DELTA DENTAL®

Delta Dental – Dental Insurance for Individuals & Families

Group Number AR1000-1001

This Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

This Plan provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats)

This Plan provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, call 1-800-971-4108 (TTY Users call 711).

If you believe that this Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with the civil rights coordinator at PO Box 1596, Indianapolis, IN 46206-1596; by phone at 1-800-971-4108 (TTY Users call 711) or fax to 1-888-984-7156. You can file a grievance by mail, fax or phone. If you need help filing a grievance, the civil rights coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201; 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html.*

OUTLINE OF COVERAGE

We are pleased that you selected Delta Dental Plan of Arkansas, Inc. ("Delta Dental") for your dental coverage. Delta Dental is a leader in dental care – both in Arkansas and in the nation.

READ YOUR CERTIFICATE CAREFULLY. This outline of coverage provides you a very brief description of the important features of your policy. This outline is not your Certificate of Coverage ("Certificate") and only the actual Certificate provisions will control. The Certificate itself sets forth in detail the rights and obligations of both you and Delta Dental. It is therefore, important that you read this outline and the Certificate carefully.

DENTAL EXPENSE COVERGE. Policies of this category are designed to provide You coverage for dental expenses. Coverage is provided for initial and periodic exams, routine prophylaxis, fluoride treatments, x-rays, fillings, extractions, endodontics, oral surgery, periodontics, bridges, crowns, implants and prosthodontics.

BENEFITS

DEDUCTIBLE:
An individual deductible of $50 is the amount the You must pay for services in any Calendar Year before certain Benefits will be paid, subject to limitations shown in Your Certificate.

ANNUAL MAXIMUM BENEFIT:
The $1,000 maximum benefit is the sum that Delta Dental will pay for Benefits in any Calendar Year.

Maximum Plan Allowance for Services: Is the maximum payment allowed by Delta Dental for the applicable Covered Service(s) provided by the Provider

Coverage A – Diagnostic and Preventative Services	Premier In Network 100% MPA PPO In Network 100% MPA Out-Of-Network 90% MPA
Coverage B – Basic Restorative Services 6 Month Wait	Premier In Network 80% MPA PPO In Network 80% MPA Out-Of-Network 72% MPA
Coverage C – Major Restorative Services 6 Month Wait	Premier In Network 50% MPA PPO In Network 50% MPA Out-Of-Network 45% MPA

COVERED SERVICES:

- Initial and routine periodic examinations
- Routine cleanings
- Topical application of fluoride
- Silver Diamine Fluoride
- Sealants
- Bitewing, periapical and full-mouth X-rays

- Minor emergency treatment
- Space maintainers
- Fillings
- Denture reline, rebase and repair
- Endodontics
- Oral surgery
- Periodontal treatment
- Stainless steel crowns
- Crowns, inlays, onlays, and veneers
- Prosthodontics
- Endosteal Implants

AGE LIMITATIONS:
***IMPORTANT NOTE ABOUT TERMINATING COVERAGE ONCE A DEPENDENT CHILD TURNS TWENTY-SIX (26) YEARS OLD*:** Benefits described in this section for a dependent child end when they turn twenty-six (26) years old. Delta Dental will automatically terminate the coverage of dependents when they reach their 26th birthday. For that reason, you must contact Delta Dental if you wish to retain coverage on such dependents, if eligible.

LIMITATIONS:

Once (1) in any twelve (12) month period	Crown and fixed partial denture recementment Topical application of fluoride
Twice (2) in any twelve (12) month period	Initial and routine periodic examinations Routine Prophylaxis Periodontal maintenance Adjustments to dentures (after the first six (6) months of delivery Silver Diamine Fluoride
Once (1) in any twenty-four (24) month period	Restorative Benefits per surface per tooth Non-surgical periodontics per quadrant Crown repair
Once (1) in any thirty-six (36) month period	Reline or rebase of dentures
Twice (2) in any thirty-six (36) month period	Tissue conditioning
Once (1) in any sixty (60) month period	Full Mouth X-rays Replacement of stainless steel crowns Replacement of any crowns, inlays, onlays or veneers Repairs for bridges and full and partial dentures Sealants, per tooth
Once (1) in a lifetime	Full-mouth debridement Endodontics, per tooth Tooth extractions, per tooth Endosteal Implants Space Maintainers and their recementment

