Delta Dental of Arkansas
P.O. Box 15965
North Little Rock, AR 72231
(501) 835-3400
(800) 462-5410
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CERTIFICATE OF COVERAGE

The coverage set out in this CERTIFICATE is offered to the group at the rates stated in and upon the terms and conditions set out in the employer CONTRACT. This includes all schedules, endorsements, APPLICATION AND AGREEMENT FOR EMPLOYERS, and amendments. Delta Dental of Arkansas (DDAR) has caused this CERTIFICATE to be duly executed as of the service date confirmed by notice.

DELTA DENTAL OF ARKANSAS

BY: Ed Choate

President

"Any person who knowingly presents a false or fraudulent CLAIM for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

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Congratulations! We are pleased that you selected Delta Dental of Arkansas (DDAR) for your dental coverage. DDAR is a leader in dental care – both in Arkansas and in the nation.

We are giving you this booklet that will explain the coverage and services provided under the group dental BENEFITS program sponsored by your employer. Complete details of your coverage are set out in the group CONTRACT. The CONTRACT is in your Employee Benefits Department.

Under your DDAR program, you may seek services from any DENTIST you choose. However, INDIVIDUALs will receive a **higher level of BENEFITS by seeking care from a PARTICIPATING DENTIST.**

PARTICIPATING DENTISTs will complete and submit CLAIM FORMs for you at no charge. PARTICIPATING DENTISTs agree to accept the DDAR MAXIMUM PLAN ALLOWANCE (MPA) for covered procedures. PARTICIPATING DENTISTs will not bill you for any amount over the MAXIMUM PLAN ALLOWANCE (MPA). Since we will pay the PROVIDER directly, you don't have to pay the entire bill and wait to be paid back.

If you visit a NON-PARTICIPATING DENTIST, you may have to complete the forms yourself or pay a service charge. You may have to pay the NON-PARTICIPATING DENTIST in advance for the entire bill. If so, DDAR will pay any BENEFITS due to you after the CLAIM is submitted. Also, NON-PARTICIPATING DENTISTs have not agreed to accept the MAXIMUM PLAN ALLOWANCE (MPA) that DDAR will pay. As a result, you will be responsible for any difference between the DENTIST's fee and the DDAR payment. **Also, the benefit allowance for services of a NON-PARTICIPATING DENTIST may be reduced as indicated on your SCHEDULE OF BENEFITS for eligible services as determined by DDAR after applying the applicable DEDUCTIBLEs, co-payments, and maximums. This means your out-of-pocket expense may be more if you choose a NON-PARTICIPATING DENTIST.**

How do I select a DENTIST?
The easiest and most accurate listing of PROVIDERs is on our website. Click on our PROVIDER Directory link. Once at the web page, select the "Searching for a DENTIST" icon. From the "Product Selection" menu choose the network selected by your group as noted on your SCHEDULES OF BENEFITS (Delta Dental Premier or Delta Dental PPO). By entering the information requested, we will provide you with a list of PARTICIPATING DENTISTs in your area.

This booklet contains a summary in English of your plan rights and BENEFITS as a PARTICIPANT of your group's dental plan. If you have trouble understanding any part of this booklet, contact DDAR's Customer Service Department at (800) 462-5410. Office hours are from 7:00 a.m. to 7:30 p.m. C.S.T., Monday through Friday.

Thank you for selecting Delta Dental of Arkansas. We look forward to serving you.

DELTA DENTAL OF ARKANSAS

CERTIFICATE OF COVERAGE

This CERTIFICATE OF COVERAGE (CERTIFICATE) gives your rights and duties as a Covered Person. Please read your CERTIFICATE carefully and be familiar with its terms.

The policy may require that the SUBSCRIBER pay part or all of the required PREMIUMs through your employer. You can get information regarding the PREMIUM and any part of the PREMIUM you may pay from your employer.

This policy is issued on the basis of the employer's APPLICATION AND AGREEMENT FOR EMPLOYERS and payment of the required PREMIUM. The APPLICATION AND AGREEMENT FOR EMPLOYERS is a part of the policy. Delta Dental of Arkansas will provide coverage to covered persons subject to the terms, conditions, exclusions, and limitations of the policy.

The policy takes effect on the date specified and will be continued in force by timely payment of the PREMIUMs when due. The policy is subject to termination as provided. All coverage under the policy will be effective at 12:01 a.m. and will end at 12:00 midnight C.S.T.

This CERTIFICATE is delivered in the State of Arkansas and is governed by the laws of the State of Arkansas.

ARTICLE 1. DEFINITIONS

As used in this CERTIFICATE:

The definitions of certain capitalized words used in this CERTIFICATE are set forth in this Article 1. Unless defined within the text of this CERTIFICATE or the context clearly denotes otherwise, these capitalized words will have the meaning set forth below.

"ANNUAL MAXIMUM BENEFIT" is the sum that DDAR will pay for BENEFITS for any BENEFIT PERIOD.

"APPLICATION" or "**APPLICATION AND AGREEMENT FOR EMPLOYERS"** is the form used for the GROUP SPONSOR to apply for coverage pursuant to the CONTRACT as provided by DDAR.

"BENEFITS" means the sums that DDAR will pay for limited-scope dental services under GROUP SPONSOR's CONTRACT as set out in this document, subject to the conditions, limitations, and restrictions set forth herein.

"BENEFIT PERIOD" is the twelve (12) month period during which BENEFITS are paid as set out in the SCHEDULE OF BENEFITS. This represents the accumulation period applicable to DEDUCTIBLEs, benefit maximums, and applicable time limits.

"CALENDAR YEAR" means the twelve (12) months beginning on January 1 and ending on December 31 of each year.

"CERTIFICATE OF COVERAGE (CERTIFICATE)" is a document evidencing that certain insurance coverage/protection is provided to a GROUP SPONSOR for the benefit of its subscribing ELIGIBLE EMPLOYEEs. This insurance protection is more specifically set out pursuant to the terms and conditions set out in the CONTRACT by and between the GROUP SPONSOR and DDAR.

"CLAIM" means a request for BENEFITS under the CONTRACT made in accordance with the CONTRACT's procedures for filing benefit CLAIMs. A CLAIM includes a request for payment for a service, supply, prescription drug, equipment or TREATMENT covered by the CONTRACT. A CLAIM must be made in accordance with the CLAIMs procedures under the CONTRACT as set forth in CLAIMs procedure section of the CONTRACT. A CLAIM does not include any BENEFITS inquiries where such inquiries do not follow the requirements established in the CLAIMs procedures.

"CLAIMS ADMINISTRATOR" is Delta Dental of Arkansas (DDAR).

"CLAIM FORM" is the standard dental form used to file a CLAIM or request PRE-DETERMINATION of BENEFITS issued by CLAIMS ADMINISTRATOR.

"COBRA" means Title X of Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272).

"COBRA-PARTICIPANT" is a PARTICIPANT who ceases to be eligible as a SUBSCRIBER or DEPENDENT but chooses to continue coverage as allowed for the time periods provided under COBRA.

"CODE" means the Internal Revenue CODE of 1986, as amended.

"CONTRACT" is the agreement between DDAR and GROUP SPONSOR, including the APPLICATION AND AGREEMENT FOR EMPLOYERS, all schedules, endorsements, and amendments as issued by DDAR.

"CONTRACT TERM" is the time commencing on the EFFECTIVE DATE plus any renewals or extensions while the CONTRACT is in effect. The CONTRACT TERM will end with the termination or cancellation of the CONTRACT.

"CONTRACT YEAR" is the twelve (12) months starting on the EFFECTIVE DATE and each subsequent twelve (12) months while the CONTRACT is in effect.

"DDAR" is Delta Dental of Arkansas, an Arkansas Not-for-Profit Corporation. As used in this CERTIFICATE, DDAR may refer to Delta Dental of Arkansas acting on its own behalf or acting on behalf of or in conjunction with a member or members of the Delta Dental Plans Association, DeltaUSA, or their successors and/or assigns.

"DEDUCTIBLE" is the amount the PARTICIPANT must pay for services in any BENEFIT PERIOD before certain BENEFITS will be paid under the CONTRACT, subject to limitations shown on the SCHEDULE OF BENEFITS.

"DELTA DENTAL PPO" is a preferred provider organization that can reduce the out-of-pocket expenses for the SUBSCRIBER and ELIGIBLE DEPENDENTs if they receive care from one of Delta Dental's PPO DENTISTs. (Please see the front page of the GROUP CONTRACT or the SCHEDULE OF BENEFITS for the network selected for your GROUP HEALTH PLAN.)

"DELTA DENTAL PPO PLUS PREMIER" is a preferred provider organization that can reduce the out-of-pocket expenses for the SUBSCRIBER and ELIGIBLE DEPENDENTs if they receive care from one of DDPAR's PPO DENTISTs. This program has back-up coverage through DELTA DENTAL PREMIER when treatment is received from a NON-PPO DENTIST. (Please see the front page of the GROUP CONTRACT or the SCHEDULE OF BENEFITS for the network selected for your GROUP HEALTH PLAN.)

"DELTA DENTAL PREMIER" is DDPAR's standard fee-for-service dental benefits program that covers the SUBSCRIBER and/or ELIGIBLE DEPENDENTS when treatment is received by a NON-PPO DENTIST. (Please see the front page of the GROUP CONTRACT or the SCHEDULE OF BENEFITS for the network selected for your GROUP HEALTH PLAN.)

"DENTIST" is a person licensed to practice dentistry when and where services are performed.

- **"DELTA DENTAL PPO DENTIST"** is a dentist who has signed an agreement with DDPAR to be a preferred provider. The PPO dentist accepts DDPAR's payment and patient's payment, if any, as payment in full.
- **"DELTA DENTAL PREMIER DENTIST"** is a dentist who has signed an agreement with DDPAR to participate in DELTA DENTAL PREMIER. The PARTICIPATING DENTIST accepts DDPAR's payment and the patient's payment, if any, as payment in full.
- **"NON-PARTICIPATING DENTIST"** is a DENTIST who has not signed an agreement with DDPAR. It is the SUBSCRIBER's responsibility to make full payment to the NON-PARTICIPATING DENTIST.

"DEPENDENT" is as defined in Schedule E of the CONTRACT.

"DISCLOSURE" means the release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.

"EFFECTIVE DATE" of this CONTRACT is 12:01 a.m. on the date coverage under the CONTRACT begins, as shown on the APPLICATION AND AGREEMENT FOR EMPLOYERS.

