, a new application will not have to be completed. The Policyholder and Company shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium. The right of the Policyholder to have this Policy reinstated is limited to one (1) reinstatement during any twelve (12) month period and to two (2) reinstatements during the Policyholder's lifetime.

POLICY TERMINATION

1. The Company will not cancel or non-renew this Policy solely on the ground of health status of the Policyholder.

2. The Company will terminate this Policy if the premium is not received within the grace period. The effective date of the termination shall be the last day of the period for which payment of the Policy premium has been received. You will not be able to apply for a new BlueExtra Dental, Vision and Hearing Aid Policy for one year from the termination effective date.

3. You the Policyholder may terminate the Policy by sending a written notice to the Company. The termination will be effective on the first day of the month following the date requested in the Policyholder's written notification, unless the premium is owed. If a premium is owed the Policy termination will be effective the first day of the month following the conclusion of the last period for which you paid the premium. You will not be able to apply for a new BlueExtra Dental, Vision and Hearing Aid Policy for one year from the termination effective date.The Company shall terminate this Policy if the Policyholder obtained or

attempted to obtain benefits or payment for benefits through deliberate or willful material misrepresentation. If benefits were provided though deliberate or willful material misrepresentation, the Policyholder agrees to reimburse the Company for such benefits.

4. The Company shall terminate this Policy if the Covered Person no longer resides in the Geographic Service Area, or are absent from the area for more than 6 consecutive months.

Benefits After Coverage Termination: The Company is not liable to pay any benefits for services which are started after the Termination Date of the Policyholder's coverage of their Policy. However, the Company will cover the completion of a dental procedure requiring two or more visits on separate days will be extended for a period of 90 days after the Termination Date in order for the procedure to be finished. The procedure must be started prior to the Termination Date. The procedure is considered "started" when the teeth are irrevocably altered. For example, for crowns or fixed Partial dentures, the procedure is started when the teeth are prepared and impressions are taken. This extension does not apply if the Policy terminates for failure to pay the Premium.

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