WAITING PERIODS:
This policy may contain waiting periods that must be satisfied before Benefits for certain Covered Services become payable. Waiting periods are further described in Your Certificate and Schedule of Benefits. If a Covered Service is started before the waiting period for that service ends, that service is not covered under the Certificate. If Your coverage under the Certificate ended and You later become insured again, Your effective date is the most recent effective date unless stated otherwise in the Certificate. The waiting periods for the Certificate vary by type of service and are listed in the Schedule of Benefits.

BENEFITS AND SERVICES NOT COVERED UNDER THIS CERTIFICATE
There are a number of services that are not Covered Services under the Certificate. These are fully described in the Certificate. Some of the services that are not covered include, but are not limited to:

- 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;
- Treatment by anyone other than a Provider;
- Services to correct congenital or developmental malformations;
- Cosmetic dentistry;
- Services or appliances started prior to the date the patient became eligible under this plan;
- Diagnosis and treatment of disturbances of the temporomandibular joint (TMJ);
- Increasing the vertical dimension or for restoring tooth structure lost by attrition;
- Experimental and/or investigational services;
- Replacement of lost, missing, or stolen appliances/devices;
- A Claim that is received for payment more than twelve (12) months after services are rendered;
- Complete occlusal adjustments, occlusal guards, occlusion analysis, enamel microabrasion, odontoplasty, bleaching, and athletic mouthguards;
- Removable appliances for control of harmful habits, including but not limited to tongue thrust appliances except when medically necessary for a Participant under the age of 19;
- General anesthesia/intravenous sedation, except when administered in conjunction with covered surgical procedures, excluding simple tooth extractions and for children three (3) and under;
- Hospital-related services;

All services that are not covered by the Certificate, including those listed above, are more fully described in the Certificate. Please read the Certificate in order to know about all of the services that are not covered.

NETWORK:
Under Your policy, You may seek services from any Provider You choose. However, You will receive a **higher level of BENEFITS by seeking care from a Participating Provider.**

Participating Providers will complete and submit claim forms for You at no charge. Participating Providers agree to accept the Delta Dental Maximum Plan Allowance for Covered Services. Participating Providers will not bill you for any amount over the Maximum Plan Allowance. Since we will pay the Participating Provider directly, You don't have to pay the entire bill and wait to be paid back.

If You visit a Non-Participating Provider, You may have to complete the forms Yourself or pay a service charge. You may have to pay the Non-Participating Provider in advance for the entire bill. If so, Delta Dental will pay any Benefits due to You after the Claim is submitted. Also, Non-Participating Providers have not agreed to accept the Maximum Plan Allowance that Delta Dental will pay. As a result, you will be responsible for any difference between the Non-Participating Provider's fee and the Delta Dental payment. **Also, the Benefit allowance for Covered Services performed by a Non-Participating Provider will be reduced by 10% for Covered Services as determined by Delta Dental after applying the applicable deductibles, co-payments, and maximums. This means your out-of-pocket expense will be more if you choose a Non-Participating Provider.**

How do I select a Provider?
The easiest and most accurate listing of Participating Providers is on Our website. Log into the Delta Dental Individual Account Manager and then click on the Provider Directory link. Once at the web page, select the "Dental" icon and enter Your zip code. From the "Network Selection" menu choose the Your network selected by your Group Sponsor as noted on your Schedule of Benefits. By entering the information requested, We will provide You with a list of Participating Providers in Your area. You can also get this information by calling Delta Dental at 1-844-368-6484.

This Certificate contains a summary in English of Your plan rights and Benefits. If You have trouble understanding any part of this policy, contact DDAR's Customer Service Department at 844-368-6484. Office hours are from 7:30 a.m. to 5:00 p.m. C.S.T., Monday through Friday.

This Certificate is guaranteed renewable as long as the Subscriber resides in Arkansas. We may change the Premium and Benefits, but only if the Premium is changed for all policies and riders for the same form number and premium classification.