"ELIGIBLE DEPENDENT" is a DEPENDENT who meets the eligibility requirements as set forth in Schedule E of the CONTRACT.

"ELIGIBLE EMPLOYEE" is an EMPLOYEE who meets the eligibility requirements as set forth in Schedule E of the CONTRACT.

"EMPLOYEE" is an INDIVIDUAL employed by the GROUP SPONSOR.

"ENROLLMENT FORM" is the form submitted to apply for coverage for an ELIGIBLE EMPLOYEE and ELIGIBLE DEPENDENTs, if applicable under the CONTRACT between the GROUP SPONSOR and DDAR.

"ENROLLMENT QUALIFYING EVENT" means the occurrence of a specified event, as described in Schedule E of the CONTRACT, that would allow an ELIGIBLE EMPLOYEE and ELIGIBLE DEPENDENT to enroll under the CONRACT after being first eligible without LATE ENTRY restrictions under Schedule E of the CONTRACT.

"FULL TIME STUDENT" is defined as an unmarried student who is a DEPENDENT of the SUBSCRIBER for support and maintenance and who meets the criteria of FULL TIME STUDENT status. Full time is twelve (12) hours for an undergraduate student and nine (9) hours for a graduate school student per semester. (Only for use with groups that cover full-time students.)

"GROUP HEALTH PLAN" is the group dental BENEFITS program to which the CONTRACT applies.

"GROUP SPONSOR" is any individual, partnership, association, corporation, or organization which agrees to sponsor a group of ELIGIBLE EMPLOYEEs and ELIGIBLE DEPENDENTs. It will pay or collect and remit by the due date to DDAR the PREMIUMs payable by the members, either by payroll allotment or otherwise. It will also receive notice, identification card, CERTIFICATE, or rider from DDAR on behalf of such members. The GROUP SPONSOR shall act only as agent of the group members. The GROUP SPONSOR shall not be the agent of DDAR for any purpose.

"HEALTH CARE OPERATIONS" means any of the following activities of the covered entity to the extent that the activities are related to covered functions, and any of the following activities of an ORGANIZED HEALTH CARE ARRANGEMENT in which the covered entity participates:

a) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities, population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care PROVIDERs and patients about TREATMENT alternatives, and related functions that do not include TREATMENT.
b) Reviewing the competence or qualifications of health care professionals; evaluating practitioner and PROVIDER performance; health plan performance; conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care PROVIDERs; training of non-health care professionals; accreditation, certification, licensing, or credentialing activities;
c) Underwriting, PREMIUM rating, and other activities relating to the creation, renewal, or replacement of a CONTRACT of health insurance or health BENEFITS and ceding, securing, or placing a CONTRACT for reinsurance of risk relating to CLAIMs for health care, (including stop-loss insurance and excess of loss insurance) provided that the requirements of HIPAA and related regulations are met, if applicable;
d) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
e) Business planning and development, such as
conducting and cost management and planning related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and
f) Business management and general administrative activities of the entity, including, but not limited to:
    1) Management activities relating to the implementation of and compliance with the requirements of this sub-chapter.
    2) Customer service, including the provision of data analyses for policy holder, plan sponsor, or customer.
    3) Resolution of internal grievances.
    4) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor of interest is a covered entity or, following the completion of sale or transfer, will become a covered entity, and
    5) Consistent with the applicable requirements of HIPAA and related regulations, creating de-identified health information, fundraising for the benefit of the covered entity, and marketing for which an individual authorization is not required as described in HIPAA and related regulations.

"HEALTH INSURANCE ISSUER" means an insurance company, insurance service, or insurance organization that is licensed to engage in the business of insurance in the State of Arkansas and is subject to Arkansas law that regulates insurance.

"INDIVIDUAL" means a person who is the subject of PROTECTED HEALTH INFORMATION.

"INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION" is information that is a subset of health information, including demographic information collected from an INDIVIDUAL, and:

a) is created or received by a health care PROVIDER, health plan, group, or healthcare clearinghouse, and
b) relates to the past, present, or future physical or mental health or condition of an INDIVIDUAL, or the past, present, or future PAYMENT for the provision of health care to an INDIVIDUAL, and
c) that identifies an INDIVIDUAL, or
d) with respect to which there is a reasonable basis to believe the information can be used to identify the INDIVIDUAL.

"LATE ENTRY" is when an ELIGIBLE EMPLOYEE or ELIGIBLE DEPENDENT enrolls in this CONTRACT after his or her initial eligibility period and not as a result of an ENROLLMENT QUALIFYING EVENT, if applicable as described in the SCHEDULE OF BENEFITS. Waiting periods may apply.

"MAXIMUM PLAN ALLOWANCE" is the maximum payment allowed by DDAR for the applicable covered service(s) provided by the DENTIST(s).

"NON-PARTICIPATING DENTIST" is any DENTIST other than a PARTICIPATING DENTIST.

"ORGANIZED HEALTH CARE ARRANGEMENT"

a) A clinically integrated care setting in which INDIVIDUALs typically receive health care from more than one health care PROVIDER,
b) An organized system of health care in which more than one covered entity participates, and in which the participating, covered entities:
    1) hold themselves out to the public as participating in a joint arrangement, and
    2) participate in joint activities that include at least one of the following:
        i) utilization review, in which health care decisions by participating entities are reviewed by other participating covered entities or by a third party on their behalf, or
        ii) quality assessment and improvement activities, in which TREATMENT provided by participating covered entities or by a third party on their behalf, or
        iii) payment activities, if the financial risk for delivering health care is shared, in part or in whole, by participating covered entities through the joint arrangement and if PROTECTED HEALTH INFORMATION created or received by a covered entity is reviewed by other participating covered entities or by a third party on their behalf for the purpose of administering the sharing of financial risk.
c) A GROUP HEALTH PLAN and a HEALTH INSURANCE ISSUER or HMO with respect to such GROUP HEALTH PLAN, but only with respect to PROTECTED HEALTH INFORMATION created or received by such HEALTH INSURANCE ISSUERs or HMOs that relates to INDIVIDUALs who are or have been PARTICIPANTs or beneficiaries in such GROUP HEALTH PLAN.
d) A GROUP HEALTH PLAN and one or more other GROUP HEALTH PLANs each of which are maintained by the same plan sponsor, or
e) HEALTH INSURANCE ISSUERs or HMOs that relate to INDIVIDUALs who are or have been PARTICIPANTs or beneficiaries in any of such GROUP HEALTH PLANs.

"PARTICIPANT" is an ELIGIBLE EMPLOYEE or an ELIGIBLE DEPENDENT who is enrolled under the CONTRACT.

"PARTICIPATING DENTIST" or "NETWORK PROVIDER" is a licensed DENTIST who has contracted with and agreed to abide by the rules and regulations of DDAR or any other organization that is a member of Delta Dental Plans Association, DeltaUSA, or its affiliates.

"PLAN ADMINISTRATOR" is the administrator of the CONTRACT, which is the GROUP SPONSOR.

"PRE-DETERMINATION" is an opinion from DDAR as to payments that would be made by DDAR as reasonably necessary for anticipated TREATMENT of a PARTICIPANT. The opinion is based upon information forwarded to DDAR. It does not guarantee such payment in that actual payment would also depend on applicable coverage being in effect at the time any such services were rendered. The payment may also be subject to DEDUCTIBLE, co-insurance, and maximum BENEFITS allowed. Similar terms also used for PRE-DETERMINATION are pre-authorization, prior-authorization, pre-TREATMENT review, and/or, pre-certification. A PARTICIPANT, however, is not required to seek a PRE-DETERMINATION for any TREATMENT under this CERTIFICATE.

"PRE-EXISTING CONDITION" means the state or condition of the mouth that exists prior to the patient's EFFECTIVE DATE of COVERAGE under this CERTIFICATE.

"PREMIUM" is the monthly amount to be paid, as agreed, by GROUP SPONSOR to DDAR for coverage under the CONTRACT.

"PROTECTED HEALTH INFORMATION" (PHI) shall have the same meaning as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and related regulations. PHI means INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION:

a) that is:
    1) transmitted by electronic media,
    2) maintained in any medium described in the definition of electronic media pursuant to HIPAA and/or related regulations, or
    3) transmitted or maintained in any other form or medium.
b) PROTECTED HEALTH INFORMATION excludes INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION in education records covered by the Family Educational Right and Privacy Act.

"PROVIDER" means a legally licensed DENTIST or any other legally licensed dental practitioner rendering services. Services must be covered under the CONTRACT and be within the scope of the DENTIST or other legally licensed dental practitioner's license.

"REQUIRED BY LAW" means a mandate contained in law that compels a covered entity to make a use or DISCLOSURE of PROTECTED HEALTH INFORMATION and that is enforceable in a court of law. REQUIRED BY LAW includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general; or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care PROVIDERs participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public BENEFITS.

"SCHEDULE OF BENEFITS" is the document that lists the BENEFITS that will be provided a PARTICIPANT. Such SCHEDULE OF BENEFITS shall be the one in effect and for which dental PREMIUMs are remitted at the time dental care is provided.

"SUBSCRIBER" is an ELIGIBLE EMPLOYEE who is enrolled in the CONTRACT.

"TOTALLY DISABLED" means, in the case of a DEPENDENT child, the complete inability, as a result of illness or injury, to perform the normal activities of a person of like age and sex in good health.

"TREATMENT" means the provision, coordination, or management of health care and related services by one or more health care PROVIDERs. This includes the coordination or management of health care by a health care PROVIDER with a third party, consultation between health care PROVIDERs relating to a patient, or the referral of a patient for health care from one health care PROVIDER to another.

"TREATMENT PLAN" is a written report showing the recommended TREATMENT of any dental disease, defect, or injury for a PARTICIPANT prepared by a DENTIST as a result of any examination made by such DENTIST while coverage under the CONTRACT is in effect for the PARTICIPANT.

"URGENT CARE" involves medical care or TREATMENT that is necessary and reasonable and if not provided:

a) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or
b) In the opinion of a physician with knowledge of the claimant's medical condition would subject the claimant to severe pain that cannot be adequately managed without the care or TREATMENT that is the subject of the CLAIM.

"USE" means, with respect to INDIVIDUALLY IDENTIFIABLE HEALTH INFORMTION, the sharing, employment, application, utilization, examination, or analysis of information within an entity that maintains such information.

"USERRA" means the Uniform Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE 2. ELIGIBILITY AND ENROLLMENT

2.01 ELIGIBLE EMPLOYEES. All active, full-time EMPLOYEE(s) of the GROUP SPONSOR working the designated number of hours per week on the EFFECTIVE DATE will be eligible to enroll for coverage under the CONTRACT. All other EMPLOYEE(s) will be eligible to enroll for coverage on the first day of the calendar month after they have completed their applicable probationary period. EMPLOYEES classified by the GROUP SPONSOR as temporary, seasonal, or leased, will not be eligible to enroll for coverage under this CERTIFICATE.

The probationary period shall be as defined by the APPLICATION AND AGREEMENT FOR EMPLOYERS or as amended by the group administrator.

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The eligibility date for ELIGIBLE EMPLOYEEs and ELIGIBLE DEPENDENTs shall be the first day of the calendar month following the completion of the probationary period.

2.02 INITIAL PLAN ENROLLMENT. ELIGIBLE EMPLOYEE(s) and their ELIGIBLE DEPENDENT(s) must enroll for coverage within thirty-one (31) days from their eligibility date under the CONTRACT. ELIGIBLE EMPLOYEEs and ELIGIBLE DEPENDENTs who do not enroll for coverage within thirty-one (31) days of their eligibility date or within thirty-one (31) days of an ENROLLMENT QUALIFYING EVENT, as described below, will only be able to enroll during an open enrollment and pursuant to LATE ENTRY restrictions, as applicable. LATE ENTRY restrictions, as applicable, include BENEFIT reductions as set forth in the SCHEDULE OF BENEFITS.

ENROLLMENT QUALIFYING EVENTs include any of the following:

a) an individual becomes an ELIGIBLE DEPENDENT of the ELIGIBLE EMPLOYEE through marriage, birth, adoption, or placement for adoption,
b) the ELIGIBLE EMPLOYEE or DEPENDENT loses coverage under another dental health plan or dental insurance.

ELIGIBLE EMPLOYEEs and ELIGIBLE DEPENDENTs must enroll for coverage within thirty-one (31) days from the ENROLLMENT QUALIFYING EVENT. Notwithstanding the foregoing, if the ENROLLMENT QUALIFYING EVENT results from the birth or adoption of a child, and the child is under the age of three (3), ELIGIBLE DEPENDENT may be enrolled, as applicable, at any time until the first of the calendar month following the child's third (3^{rd}) birthday.

Coverage for an adopted child shall begin on the date of the filing of a petition for adoption if the ELIGIBLE EMPLOYEE applies for coverage within sixty (60) days after the filing of the petition for adoption. However, the coverage shall begin from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the child.

For groups that cover FULL TIME STUDENTS: If a DEPENDENT loses coverage due to the occurrence of their birthday specified in the APPLICATION AND AGREEMENT FOR EMPLOYERS, and said DEPENDENT enrolls in an eligible college or university on a full-time basis at a time prior to the age designated by their GROUP SPONSOR, that FULL TIME STUDENT can be enrolled under an ENROLLMENT QUALIFYING EVENT.

An ENROLLMENT FORM shall be completed to enroll any newly ELIGIBLE DEPENDENTs even if SUBSCRIBER already has selected DEPENDENT coverage under the CONTRACT. If no ENROLLMENT FORM is submitted to DDAR within thirty-one (31) days from the satisfaction of the enrollment provisions set forth above, no coverage will be provided under the CONTRACT on behalf of the ELIGIBLE DEPENDENT and ELIGIBLE EMPLOYEE, as applicable.

2.03 **LATE ENTRY ENROLLMENT PERIOD.** ELIGIBLE EMPLOYEEs and ELIGIBLE DEPENDENTs who do not enroll for coverage on a timely basis upon initial eligibility or upon an ENROLLMENT QUALIFYING EVENT will be permitted to enroll for coverage under the CONTRACT during annual enrollment or as allowed by the group pursuant to LATE ENTRY restrictions, as applicable. LATE ENTRY restrictions, as applicable, include BENEFIT reductions as set forth in the SCHEDULE OF BENEFITS.

2.04 **ELIGIBLE DEPENDENTS.** ELIGIBLE DEPENDENTs include SUBSCRIBER's legally married spouse (not legally separated) and each child who is the age specified in the APPLICATION AND AGREEMENT FOR EMPLOYERS or younger. Such DEPENDENT must be a resident of the United States. Under certain circumstances, the SUBSCRIBER may be required to provide PLAN ADMINISTRATOR or DDAR with proof of the SUBSCRIBER/DEPENDENT relationship.

The term child means a) a natural born child, b) a stepchild, c) an adopted child, d) a child for whom the ELIGIBLE EMPLOYEE is the legal guardian, or e) a child for whom the ELIGIBLE EMPLOYEE is legally required to provide medical coverage.

No individual may be covered under this PLAN as both an EMPLOYEE and a DEPENDENT. Also, no individual will be considered an ELIGIBLE DEPENDENT of more than one EMPLOYEE.

For groups that cover full time students: A DEPENDENT child who is a FULL TIME STUDENT will continue to be an ELIGIBLE DEPENDENT until the day such DEPENDENT child attains the limiting age as defined by the APPLICATION AND AGREEMENT FOR EMPLOYERS. School vacation periods during any CALENDAR YEAR which interrupt but do not terminate what otherwise would have been a continuous course of study in that CALENDAR YEAR shall be considered part of school attendance on a FULL TIME STUDENT basis.

If an unmarried, DEPENDENT child, upon reaching age nineteen (19), is TOTALLY DISABLED and resides with the SUBSCRIBER, such DEPENDENT child will continue to be an ELIGIBLE DEPENDENT under the CONTRACT until such time as the DEPENDENT child is no longer TOTALLY DISABLED or coverage under the CONTRACT terminates for any reason.

The EMPLOYEE will be required to provide DDAR with written evidence of a DEPENDENT child's FULL TIME STUDENT status, if applicable, or disability status.

2.05 **EFFECTIVE DATE OF COVERAGE.** Coverage for an ELIGIBLE EMPLOYEE or ELIGIBLE DEPENDENT who timely enrolls will be effective on whichever of the following occurs first:

ELIGIBLE EMPLOYEE:

a) The ELIGIBLE EMPLOYEE's eligibility date, provided ELIGIBLE EMPLOYEE enrolls within thirty-one (31) days of eligibility date;
b) The first day of the calendar month following the date of the ENROLLMENT QUALIFYING EVENT, provided ELIGIBLE EMPLOYEE enrolls within thirty-one (31) days from the ENROLLMENT QUALIFYING EVENT;
c) As of the first day of the plan year following the annual enrollment period, if the ELIGIBLE EMPLOYEE enrolls for coverage during the annual enrollment period
d) As allowed by the group pursuant to LATE ENTRY restrictions, as applicable.

ELIGIBLE DEPENDENTS:

a) The ELIGIBLE DEPENDENT's eligibility date, provided ELIGIBLE DEPENDENT enrolls within thirty-one (31) days of the eligibility date;
b) The first day of the calendar month following the ENROLLMENT QUALIFYING EVENT, provided ELIGIBLE DEPENDENT enrolls within thirty-one (31) days from the ENROLLMENT QUALIFYING EVENT;
c) As of the first day of the plan year following the annual enrollment period, if the ELIGIBLE EMPLOYEE enrolls for coverage during the annual enrollment period
d) As allowed by the group pursuant to LATE ENTRY restrictions, as applicable.

2.06 The APPLICATION AND AGREEMENT FOR EMPLOYERS for coverage is subject to DDAR's approval.

2.07 The PARTICIPANT will be allowed to continue BENEFITS during a PARTICIPANT's unpaid leave of absence as determined by the policy of the GROUP SPONSOR. If it is the policy of the GROUP SPONSOR not to continue BENEFITS for an unpaid leave of absence, the PARTICIPANT will not have coverage during this leave. Coverage will resume on the first day of the month after the

EMPLOYEE returns to work if return to work is within six (6) months. After six (6) months, a new probationary period will apply. PARTICIPANTs may continue coverage under COBRA, if applicable, or an applicable state continuation of coverage provision when the EMPLOYEE is on strike or layoff.

2.08 If it is the policy or legal responsibility of the GROUP SPONSOR to continue coverage during a leave of absence, the GROUP SPONSOR will be responsible for the timely payment of all PREMIUMs due to DDAR for the EMPLOYEE on leave of absence. The GROUP SPONSOR must continue to consider the person a permanent EMPLOYEE, and all other group BENEFITS, including dental, must be continued.

2.09 An EMPLOYEE loses coverage when employment BENEFITS are terminated by the GROUP SPONSOR at the end of employment, when applicable PREMIUM(s) are not paid/received, when EMPLOYEE loses eligibility, or at the end of the CONTRACT. DEPENDENT(s) will lose coverage along with the EMPLOYEE or earlier if DEPENDENT loses his or her DEPENDENT status. EMPLOYEE(s) will lose coverage on the last day of the month during which last employed.

2.10 Possession of an identification card does not guarantee a PARTICIPANT is eligible for BENEFITS. Eligibility is based on information reported to DDAR by the group. Eligibility may be confirmed by calling DDAR's Customer Service Representatives, but the card **is not a guarantee of payment.**

2.11 DDAR will not continue to pay BENEFITS for any PARTICIPANT(s) when they lose eligibility upon notification from the GROUP SPONSOR. As provided by COBRA, USERRA, or any applicable state continuation of coverage provision, if applicable, coverage may continue for up to eighteen (18) months where the EMPLOYEE's coverage ends as a result of a reduction in work hours or termination of employment in accordance with and pursuant to such provisions. Coverage may not continue if the termination is the result of gross misconduct.

Under COBRA, or an applicable state continuation of coverage provision, DEPENDENTs may continue coverage under this CONTRACT for up to thirty-six (36) months. To continue coverage, the DEPENDENT must be a:

a) surviving spouse or child of a deceased EMPLOYEE;
b) separated or divorced spouse; or
c) DEPENDENT ineligible for Medicare who reaches the limiting age or otherwise ceases to meet the definition of DEPENDENT. In any case, coverage shall end if the PARTICIPANT fails to pay the required PREMIUM to the GROUP SPONSOR, becomes eligible for Medicare, obtains other group coverage, or the GROUP SPONSOR cancels group dental coverage.

If applicable, PARTICIPANTs must choose whether or not to continue their coverage. PARTICIPANTs have sixty (60) days to make such an election. The sixty (60) day period shall start at the earlier of the date the PARTICIPANT's coverage would otherwise end or the date the PARTICIPANT receives notice of his/her rights. **GROUP SPONSOR should terminate PARTICIPANT's coverage until election is made and PAYMENT is received.** Coverage will be reinstated with no break.