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

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

CERTIFICATE OF COVERAGE

INTRODUCTION TO YOUR CERTIFICATE

Delta Dental Plan of Arkansas, Inc. ("Delta Dental") is a not-for-profit medical service corporation. As used in this Certificate, Delta Dental may refer to Delta Dental Plan of Arkansas, Inc., acting on its own behalf or acting on behalf of or in conjunction with a member or members of the Delta Dental Plans Association or their successors and/or assigns.

If you have any questions about this Certificate, please call Delta Dental at 1-844-368-6484 or access our website at www.DeltaDentalAR.com.

We look forward to serving you!

DELTA DENTAL PLAN OF ARKANSAS, INC.

BY:

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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Note: Please read this Certificate together with your Schedule of Benefits. The Schedule of Benefits lists the specific provisions of Your health plan. If a statement in the Schedule of Benefits conflicts with a statement in this Certificate, the statement in the Schedule of Benefits applies to Your policy and you should ignore the conflicting statement in this Certificate.

Delta Dental PPO plus Premier

Schedule of Benefits for Arkansas Individual Plan 1000

Group Number: AR1000

Deductible: Applies to Diagnostic and Preventative, Basic Restorative and Major Restorative Services per benefit period.

	Premier and PPO In Network	Out-of-Network
Individual	$50	$50

Annual and Lifetime Maximum Payment: The annual maximum amount applies to Diagnostic and Preventative Services, Basic Restorative Services and Major Restorative Services per benefit period.

	Premier and PPO In Network	Out-of-Network
Annual Individual	$1,000	$1,000

Benefit period: A benefit period for each eligible participant shall mean a calendar year, the period from January1st to December 31st of each year.

Dependent Age Limit: To the end of the month year in which the child reaches age 26.

Coverages and Maximum Plan Allowances (MPA)

Coverage A – Diagnostic and Preventative Services

Premier In Network 100% MPA
PPO In Network 100% MPA
Out-Of-Network 90% MPA

- Routine periodic and specialty evaluations are Covered Services up to two (2) time(s) in any Calendar Year. This is inclusive of an initial, oral evaluation.
- Prophylaxis (Cleaning) is a Covered Service up to two (2) time(s) per Calendar Year. (*Please see information on Evidence Based Dentistry)
- Sealants are Covered Services for Eligible Dependents prior to age sixteen (16) one (1) time per sixty (60) consecutive month period]
- Topical application of fluoride is a Covered Service one (1) time per Calendar Year for Eligible Dependents prior to age nineteen (19).
- A Caries Risk Assessment is a Covered Service once every twelve (12) months for Eligible Dependents to age three (3) to nineteen (19).
- Application of silver diamine fluoride is a Covered Service two (2) times in a Calendar Year, per tooth.
- Bitewing x-rays are Covered Services as required in any Calendar Year.
- Bitewing x-rays are limited to two (2) films in any single visit for children under the age of ten (10).
- Periapical x-rays are Covered Services as required in any Calendar Year.
- A full mouth series x-ray or panoramic x-ray is a Covered Service one (1) time within any sixty (60) consecutive month period.
- A space maintainer is a Covered Service when used to replace prematurely lost or extracted teeth for Eligible Dependents prior to age fourteen (14).
- A space maintainer is a Covered Service up to one (1) space per lifetime.

Coverage B – Basic Restorative Services
6 Month Wait

Premier In Network 80% MPA
PPO In Network 80% MPA
Out-Of-Network 72% MPA

- Palliative treatment is a Covered Service once per visit as long as no other procedures, except for x-rays, exams, or any diagnostic service, are performed on the same date.
- Restorative benefits (fillings) are Covered Services once per surface, per tooth in a twenty-four (24) month period.
- Stainless Steel Crowns used as a restoration to natural teeth are Covered Services for Eligible Dependent(s) to age sixteen (16) when the teeth cannot be restored with a filling material.
- Simple extractions.