EMPLOYEE is responsible for notifying the GROUP SPONSOR immediately of any change(s) in eligibility. EMPLOYEE should tell GROUP SPONSOR of changes in DEPENDENT status, divorce, or eligibility for Medicare.

Pursuant to USERRA, GROUP SPONSOR must provide certain reemployment and benefit rights to EMPLOYEEs who take a leave of absence for military service. ELIGIBLE EMPLOYEEs who meet the requirements under USERRA are generally entitled to reemployment upon their return from uniformed service and to reinstatement and continuation of their employment BENEFITS.

An ELIGIBLE EMPLOYEE who is absent from employment in order to serve in the uniformed services, as well as his or her ELIGIBLE DEPENDENTs, may elect to continue health coverage during the period of uniformed service, if applicable. The maximum length of the continuation coverage required under USERRA is the lesser of:

a) eighteen (18) months (beginning on the day that the uniformed service leave commences), or
b) a period beginning on the day the uniformed service leave commences and ending on the day the EMPLOYEE fails to return to or reapply for employment within the time allowed by USERRA.

If a PARTICIPANT elects to continue health coverage pursuant to USERRA, such PARTICIPANT will be required to pay 102% of the full PREMIUM for the coverage elected. However, if the uniformed service leave of absence is less than thirty-one (31) days, the PARTICIPANT will not be required to pay more than the PARTICIPANT would have been required to pay if PARTICIPANT had not been on uniformed service leave.

A PARTICIPANT whose coverage was terminated during the period of uniformed service shall not be subject to any exclusions or restrictions for PRE-EXISTING CONDITIONS upon reinstatement of the health coverage under the CONTRACT if an exclusion would not have been imposed under the CONTRACT had coverage not been terminated by reason of the uniformed service. However, CONTRACT exclusions may be imposed for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of service in the uniformed services.

It shall be PLAN ADMINISTRATOR's sole responsibility to ensure that all COBRA, USERRA, or any other applicable state continuation of coverage provisions are complied with.

2.12 TAKE OVER PROVISIONS. Within sixty (60) days from the date of the end of a prior plan, DDAR will cover all ELIGIBLE EMPLOYEEs and DEPENDENTs:

a) If each EMPLOYEE or DEPENDENT was validly covered under the previous plan at the date of the end of the plan.
b) If each EMPLOYEE or DEPENDENT is a member of the class of INDIVIDUALs eligible for coverage under the prior carrier's plan, regardless of any of the plan's limitations or exclusions related to "actively at work" or hospital confinement.
c) Only if the group accident and health BENEFITS were provided to a group consisting of more than fifteen (15) members.

The succeeding carrier should be entitled to deduct from its BENEFITS any BENEFITS payable by the prior carrier pursuant to an extension of BENEFITS provision.

No provision in a succeeding carrier's plan of replacement coverage which would operate to reduce or exclude BENEFITS on the basis the condition giving rise to BENEFITS pre-existed the EFFECTIVE DATE of the succeeding carrier's plan shall be applied with respect to those ELIGIBLE EMPLOYEEs and DEPENDENTs validly insured under the previous carrier's policy on the date of discontinuance, and only if BENEFITS for the condition would have been payable under the previous carrier's plan.

This will apply upon the issuance of an insurance policy or health care plan:

a) To a group whose BENEFITS had previously been self-insured.
b) To a self-insurer providing coverage to a group which had been previously covered by an insurer.
c) To a group which had been previously covered by an insurer.

ARTICLE 3. EXCLUSIONS FOR ALL BENEFITS

3.01 DDAR will only pay the BENEFITS stated for each type of dental service set out in the SCHEDULE OF BENEFITS. **Not all dental services are BENEFITS under the CONTRACT**. BENEFITS will only be provided for PARTICIPANTs who are enrolled on the date of TREATMENT. BENEFITS will be determined based on the date services were rendered. Services must be provided by a DENTIST or properly licensed EMPLOYEE of the DENTIST. Services must be necessary and customary. Services must be provided following generally accepted dental practice standards as determined by the dental profession to be a paid benefit. DDAR will pay allowable BENEFITS based upon the percentages and subject to the ANNUAL MAXIMUM BENEFIT as stated on the SCHEDULE OF BENEFITS. Such percentages will be applied to the lesser of the MAXIMUM PLAN ALLOWANCE (MPA) or the fees the DENTIST charges for the service. **The maximum payment for NON-PARTICIPATING DENTISTs may be less than to a PARTICIPATING DENTIST, please refer to your SCHEDULE OF BENEFITS.** Payments for covered services by NON-PARTICIPATING DENTISTs will be sent to the patient(s). NON-PARTICIPATING DENTISTs may balance-bill patients for the difference of their charges and DDAR's payment. PARTICIPATING DENTISTs shall not balance-bill patients for charges in excess of the MPA for covered BENEFITS under the CONTRACT.

3.02 OPTIONAL SERVICES

a) Services that cost more than the TREATMENT usually provided under accepted dental practice standards are called Optional Services. Optional Services also include the use of specialized instead of standard procedures. BENEFITS for Optional Services will be based on the cost of the standard service. The PARTICIPANT will be responsible for the remainder of the DENTIST's fee.
b) Payment made by DDAR for any surgical service will include charges for routine, post-operative evaluations or visits.
c) If a PARTICIPANT transfers from one DENTIST to another during the course of TREATMENT, BENEFITS will be limited to the amount that would have been paid if one DENTIST rendered the service.

3.03 EXCLUSIONS

DDAR does not pay BENEFITS for:

a) BENEFITS or services for injuries or conditions covered under Worker's Compensation or Employer's Liability laws. BENEFITS or services available from any federal or state government agency; municipality, county, other political subdivision; or community agency; or from any foundation or similar entity.
b) Charges for services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.
c) Charges for services or supplies for which no charge is made that the patient is legally obligated to pay. Charges for which no charge would be made in the absence of dental coverage.
d) Charges for TREATMENT by other than a DENTIST except that a licensed hygienist may perform services in accordance with applicable law. Services must be under the supervision and guidance of the DENTIST in accordance with generally accepted dental standards.
e) Charges for the completion of forms and/or submission of supportive documentation required by DDAR for a benefit determination. A charge for these services is not to be made to a DDAR-covered patient by a PARTICIPATING DENTIST.
f) BENEFITS to correct congenital or developmental malformations.

g) Services for the purpose of improving appearance when form and function are satisfactory, and there is insufficient pathological condition evident to warrant the TREATMENT (cosmetic dentistry).
h) BENEFITS for services or appliances started prior to the date the patient became eligible under this plan, including, but not limited to, restorations, prosthodontics, and orthodontics.
i) Services with respect to diagnosis and TREATMENT of disturbances of the temporomandibular joint (TMJ), unless optional coverage is purchased.
j) Services for increasing the vertical dimension or for restoring tooth structure lost by attrition, for rebuilding or maintaining occlusal services, or for stabilizing the teeth.
k) Experimental and/or investigational services, supplies, care and TREATMENT which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards or a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered. The CLAIMS ADMINISTRATOR must make an independent evaluation of the experimental or non-experimental standings of specific technologies. The CLAIMS ADMINISTRATOR's decision will be final and binding on the CONTRACT. Drugs are considered experimental if they are not commercially available for purchase and/or are not approved by the Food and Drug Administration for general use.
l) Charges for replacement of lost, missing, or stolen appliances/devices.
m) Charges for services when a CLAIM is received for payment more than twelve (12) months after services are rendered.
n) Charges for complete occlusal adjustments, occlusal guards, occlusion analysis, enamel microabrasion, odontoplasty, bleaching, and athletic mouthguards.
o) Specialized techniques that entail procedure and process over and above that which is normally adequate. Any additional fee is the patient's responsibility.
p) Behavior management.
q) Those services and BENEFITS excluded by the rules and regulations of DDAR, including DDAR's processing policies.
r) Removable appliances for control of harmful habits, including but not limited to tongue thrust appliances.
s) Charges for general anesthesia/intravenous sedation are not covered except when administered in conjunction with covered oral surgery, excluding single tooth extractions (ADA procedure Code 7140) and for children three (3) and under.
t) Procedures that do not comply with DDAR's guidelines.
u) Charges for precision attachments, provisional splinting, desensitizing medicines, home care medicines, premedications, stress breakers, coping, office visits during or after regularly scheduled hours, case presentations, and hospital-related services.
v) All other BENEFITS and services not specifically covered in the CONTRACT and/or SCHEDULE OF BENEFITS.

ARTICLE 4. DEDUCTIBLE, MAXIMUM, AND COORDINATION OF BENEFITS

4.01 DDAR will not pay BENEFITS until the annual DEDUCTIBLE amount has been satisfied, unless the covered procedure is not subject to the DEDUCTIBLE. The DEDUCTIBLE will apply as listed on the SCHEDULE OF BENEFITS.

4.02 The DEDUCTIBLE applies to the BENEFITS as shown on the SCHEDULE OF BENEFITS. Only fees a PARTICIPANT pays for services covered under the benefit schedules in this CERTIFICATE will count toward satisfying the DEDUCTIBLE.

4.03 Unless otherwise listed on the SCHEDULE OF BENEFITS, the DEDUCTIBLE and maximums apply to each BENEFIT PERIOD.

4.04 COORDINATION OF BENEFITS

If a PARTICIPANT is entitled to coverage under more than one insurance policy or benefit program, the BENEFITS of this CERTIFICATE will be subject to the following conditions:

a) If the other program is not primarily a dental program, this program is primary.
b) If the other program is for dental coverage, the following rules apply:
    1) The program covering the patient as an EMPLOYEE is primary over a program covering the patient as a DEPENDENT.
    2) Where the patient is a DEPENDENT child, primary dental coverage will be determined as follows:
        i) The coverage of the parent whose date of birth occurs earlier in the CALENDAR YEAR will be primary.
        ii) Except for a DEPENDENT child of legally separated or divorced parents, the coverage of the parent with legal custody, or the coverage of the custodial parent's spouse (i.e., stepparent) will be primary, unless there is a court decree stating that one parent has financial responsibility for a child's health care expenses. If so, any DEPENDENT coverage of that parent will be primary to any other DEPENDENT coverage.
c) When primary coverage cannot be determined according to a) and b), the program that has covered the patient for the longer period will be primary.
d) Coordination of BENEFITS within the same group will not be allowed.

If this coverage is primary, BENEFITS will be provided without regard to any other coverage. If this coverage is not primary, BENEFITS are limited to services which are BENEFITS of this CONTRACT that are not fully paid by any other coverage. However, BENFITS can not exceed the amount of actual charges for any service(s).

ARTICLE 5. CONDITIONS UNDER WHICH BENEFITS WILL BE PROVIDED

5.01 **CHOICE OF DENTIST**. DDAR does not furnish covered services directly. DDAR pays for licensed DENTISTs to provide these services. A PARTICIPANT may choose any DENTIST. PARTICIPANTs should determine the qualifications of the DENTIST they select. Participation in DDAR is open to all DENTISTs who meet DDAR's standards and who are licensed in Arkansas unless they have previously had their participation in DDAR terminated. DDAR only controls credentialing in Arkansas. However, there is currently in effect a policy by Delta Dental Plans Association (National), which is applicable to DeltaUSA groups. This policy requires all Delta Plans to have credentialing. Other state's credentialing policies are available upon request. Whether a DENTIST is a PARTICIPATING or NON-PARTICIPATING DENTIST should not be viewed as a statement about that DENTIST's abilities.

DDAR shares the public and professional concern about the possible spread of HIV and other infectious diseases in the dental office. However, DDAR cannot ensure your DENTIST's use of precautions against the spread of such diseases. Also, DDAR cannot compel your DENTIST to be tested for HIV or to disclose test results to DDAR or to a PARTICIPANT. If there are questions about your DENTIST's health status or use of recommended clinical precautions, PARTICIPANT should discuss them with the DENTIST.

5.02 **CLINICAL EXAMINATION**. Before approving a CLAIM, DDAR may obtain from any DENTIST or hospital such information and records DDAR may require to administer the CLAIM. DDAR may require that a PARTICIPANT be examined by a dental consultant, retained by DDAR, in or near his/her place of residence.

5.03 **PRE-DETERMINATION**. A DENTIST may file a CLAIM FORM showing the services he or she recommends. DDAR will then pre-determine the BENEFITS payable under this CONTRACT. PAYMENT will only be made for pre-determined services if the PARTICIPANT receives TREATMENT for which BENEFITS are payable, remains eligible, and has not exceeded his or her ANNUAL MAXIMUM BENEFITS. A CLAIM FORM requesting a PRE-DETERMINATION may be submitted electronically.

5.04 **TREATMENT OF BENEFITS ON LACK OF ELIGIBILITY**. DDAR will not pay BENEFITS for any services received by a patient who is not eligible at the time of TREATMENT. GROUP SPONSOR will repay DDAR, limited to the monthly PREMIUM, for any payments due to errors or delays in reporting by the GROUP SPONSOR.

5.05 **TO WHOM BENEFITS ARE PAID**. BENEFITS provided under this CONTRACT will be paid as follows:

a) For services provided by a PARTICIPATING DENTIST, payment will be made to the PARTICIPATING DENTIST.
b) For services provided by a NON-PARTICIPATING DENTIST, payment will be made to SUBSCRIBER. The SUBSCRIBER is responsible for all payments to a NON-PARTICIPATING DENTIST.

ARTICLE 6. CLAIMS PROCEDURES

6.01 **CLAIMS**. CLAIMs must be filed by PARTICIPANT or PARTICIPANT's authorized representative with DDAR within twelve (12) months after completion of TREATMENT for which BENEFITS are payable. Any CLAIM filed after this period will be denied. The CLAIMS ADMINISTRATOR has complete discretion to interpret the terms of the BENEFITS under the CONTRACT and such interpretation shall be final and conclusive.

6.02 **FILING CLAIMS/PARTICIPATING DENTISTS.** PARTICIPATING DENTISTS will complete and submit CLAIM FORMs for PARTICIPANTS at no charge. PARTICIPATING DENTISTS may ask PARTICIPANTs to fill out the patient section of the CLAIM FORM, which includes the SUBSCRIBER's name, social security number (SSN), and address; the PARTICIPANT's name, date of birth, and relationship to SUBSCRIBER; and coordination of BENEFITS information, if applicable.

6.03 **FILING CLAIMS/NON-PARTICIPATING DENTISTS.** If the PARTICIPANT visits a NON-PARTICIPATING DENTIST, PARTICIPANT may be required to complete the CLAIM FORM or pay a service charge. The patient section should be completed, which includes the SUBSCRIBER's name, SSN, and address; the PARTICIPANT's name, date of birth, and relationship to SUBSCRIBER, and coordination of BENEFITS information, if applicable.

PARTICIPANT will also be responsible for ensuring the NON-PARTICIPATING DENTIST completes the DENTIST and the Diagnostic (TREATMENT) Sections of the CLAIM FORM. The DENTIST Section includes the DENTIST's name, address, SSN or TIN number, license number, and phone number. The DENTIST must also indicate whether x-rays are attached and answer questions regarding TREATMENT that is the result of an accident. The DENTIST must also indicate if dentures, bridges, and crowns are replacements, and if so, the date of prior placement and reason for replacement must be noted.

The Diagnostic Section (TREATMENT) includes services performed (name description and ADA procedure code), including date of service, fee for service, and if applicable, tooth number or letter and tooth surface. For any unusual services, the Remarks Section of the CLAIM FORM must give a brief description. The CLAIM FORM needs to be signed by the DENTIST who performed the services and by the SUBSCRIBER/PARTICIPANT.

6.04 **PROCESSING THE CLAIM.** If PARTICIPANT visits a PARTICIPATING DENTIST, upon receipt of the CLAIM, it will be processed according to the GROUP SPONSOR's CONTRACT BENEFITS. For PARTICIPANTS who visit a PARTICIPATING

DENTIST, notification of the benefit determination will be sent to the SUBSCRIBER in the form of an Explanation of BENEFITS, which details by service rendered what the CONTRACT allowed and the PARTICIPANT's obligation, if any.

If PARTICIPANT visits a NON-PARTICIPATING DENTIST, the SUBSCRIBER will receive a CLAIM Payment Statement, which will detail by service rendered what the CONTRACT allowed and the PARTICIPANT's obligation, if any. The CLAIM Payment Statement will also include a benefit check made payable to the SUBSCRIBER.

6.05 INITIAL CLAIM DETERMINATION. If the CLAIMS ADMINISTRATOR denies all or a portion of the CLAIM, PARTICIPANT will receive an Explanation of BENEFITS (for PARTICIPANTs visiting a PARTICIPATING DENTIST) or a CLAIM Payment Statement (for PARTICIPANTs visiting a NON-PARTICIPATING DENTIST) indicating the reason for the denial. The denial explanation will be printed at the bottom of the page.

The SUBSCRIBER will be notified within thirty (30) days of the receipt of the CLAIM by CLAIMS ADMINISTRATOR of the benefit determination.

In the case of an URGENT CARE CLAIM, the SUBSCRIBER will be notified within seventy-two (72) hours from the time the CLAIM is received by the CLAIM ADMINISTRATOR of the benefit determination.

6.06 APPEAL OF DENIED CLAIM. If the CLAIMS ADMINISTRATOR has denied a CLAIM, claimant may appeal the denial. Both the claimant and CLAIMS ADMINISTRATOR must take the following steps to complete an appeal (decision review):

a) Procedures the PARTICIPANT or PARTICIPANT's attending DENTIST Must Follow:
   1) Write to the CLAIMS ADMINISTRATOR at the following address: Customer Service Support, Post Office Box 15965, North Little Rock, Arkansas, 72231 within one-hundred-eighty days (180) of the date on the notice of PARTICIPANT's CLAIM denial.
   2) State why the CLAIM should not have been denied.
   3) Include the denial notice and any other documents, data information, or comments that claimant believe may have an influence on the appeal of the CLAIM.
   4) If requested, claimant will receive, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the denied CLAIM.
   5) For an expedited review of an URGENT CARE CLAIM, the request may be submitted orally (by telephone) or in writing (by facsimile or another similarly expeditious method).

b) Procedures CLAIMS ADMINISTRATOR must follow for a full and fair appeal:
   1) Identify the medical or vocational experts whose advice was obtained and utilized on behalf of CLAIMS ADMINISTRATOR in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.
   2) Not consider the initial denial in the review.
   3) Conduct a review that includes one or more of the members of the CLAIMS ADMINISTRATOR's Appeals Committee (to be determined at the sole discretion of CLAIMS ADMINISTRATOR), but in no event will the individual who made the initial CLAIM denial, nor the subordinate of that individual be part of the review.
   4) Consult a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted initially, nor who is the subordinate of such individual if your denial is based in whole or in part on a medical judgment, including determinations with regard to whether a particular TREATMENT, drug, or other item is experimental, investigational, or not medically necessary or appropriate.

c) Procedures CLAIMS ADMINISTRATOR must follow to notify claimant of its decision (if adverse):
   1) Provide claimant with a notice that includes the following information, to wit:
      i) The specific reason(s) for the adverse determination.
      ii) Reference to the specific CONTRACT provision(s) on which the adverse determination is based.
      iii) A statement that claimant is entitled to receive, free of charge, access to and copies of all information relevant to the CLAIM.
      iv) A statement describing any voluntary appeal procedures, if any, and a statement of claimant's right to bring an action under section 502 (a) of the EMPLOYEE Retirement Income Security Act.
      v) The internal rule that was relied upon in making the adverse determination.
      vi) If adverse determination is based on a medical necessity or experimental TREATMENT, either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request.
      vii) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."
   2) Provide claimant with the aforementioned notice within seventy-two (72) hours if the CLAIM is an URGENT CARE CLAIM.

   3) Provide claimant with the aforementioned notice within sixty (60) days if the CLAIM is a post-service CLAIM.

ARTICLE 7. DELTA DENTAL OF ARKANSAS

PRIVACY POLICY STATEMENT
FOR
INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Protecting your privacy is a priority of DDAR. The purpose of this statement is to help you understand how DDAR uses and protects your INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION in compliance with the Health Insurance Portability and Accountability Act of 1996 and related regulations, as amended from time to time ("HIPAA").

7.01 INFORMATION DDAR RECEIVES

DDAR receives INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION about you from the following sources:

a) Information we receive from you on applications and other forms or from your group dental plan or employer and from our agents, PROVIDERs, and PLAN ADMINISTRATORs;
b) Information you provide to DDAR in order to receive our services;
c) Information about your transactions with us, our affiliates, or others; and,
d) Information we receive from a DENTIST who provides dental services to you.