Coverage C – Major Restorative Services
6 Month Wait

Premier In Network 50% MPA
PPO In Network 50% MPA
Out-Of-Network 45% MPA

- Surgical periodontics.
- Non-surgical periodontics.
- Periodontal Maintenance is a Covered Service up to two (2) per Calendar Year following active periodontal treatment. (*Please see information on Evidence Based Dentistry)
- Crowns, inlays, onlays, and veneers are Covered Services 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.
- Endosteal implants are Covered Services once in a lifetime per tooth.
- Prosthodontics, including procedures for construction of fixed bridges, full or partial, and repair of fixed bridges.
- Endodontics, including pulpal therapy and root canal filling.
- Oral surgery, including pre- and post-operative care and surgical extractions, except TMJ surgery.

Carry Over Benefit

- Carry Over Benefit: $250
- Claims Threshold: $249
- Carry Over Benefit Maximum: $500

The benefit allowance for covered services performed by non-participating providers will be reduced by 10% 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 a non-participating provider.

(*) Evidence Based Dentistry: DDAR covers additional routine cleanings or periodontal maintenance procedures up to four per benefit period for Participants 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 (844)368-6484.

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

1. DELTA DENTAL CERTIFICATE

Delta Dental (referred to as "Us", "We", or "Our") issues this Certificate to You as the Subscriber (referred to as "You", "Your", or "Yourself").

On its effective date, this Certificate replaces any certificate that Delta Dental may have previously issued to You. This Certificate will in turn be replaced by any certificate we issue to You in the future.

This Certificate takes effect at 12:01 a.m. on the first day of the month after We receive Your Application, the required Premium is paid, and Your eligibility is confirmed.

Coverage will end at 12:00 midnight standard central time zone on the date set out in Section 8. Delta Dental will continue Your coverage unless and until You or Delta Dental terminates it for any of the reasons described in this Certificate. Delta Dental determines Your eligibility for Benefits under this Certificate.

Delta Dental is delivering this Certificate in the State of Arkansas. To the extent that state law applies, the laws of the State of Arkansas shall govern this Certificate.

This Certificate is guaranteed renewable as long as the Subscriber resides in Arkansas. We may change the Premium and Benefits, but only if the Premium is changed for all policies and riders for the same form number and premium classification.

The rates for your policy are guaranteed for 12 months from the effective date of the policy. If You wish to move to another Delta Dental Individual policy, you must wait until the anniversary (or renewal) date of the policy. Should You terminate this policy, you are not eligible to re-enroll for 12 months and any waiting periods will apply.

This Certificate should be read in its entirety. Since many of the provisions of this Certificate are interrelated, You should read the entire Certificate to get a full understanding of Your coverage.

Certain words in this Certificate are capitalized and have special meaning and, unless defined elsewhere, are defined in Section 10, "Definitions".

2. HOW THE POLICY WORKS

2.1. Selecting a Provider

You may seek services from any Provider You choose. However, You may receive a higher level of Benefits by seeking care from a Participating Provider.

2.1.1. How do I select a Dental Provider?

The easiest and most accurate listing of Participating Providers is on Our website. Log into the Delta Dental Member Portal and then click on the Provider Directory link. Once at the web page, select the "Dental" icon and enter Your zip code. From the "Network Selection" menu choose Your network as noted on your Schedule of Benefits. By entering the information requested, We will provide You with a list of Participating Providers in Your area. You can also get this information by calling Delta Dental at 1-844-368-6484.

2.2. Accessing Your Benefits

To utilize Your dental benefits, follow these steps:

Please read this Certificate and the Schedule of Benefits carefully so You are familiar with Your Benefits, payment methods, and terms of Your Policy.

You can easily verify Your own Benefits, Claims and eligibility information online 24 hours a day, seven days a week by visiting www.DeltaDentalAR.com and selecting the link for the Member Portal. The Member Portal will also allow You to print claim forms and ID cards, select paperless explanation of benefits, search Our Participating Provider directories, and read health and wellness tips.

Make an appointment with Your Provider and tell him or her that You have dental benefits with Delta Dental. If Your Provider is not familiar with Delta Dental or has any questions, have him or her contact Delta Dental by writing to Delta Dental, Attention: Customer Service, P.O. Box 15695, Little Rock, AR 72231 or calling Delta Dental at 1-844-368-6484.

After You receive treatment from Your Provider, You, Your Provider, or Your authorized representative will need to file a claim form, as outlined in Section 2.3 below.

2.3. The Claims Process

Claims must be filed by You, Your Provider, or Your authorized representative with Delta Dental within twelve (12) months after completion of treatment for Benefits that are payable. Any Claim filed after this time period will be denied.

Delta Dental has complete discretion to interpret the terms of the Benefits under this Certificate and Our interpretation shall be final and conclusive.

Participating Providers will complete and submit claim forms for You at no charge. Participating Providers may ask Participants to fill out the patient section of the claim form, which includes Your name, social security number (SSN), and address; the Participant's name, date of birth, and relationship to You; and coordination of Benefits information, if applicable.

If You visit a Non-Participating Provider, You may be required to complete the claim form or pay a service charge. The patient section of the claim form should be completed, which includes Your name, SSN, and address; the Participant's name, date of birth, and relationship to You; and coordination of Benefits information, if applicable.

You will also be responsible for ensuring the Non-Participating Provider completes the Provider and the diagnostic sections of the claim form.

THE PROVIDER SECTION

The Provider section includes the Provider's name, address, SSN or TIN number, license number, and phone number. The Provider must also indicate whether x-rays are attached and answer questions regarding treatment that is the result of an accident. The Provider 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

The diagnostic section includes a description of services performed and the corresponding ADA procedure code, including date of service, and 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 Provider who performed the services and by You or Covered Dependent.

If Your Provider does not file Your Claim, You can obtain a Claim form from the Provider's office, by visiting www.DeltaDentalAR.com, or calling Delta Dental at 1-844-368-6484.

2.4. Pre-Treatment Estimate

A Pre-Treatment Estimate is an opinion from Delta Dental that is made prior to services being provided to You which estimates the amount that Delta Dental will pay for the services submitted by You or Your Provider to Delta Dental. It does not guarantee such payment in that actual payment, if any, also depends on applicable coverage being in effect at the time any such services were rendered. The payment may also be subject to deductible, co-payment, co-insurance, and maximum benefits allowed.

A Pre-Treatment Estimate is not required to receive payment, but it allows Claims to be processed more efficiently and allows You to know the extent to which services may be covered before Your Provider provides them. You and Your Provider should review Your Pre-Treatment Estimate notice before treatment begins.

Because the amount of Your Benefits is not conditioned on a Pre-Treatment Estimate decision by Delta Dental, all Claims under this Certificate are post-service Claims. This also means that Pre-Treatment Estimates cannot be appealed, but You may resubmit Your Pre-Treatment Estimate with additional information to support the requested services.

Once the treatment has been performed, You or Your Provider may submit the Claim to Delta Dental for a benefit determination. All Claims for Benefits must be filed with Delta Dental within one year of the date the services were completed.

2.5. Processing the Claim.

Upon receipt of the Claim, Delta Dental will process it according to the terms of this Certificate.

If You visit a Participating Provider, notification of the Benefit determination will be sent to You in the form of an explanation of benefits, which details by service rendered what the Contract allowed and Your obligation, if any. If You visit a Non-Participating Provider, the explanation of benefits will also include a check for Benefits, if any, made payable to You.

You will be notified within thirty (30) days of the receipt of the Claim of the Benefit determination.

If Delta Dental denies all or a portion of the Claim, You will receive an explanation of benefits indicating the reason for the denial.

In the case of an Urgent Care Claim, You will be notified within seventy-two (72) hours from the time the Claim is received by Delta Dental of the Benefit determination.

If additional information is needed by Delta Dental in order to make a Benefit determination, then an information request will be sent to You and the Provider. The information request will (a) describe the information needed, (b) explain why it is needed, (c) request an extension of time in which to make the Benefit determination, and (d) inform You or Your Provider that the information must be received within 45 days or Your Claim will be denied. You will receive a copy of any notice sent to Your Provider. Once Delta Dental receives the requested information, it has 15 days to make a Benefit determination. If You or Your Provider does not supply the requested information, Delta Dental will deny Your Claim.