7.02 HOW INFORMATION IS USED AND DISCLOSED

DDAR does not sell the INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION of its customers or former customers to any unaffiliated third parties. Such information is used for underwriting and processing your claim. This information is only provided to third parties under certain circumstances. The INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION DDAR collects, as described above, may be disclosed as follows:

a) For TREATMENT, payment, and HEALTH CARE OPERATIONS as defined under HIPAA with respect to DDAR's administration of your dental BENEFITS program.
b) For the proper management and administration of DDAR.
c) To provide data aggregation services to your GROUP HEALTH PLAN.
d) If applicable, to your employer's EMPLOYEEs, classes of EMPLOYEEs, or other persons identified by your employer to carry out the plan administration functions that it performs for the GROUP HEALTH PLAN.
e) If applicable, to the Plan Sponsor as a summary of health information for the purpose of obtaining PREMIUM bids for providing dental BENEFITS coverage under the GROUP HEALTH PLAN or modifying, amending, or terminating the GROUP HEALTH PLAN.
f) To other companies as is necessary to process your claims. For example, claim and transactional information is transmitted to the company that processes and prints CLAIMs statements. These companies are required by agreements to use this information only for the purpose for which it was disclosed.
g) As REQUIRED BY LAW. For example, DDAR may be required to disclose the information described above in response to a court order or subpoena or as required by a regulatory investigation.
h) To companies that perform marketing services on our behalf. DDAR may disclose the information DDAR collects, as described above. These companies are required by agreements to use this information only for the purpose for which it was disclosed.
i) As necessary to prevent fraud or unauthorized use.
j) As otherwise required or permitted by HIPAA or federal or state law without your authorization.

7.03 HOW INFORMATION IS PROTECTED

DDAR maintains and implements all physical, electronic, and procedural safeguards that comply with federal regulations to guard your INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION and to prevent its use or DISCLOSURE other than as described above.

ARTICLE 8. GENERAL PROVISIONS

8.01 ENTIRE CERTIFICATE - CHANGES. The CONTRACT, including the SCHEDULE OF BENEFITS and any endorsements or amendments issued by DDAR, make up the entire CONTRACT between the parties. The CERTIFICATE is evidence of coverage, but it is not controlling. If there is conflict between the CONTRACT and the CERTIFICATE, the CONTRACT will control. No agent has authority to change this CERTIFICATE or waive any of its provisions. No change in this CERTIFICATE will be valid unless made by written amendment signed by an Officer of DDAR. Verbal approval(s) of coverage and/or BENEFITS shall not modify this agreement in any way and are invalid and void and of no effect.

8.02 SEVERABILITY. If any part of this CERTIFICATE or any amendment is found to be illegal, void, or not enforceable, all other portions will remain in full force and effect until cancelled as provided by the CONTRACT.

8.03 CONFORMITY WITH STATE LAWS. The laws of the State of Arkansas will govern this CERTIFICATE. Any part of this CERTIFICATE, which, on its EFFECTIVE DATE, conflicts with the laws of Arkansas is amended to conform to the minimum requirements of such laws.

8.04 **LEGAL ACTIONS**. No action at law or in equity will be brought before sixty (60) days after proof of loss has been filed as required by this CERTIFICATE, nor prior to the completion of all administrative remedies. Any action must be brought within three (3) years from the time proof of loss is required by this CERTIFICATE. In any case, action may only be brought after a PARTICIPANT has exercised all the review and appeal rights and completed all administrative remedies under this CERTIFICATE.

8.05 **CHOICE OF JURISDICTION**. All litigation related to the terms or conditions of this CERTIFICATE will be in a court of valid jurisdiction in Pulaski County, Arkansas.

8.06 **DOES NOT REPLACE WORKERS' COMPENSATION**. This CERTIFICATE does not affect any requirements for coverage by Worker's Compensation Insurance.

8.07 **CONFLICTS**. The terms of the CONTRACT, along with any amendments or endorsements issued by DDAR will in all cases be controlling. Should the wording of the CONTRACT, along with any amendments or endorsements issued by DDAR conflict with the SCHEDULE OF BENEFITS, APPLICATION AND AGREEMENT FOR EMPLOYERS, or proposal, the CONTRACT, along with any amendments or endorsements issued by DDAR will govern.

8.08 **RIGHT TO RECOVERY**. Whenever BENEFITS greater than the maximum amount of allowable BENEFITS are provided, DDAR will have the right to recover any excess. DDAR will recover the excess from any persons, insurance companies, or other organizations involved to whom the payment was made. Any PARTICIPANT covered under the CONTRACT will execute and deliver any necessary documents and do what is necessary to secure such rights to DDAR.

8.09 **SUBROGATION**. DDAR acquires the PARTICIPANT's legal rights to recovery for payment for dental services the patient required because of the action or fault of another. DDAR has the right to recover from the PARTICIPANT any payments made by or for the other party. In such cases, DDAR has the right to recover amounts equal to the BENEFITS paid by DDAR. DDAR also has the right to recover collection costs and attorney's fees in the proportion each benefits from the recovery.

DDAR has the right to make the recovery by suit, settlement, or otherwise from the person who caused the dental problem or injury. Such recovery may be from the other person, his or her insurance company, or any other source, such as third party motorist coverage.

The PARTICIPANT must help DDAR recover from other sources. PARTICIPANT must provide all requested information and sign necessary documents. If the PARTICIPANT fails to help DDAR or settles any CLAIM without DDAR's written consent, DDAR may recover from the PARTICIPANT. DDAR will be entitled to any recovery received by the PARTICIPANT and reasonable attorney's fees and court costs.

8.10 **ENDORSEMENTS/AMENDMENTS**. The CONTRACT is subject to amendment by DDAR. Nothing contained in any endorsement shall affect any of the conditions, provisions, or limitations of the CONTRACT except as expressly provided in the endorsement. All conditions, provisions, and limitations of the CONTRACT shall apply to any endorsement if they are not in conflict.

8.11 **SUBCONTRACTOR(S) AND AGENT(S)**. DDAR may subcontract certain functions or appoint an agent or agents to act on DDAR'S behalf. The agent(s) may fulfill expressed, limited duties under this CERTIFICATE. Such agent(s) have no authority to change or amend this document.

8.12 **DDAR LIABILITY.** DDAR shall have no liability for any wrongful conduct. This includes but is not limited to tortuous conduct, negligence, wrongful acts or omissions, or any other act of any person. This includes but is not limited to DENTISTs, dental assistants, dental hygienists, dental EMPLOYEEs, hospitals, or hospital EMPLOYEEs receiving or providing services. DDAR shall also have no liability for any services, equipment, or facilities.

8.13 **RIGHT TO INFORMATION**. In order for CLAIMs to be approved, DDAR, upon its request, shall be entitled to receive from any attending or examining DENTIST or from hospitals in which a DENTIST's care is rendered certain information and records. This data will relate to the attendance to, examination of, or TREATMENT rendered to a PARTICIPANT. DDAR, at its own expense, shall have the right but not the duty to cause any PARTICIPANT to be examined when and so often as it reasonably requires. The receipt of any PARTICIPANT of any service constitutes the consent of such PARTICIPANT to the release to DDAR of all such information and records. The PARTICIPANT shall execute a medical release as requested by DDAR.

8.14 **MISREPRESENTATIONS**. All statements made by the group or by an INDIVIDUAL EMPLOYEE are deemed representations and warranties.

8.15 **NOTICE TO EMPLOYEES.** Pursuant to the Gramm-Leach-Bliley Act (GLB) and Regulation 74 enacted by the Arkansas Insurance Department, DDAR shall provide notice to its customers about its privacy policies and practices. Notice will be made upon an INDIVIDUAL's enrollment in the plan and annually thereafter for the duration of the term of coverage. GROUP SPONSOR agrees to distribute copies of this notice to their EMPLOYEEs who receive dental insurance through DDAR.

8.16 **FRAUD NOTICE.** Any person who knowingly presents a false or fraudulent CLAIM for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

8.17 **DeltaUSA.** The parties acknowledge that DDAR is subject to certain Rules and Regulations (and that same may be amended from time to time) by DeltaUSA, a national organization. The parties will act in good faith to comply with any such Rules and Regulations (and amendments, if any).

8.18 **STATEMENT OF ERISA RIGHTS.** As a PARTICIPANT in this dental BENEFITS plan, you are entitled to certain rights and protections under the EMPLOYEE Retirement Income Security Act (ERISA) of 1974. ERISA provides that all plan PARTICIPANTS shall be entitled to:

Receive Information About Your Plan and BENEFITS

Examine, at no charge, at the PLAN ADMINISTRATOR's office and at other specified locations, such as worksites or union halls, all documents governing the plan. This includes insurance CONTRACTs and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the US Insurance Department of Labor. This is available at the Public DISCLOSURE Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the PLAN ADMINISTRATOR, copies of documents governing the operation of the plan. Documents include insurance CONTRACTs and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The PLAN ADMINISTRATOR may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The PLAN ADMINISTRATOR is REQUIRED BY LAW to furnish each PARTICIPANT with a copy of the summary annual report.

Continue GROUP HEALTH PLAN Coverage

Continue health care coverage for yourself or for your DEPENDENTs if there is a loss of coverage under the plan as a result of a QUALIFYING EVENT. You or your DEPENDENTs may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for PRE-EXISTING CONDITIONs. Your plan does not have exclusionary periods for PRE-EXISTING CONDITIONs. Because your plan is limited to dental coverage, it is exempt from the certification of credible coverage provisions of the Health Insurance Portability and Accountability Act (HIPAA) and Section 733 of ERISA.

Prudent Actions of Plan Fiduciaries

In addition to creating rights for plan PARTICIPANTs, ERISA gives duties to the people responsible for the operation of the EMPLOYEE benefit plan. The people who operate your plan are called "fiduciaries" of the plan, and they have a duty to do so prudently and in the interest of you and other PARTICIPANTs. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your CLAIM for a benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time restraints.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such case, the court may require the PLAN ADMINISTRATOR to provide the materials and pay you up to $110.00 a day until you receive the materials, unless they were not sent because of reasons beyond the control of the administrator. If you have a CLAIM for BENEFITS that is denied or ignored in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your CLAIM is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the PLAN ADMINISTRATOR. If you have any questions about this statement about your rights under ERISA, or if you need assistance in obtaining documents from the PLAN ADMINISTRATOR, you should contact the nearest office of the Pension and Welfare BENEFITS Administration, US Department of Labor. This will be listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare BENEFITS Administration, US

Department of Labor, 200 Constitution Avenue N.W., Washington, DC, 20210. You may also obtain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare BENEFITS Administration.

If we at Delta Dental of Arkansas fail to provide you with reasonable and adequate service, feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
(501) 371-2640
(800) 852-5494

DELTA DENTAL

Delta Dental PPO Plus Premier

Schedule of Benefits for SILOAM SPRINGS SCHOOL DISTRICT/ACTIVE

a) Original Effective Date: 12:01 a.m. Central Standard Time, 10/01/2004

b) Group Number: 000009299

c) Deductible: $50 for benefits received in

- Coverage B
- Coverage C
- Child Orthodontic Rider

per person, per benefit period.

d) Annual Maximum Payment: $1,000 per person per benefit period.

e) Benefit Period: A benefit period for each eligible participant shall mean a calendar year, the period from January 1st to December 31st of each year.

Covered Services:

Coverages and Maximum Plan Allowances (MPA)

Coverage A – Diagnostic and Preventative Services **In-Network 100% MPA**

- Routine periodic examinations not more than two (2) in any benefit period, inclusive of an initial oral examination.
- Bitewing and periapical x-rays as required.
- Full-mouth x-rays one (1) in any thirty-six (36) consecutive month period.
- Prophylaxis (cleaning) not more than two (2) in any benefit period.
  * Please see information on Evidence Based Dentistry.
- Topical application of fluoride one (1) per benefit period for dependent children to age nineteen (19).
- Sealants one (1) per tooth on permanent maxillary and mandibular first and second molars with no caries (decay) on the occlusal surface, for dependent children to age nineteen (19).

Coverage B – Basic Restorative Services **In-Network 80% MPA**

- Minor emergency treatment for the relief of pain as needed by the participant.
- Amalgam (silver) and composite/resin (white) fillings (composites are not a covered benefit on molars).
- Simple extractions.
- Space maintainers for prematurely lost teeth of eligible dependent children to age sixteen (16) .
- Endodontics, including pulpal therapy and root canal filling.
- Oral surgery, including pre- and post-operative care and surgical extractions, except TMJ surgery.

- Stainless steel crowns used as a restoration to natural teeth for dependent children to age sixteen (16) when the teeth cannot be restored with a filling material.
- Non-surgical periodontics.
- Periodontal maintenance; two (2) per benefit period following active periodontal treatment. * Please see information on Evidence Based Dentistry .

Coverage C – Major Restorative Services	**In-Network**
	50% MPA

- Crowns, inlays, onlays, and veneers are benefits for the treatment of visible decay and fractures of tooth structure when teeth are so badly damaged they cannot be restored with amalgam or composite restorations.
- Prosthodontics, including procedures for construction of fixed bridges, partial or complete dentures, and repair of fixed bridges.
- Complete or partial denture reline, including chair side or laboratory procedures to improve the fit of the appliance to the tissue.
- Complete or partial denture rebase, including laboratory replacement of the acrylic base of the appliance.
- Surgical periodontics.
- Coverage for an endosteal implant to support a crown.

Rider(s)	**In-Network**
Child Orthodontic Rider – Orthodontic services for dependent children to age nineteen (19). **Lifetime Maximum Payment – $1,000**	**50% MPA**

Carry Over Benefit Rider
Carry over benefit: **$250**
Claims threshold: **$499**
Carry over benefit maximum: **$1,000**

The benefit allowance for services of an out-of-network dentist will be reduced by 10% for eligible services as determined by Delta Dental after applying the applicable deductibles, co-payments and maximums. This means your out-of-pocket expense may be greater if you choose an out-of-network dentist.

(*)Evidence Based Dentistry: DDAR covers additional routine cleanings or periodontal maintenance procedures (up to four per year) for covered members with diabetes, heart disease, who are pregnant or have a history of periodontal disease. The additional benefits may not be combined by those with more than one of the above conditions.

Questions? Contact Delta Dental's Customer Service Department at (800) 462-5410.

Delta Dental's network of participating providers may be found on our website at www.deltadentalar.com.

DELTA DENTAL OF ARKANSAS, INC.
SCHEDULE A
DIAGNOSTIC AND PREVENTIVE BENEFITS
AND THEIR
LIMITATIONS AND EXCLUSIONS

A1.00 DIAGNOSTIC AND PREVENTIVE BENEFITS
Covered at 100% MPA

• Diagnostic	Routine periodic and specialty examinations not more than two (2) in any BENEFIT PERIOD. This is inclusive of an initial, oral examination.
• Bitewings	Bitewing and periapical x-rays as required.
• Full Mouth x-rays	Full-mouth x-rays one (1) time(s) in any thirty-six (36) consecutive month period.
• Cleanings	Prophylaxis (cleaning).
• Fluoride	Topical application of fluoride one (1) per BENEFIT PERIOD.
• Sealants	Sealants one (1) per tooth.

A2.00 LIMITATIONS AND EXCLUSIONS ON DIAGNOSTIC AND PREVENTIVE BENEFITS

- DDAR will pay for two (2) oral examination(s) and cleaning(s) in BENEFIT PERIOD. (* Please see information on Evidence Based Dentistry)
- Diagnostic casts, photographs, and cephalometric films are a benefit only if done for orthodontic purposes.
- DDAR will pay for full mouth x-rays one (1) time within any thirty-six (36) consecutive month period. A combination of periapical and bitewing x-rays (ten or more films) or a panoramic film and additional x-rays make up a full mouth series.
- A sealant is a benefit only on the unrestored, decay free chewing surface (occlusal surface) of the maxillary (upper) and mandibular (lower) first and second molars. Sealants are a benefit for DEPENDENT children to age nineteen (19). Sealants are payable one (1) per tooth in any sixty (60) consecutive month period.
- Preventative control programs (oral hygiene instructions, carries susceptibility tests, dietary control, tobacco counseling, etc.) are not a benefit.
- DDAR will pay for one (1) topical application of fluoride one (1) time(s) in a BENEFIT PERIOD for DEPENDENT children to age nineteen (19). Fluoride rinses or self-applied fluorides are not a benefit.
- DDAR will not pay for adult cleanings for PARTICIPANT(s) to age fourteen (14).
- Pulp vitality tests are payable per visit, not per tooth, and only for the diagnosis of emergency conditions.
- General Limitations and Exclusions found in Article 3 of this POLICY also apply to Diagnostic and Preventive BENEFITS.

(*) Evidence Based Dentistry: DDAR covers additional routine cleanings or periodontal maintenance procedures (up to four per year) for covered members with diabetes, heart disease, who are pregnant or have a history of periodontal disease. The additional benefits may not be combined by those with more than one of the above conditions.

DELTA DENTAL OF ARKANSAS, INC.
SCHEDULE B
BASIC RESTORATIVE BENEFITS
AND THEIR
LIMITATIONS AND EXCLUSIONS

B1.00 BASIC RESTORATIVE BENEFITS
Covered at 80% MPA

• Palliative Emergency TREATMENT	Minor emergency TREATMENT for the relief of pain as needed by the PARTICIPANT.
• Fillings	Amalgam (silver) and composite/resin (white) fillings (composites are not a covered benefit on molars).
• Extractions	Simple extractions.
• Space Maintainers	For prematurely lost teeth of eligible DEPENDENT children to age sixteen (16).
• Stainless Steel Crowns	Used as a restoration to natural teeth for DEPENDENT children to age sixteen (16) when the teeth cannot be restored with a filling material.
• Endodontics	Includes pulpal therapy and root canal filling.
• Oral Surgery	Oral surgery, including pre- and post-operative care and surgical extractions, except TMJ surgery.
• Non-Surgical Periodontics	Includes TREATMENT for the disease of the gums and bone supporting the teeth.
• Periodontal Maintenance	Limited to two (2) per BENEFIT PERIOD following active periodontal treatment**.** (* Please see information on Evidence Based Dentistry)

B2.00 LIMITATIONS AND EXCLUSIONS ON BASIC RESTORATIVE BENEFITS

- Palliative TREATMENT is payable on a per visit basis, once on the same date and only payable in conjunction with x-rays and / or diagnostic procedures.
- Restorative BENEFITS are allowed once per surface, per tooth in a twelve (12) month period. This is allowed irrespective of the number of combinations of procedures requested or performed. Composites on molars are not covered. An amalgam allowance will be made for molars with any fee difference the responsibility of the patient.
- A space maintainer is a benefit when used to replace prematurely lost or extracted teeth for children to age sixteen (16), limited to one (1) in a sixty (60) consecutive month period. Recementation of a space maintainer is limited to one (1) in sixty (60) consecutive months. Recementation of a space maintainer within six (6) months of the seating date is part of the original procedure. A space maintainer is not considered an orthodontic appliance.
- DDAR will not pay for the replacement of a stainless steel crown within a twenty-four (24) month period of the initial placement.
- Composite resin crowns are not a benefit on primary teeth. A stainless steel crown allowance will be made with any fee difference the responsibility of the patient.
- Payment for root canal TREATMENT includes charges for temporary restorations. Root canal TREATMENT is limited to one (1) in a lifetime, per tooth, by the same DENTIST or dental office. Retreatment of root canal by the same DENTIST or dental office will be considered after twenty-four (24) consecutive months have lapsed since initial treatment. Root canals on deciduous teeth are not a benefit, unless there is no permanent successor. Pulpal therapy is limited to primary teeth, and therapeutic pulpotomy is limited to primary teeth one (1) time in a lifetime.

- Extractions, surgical extractions, root removal, alveoplasty, surgical exposure of impacted or unerupted tooth, tooth reimplantation and/or stabilization, transseptal fiberotomy, and oroantral fistula closure are limited to one (1) in a lifetime.
- Charges for general anesthesia/intravenous sedation are not covered except when administered in conjunction with covered oral surgery, excluding single tooth extractions (ADA procedure code 7140) and for children three (3) years of age and under.
- Analgesia, anxiolysis, inhalation of nitrous oxide, therapeutic drug injection, other drugs and/or medicines, and desensitizing medicines are not covered.
- TREATMENT of complications (post-surgical) or unusual circumstances are a benefit one (1) time) in three (3) months (i.e., TREATMENT of a dry socket).
- Non-surgical periodontics will not be provided more often than one (1) time in a twenty-four (24) consecutive month period per quadrant.
- Periodontal maintenance is a benefit after three (3) consecutive months following active periodontal TREATMENT.
- General Limitations and Exclusions found in Article 3 of this POLICY also apply to Basic Restorative BENEFITS.

DELTA DENTAL OF ARKANSAS, INC.
SCHEDULE C
MAJOR RESTORATIVE BENEFITS
AND THEIR
LIMITATIONS AND EXCLUSIONS

C1.00 MAJOR RESTORATIVE BENEFITS
Covered at 50% MPA

• Crowns, Inlays, Onlays, and Veneers	Crowns, inlays, onlays, and veneers are BENEFITS for the TREATMENT of visible decay and fractures of tooth structure when teeth are so badly damaged they cannot be restored with amalgam or composite restorations.
• Prosthodontics	Procedures for construction of fixed bridges, partial or complete dentures, and repair of fixed bridges.
• Complete or Partial Denture Reline	Chair side or laboratory procedure to improve the fit of the appliance to the tissue (gums).
• Complete or Partial Denture Rebase	Laboratory replacement of the acrylic base of the appliance.
• Surgical Periodontics	Includes TREATMENT and surgical procedures for the disease of the gums and bone supporting the teeth.
• Implants	Endosteal implants are covered once in a lifetime per tooth.

C2.00 LIMITATIONS AND EXCLUSIONS ON MAJOR RESTORATIVE BENEFITS

- DDAR will not pay to replace any crowns, inlays, onlays, or veneers received in the previous sixty (60) months. Payment for crowns, inlays, onlays, and veneers shall include charges for preparations of tooth, gingival, and impression.
- DDAR will not pay for a crown, inlay, onlay, or veneer on a tooth that can be restored with an amalgam or composite restoration.
- Porcelain/ceramic or cast crowns for children to age thirteen (13) are not BENEFITS.
- Crown repair is limited to one (1) in a twenty-four (24) consecutive month period on the same tooth. Crown recement is limited to one (1) in twelve (12) consecutive months per tooth. Repairs for bridges and full and partial dentures are limited to one (1) in a sixty (60) consecutive month period.
- DDAR will not pay to replace any fixed bridges or partial or complete dentures that the PARTICIPANT received in the previous sixty (60) consecutive months, except where the loss of additional teeth requires the construction of a new appliance. DDAR will not pay to replace a bridge or denture unless it cannot be made satisfactory.
- Recementation of a bridge within six (6) consecutive months of the seating date is part of the original procedure.
- Payment for a partial or complete denture shall include charges for any necessary adjustment within a six (6) consecutive month period. Payment for a reline or rebase of a partial or complete denture is limited to one (1) in a thirty-six (36) consecutive month period. Adjustments made within the first six (6) consecutive month period after delivery are not covered. Adjustments after the post six (6) month delivery period are limited to not more than two (2) in any twelve (12) consecutive month period.
- A posterior, fixed partial denture and a removable partial denture in the same dental arch is not covered. The benefit is limited to the allowance for the partial, removable denture.
- Adjustments to complete or partial dentures are limited to two (2) adjustments per denture per twelve (12) consecutive months after six (6) consecutive months have elapsed since initial placement.

- DDAR limits payment for standard dentures to the maximum allowable fee for a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth. A standard denture is made by conventional means from acceptable materials. If a denture is constructed by specialized techniques and the fee is higher than the fee allowable for a standard denture, the patient is responsible for the difference.
- DDAR does not pay for fixed bridges or full or partial dentures for children to age seventeen (17).
- A fixed bridge where a partial denture is constructed in the same arch is not a covered benefit.
- Fixed partial denture retainers are a benefit one (1) time in any sixty (60) consecutive month period.
- Temporary and provisional crowns and partial dentures are not a benefit.
- Payment for periodontal surgery shall include charges for three (3) months' post-operative care and any surgical re-entry for a thirty-six (36) consecutive month period. Root planing, curettage, and osseous surgery are not a benefit for PARTICIPANT(s) to age fifteen (15).
- Endosteal implants are covered one (1) in a lifetime per tooth.
- Implant abutments are covered one (1) time in every sixty (60) consecutive month period.
- An implant or abutment supported crown is covered one (1) time in any sixty (60) consecutive month period.
- An implant or abutment supported retainer is covered one (1) time in any sixty (60) consecutive month period.
- Repair of implant supported prosthesis or implant abutment is covered one (1) time in any sixty (60) consecutive month period.
- Recementation of implant /abutment supported crown or fixed partial denture is covered one (1) time in any twelve (12) consecutive month period after six (6) months have elapsed since initial placement.
- Implant maintenance procedure is covered one (1) time in any twelve (12) months.
- Implant removal is covered one (1) time in a lifetime per tooth.
- Tissue conditioning is limited to two (2) in a thirty-six (36) consecutive month period. Tissue conditioning is not a benefit if performed on the same day a denture is delivered or a reline/rebase is provided.
- Procedures for purely cosmetic reasons are not a benefit.
- General Limitations and Exclusions found in Article 3 of this POLICY also apply to Major Restorative BENEFITS.

DELTA DENTAL OF ARKANSAS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective: January 1, 2007

If you have any questions about this notice, please contact the Delta Dental of Arkansas Privacy Officer at 800-462-5410.

WHO WILL FOLLOW THIS NOTICE:

This notice describes the practices of Delta Dental of Arkansas ("Delta Dental") and that of:

- My group dental plan, my employer or its agent regarding my enrollment in and payment for a dental/vision program.
- My insurance producer regarding the enrollment, payment, and renewal of my dental coverage.
- All individuals that I may request to contact Delta Dental about my dental/vision benefits or claims.
- Any dentist, vision care provider, or other person who assists Delta Dental with the review of the quality of dental/vision services provided to me.
- Any investigators and other persons who assist Delta Dental in detecting fraud and abuse.
- Any persons who provide services to Delta Dental for the administration of my dental/vision benefits, including, but not limited to, lawyers, accountants, actuaries, data processors or other computer companies, storage facilities and auditors.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical/dental/vision information about you, including information about your claims history and payments for services (referred to as "Protected Health Information" or "PHI"). We create a record of the services you receive from Delta Dental. We need this record to provide you with dental/vision benefits and to comply with certain legal requirements. This notice applies to all of the PHI maintained by Delta Dental, whether originally generated by Delta Dental or a

third party. Your personal dentist/eye care provider may have different policies or notices regarding the use and disclosure of your PHI that is created in or maintained in the dentist's/eye care provider's office or clinic.

This notice will tell you about the ways in which we may use and disclose PHI about you. We also describe your rights and certain obligations we have regarding the use and disclosure of such PHI.

We are required by law to:

- Make sure your PHI is kept private;
- Give you this notice of our legal duties and privacy practices with respect to your PHI; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

Delta Dental may use and disclose your PHI to predetermine, process and pay for dental/vision services submitted under your dental/vision plan and to otherwise administer your dental/vision benefits as follows:

- To review all information and documentation necessary to determine your eligibility for coverage.
- To review all information and documentation necessary to determine if the submitted services are covered under your dental/vision plan.
- After payment is made, to review the claim for accuracy of processing and payment and to recover payment for the claim from another insurance company or payer.
- To review the quality and appropriateness of the services provided to you.
- To conduct fraud and abuse detection in investigations.
- To respond to inquiries and complaints regarding your benefits.
- When required to do so by federal, state, or local law.
- When necessary to prevent serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS:

Military and Veterans. If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release PHI about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. As required by law, we may disclose PHI about you to authorities charged with preventing or controlling disease or disability.

Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. We may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release PHI if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct at Delta Dental; and in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release PHI about patients of Delta Dental to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law

enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

OTHER USES OF MEDICAL INFORMATION:

Other uses and disclosures of PHI not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time and we will no longer use or disclose such PHI about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU:

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Obtain a Copy. You have the right to inspect and obtain a copy of PHI that may be used by Delta Dental to make decisions about your dental/vision coverage. Usually, this includes medical and billing records.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Delta Dental of Arkansas, P.O. Box 15965, North Little Rock, Arkansas, 72231, Attention: Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to PHI you may request that the denial be reviewed. Another individual chosen by Delta Dental will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Delta Dental.

To request an amendment, your request must be made in writing and submitted to Delta Dental of Arkansas, P.O. Box 15965, North Little Rock, Arkansas, 72231, Attention: Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

- Is not part of the medical information kept by or for Delta Dental;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of PHI about you.

To request this list or accounting of disclosures, you must submit your request in writing to Delta Dental of Arkansas, P.O. Box 15965, North Little Rock, Arkansas, 72231, Attention: Privacy Officer. Your request must state a time period which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a twelve (12) month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a dental/vision treatment you received.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the Delta Dental Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse. You will be provided a written response detailing whether Delta Dental agrees to or rejects the proposed restriction.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Delta Dental Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at our website, www.deltadentalar.com.

To obtain a paper copy of this notice, please contact the Delta Dental Privacy Officer.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice on our website, www.deltadentalar.com. The notice will contain on the first page, on the top of the page in the middle, the effective date.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with Delta Dental or with the Secretary of the Department of Health and Human Services. To file a complaint with Delta Dental, contact the Privacy Officer at Delta Dental of Arkansas, P.O. Box 15965, North Little Rock, Arkansas, 72231. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

Effective Date: January 1, 2007

PRIVACY NOTICE AND POLICIES OF DELTA DENTAL OF ARKANSAS

Protecting your privacy is a priority of Delta Dental of Arkansas (DDAR). The purpose of this notice is to help you understand how DDAR collects, uses, and protects your nonpublic personal information.

A. INFORMATION DDAR COLLECTS

DDAR collects nonpublic personal information about you from the following sources:

1. Information we receive from you on applications and other forms, or from our agents, providers and plan administrators;
2. Information you provide to DDAR in order to receive our services; and
3. Information about your transactions with us, our affiliates, or others.

B. HOW INFORMATION IS USED AND DISCLOSED

DDAR does not sell the nonpublic personal information of its customers or former customers to any unaffiliated third parties. Such information is used for underwriting and processing your claims, and is only provided to third parties under certain circumstances. The information DDAR collects, as described above, may be disclosed as follows:

1. To other companies as is necessary to process your claims. For example, claim and transactional information is transmitted to the company that processes and prints claims statements. These companies are required by agreements to use this information only for the purpose for which it was disclosed.

2. As required by law. For example, DDAR may be required to disclose the information described above in response to a court order or subpoena, or as required by a regulatory investigation.

3. To companies that perform marketing services on our behalf. DDAR may disclose the information DDAR collects, as described above. These companies are required by agreements to use this information only for the purpose for which it was disclosed.

4. As necessary to prevent fraud or unauthorized use.

5. As otherwise permitted by law.

C. HOW INFORMATION IS PROTECTED

We restrict access to nonpublic personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.