2.6. Authorized Representative

You may appoint an authorized representative to deal with Delta Dental on Your behalf with respect to any Claim You file or any appeal of a denied Claim You wish to pursue (see the Claims Appeal Procedure section). You should contact Delta Dental, toll-free at 1-844-368-6484 or write Delta Dental at P.O. Box 15969, Little Rock, Arkansas 72231, to request a form to designate the person You wish to appoint as Your representative.

2.7. How Payment is Determined

Network Benefits

If Your Provider is a Participating Provider, Delta Dental will base its payment on the Maximum Plan Allowance for Covered Services.

Delta Dental will send payment directly to the Participating Provider and You will be responsible for any applicable deductibles, co-payments or co-insurance and maximum Benefits allowed. For non-Covered Services, You will be responsible for the Provider's submitted amount.

Non-Network Benefits

If Your Provider is a Non-Participating Provider, Delta Dental will base payment on Delta Dental's Non-Participating Provider fee for Covered Services.

Out-of-Country Benefits

If your Provider is an out-of-country Provider, Delta Dental will base payment on Delta Dental's out-of-country Provider fee for Covered Services.

For Covered Services rendered by a Non-Participating Provider or out-of-country Provider, Delta Dental will usually send payment to You, and You will be responsible for making full payment to the Provider. You will be responsible for any difference between Delta Dental's payment and the Provider's submitted amount.

2.8. Other Benefits

a) Services that are more expensive than the treatment usually provided under accepted dental practice standards are called optional services. Optional services also include the use of specialized techniques instead of standard procedures. Benefits for optional services will be based on and paid the same as the standard service. You will be responsible for the remainder of the Provider's fee.

b) Payment made by Delta Dental for any surgical services will include charges for routine, post-operative evaluations or visits.

c) If You transfer from one Provider to another during the course of treatment, Benefits will be limited to the amount that would have been paid if one Provider rendered the services.

2.9. Questions and Assistance

Questions regarding Your coverage should be directed to Delta Dental, toll-free, at 1-844-368-6484. You may also write to Delta Dental at P.O. Box 15969, Little Rock AR 72231. When writing to Delta Dental, please include Your name, the Subscriber's member ID number, and Your daytime telephone number.

Policyholders have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:

Arkansas Insurance Department

1 Commerce Way, Suite 102

Little Rock, AR 72202

3. BENEFIT CATEGORIES

A description of various dental services that *may* be a Covered Services are included below. *Only the Covered Services listed in Your Schedule of Benefits are covered by this Certificate.* Covered Services are also subject to exclusions and limitations. You will want to review the "Exclusions and Limitations" section of this Certificate carefully.

Diagnostic and Preventive Services

Services and procedures to determine Your dental health or to prevent or reduce dental disease.

These services include examinations, evaluations, and prophylaxes (cleanings). (*Please see information on Evidence Based Dentistry

Space Maintainers

Space maintainers for prematurely lost teeth of a child.

Sealant

A sealant is a thin, plastic coating painted on the chewing surfaces of the first and second permanent molars to prevent tooth decay.

Fluoride Treatments

Topical application of fluoride for a child.

Bitewing and Periapical Radiographs

Required for routine care or to diagnose the condition of Your teeth.

Full Mouth Radiographs

Required for routine care or to diagnose the condition of Your teeth.

Emergency Palliative Treatment

Emergency treatment to temporarily relieve pain.

Simple Extractions

Extraction of an erupted tooth or teeth.

Oral Surgery Services

Extractions and dental surgery, including pre-operative and post-operative care.

Endodontic Services

The treatment of teeth with diseased or damaged nerves (for example, root canals).

All Other Endodontic Services

Hemisection performed on multirooted teeth.

Surgical Periodontic Services

The surgical treatment of diseases of the gums and supporting structures of the teeth.

Non- Surgical Periodontic Services

The treatment of diseases of the gums and supporting structures of the teeth.

Periodontal Maintenance Services

The treatment of diseases of the gums and supporting structures of the teeth following active periodontal treatment. (*Please see information on Evidence Based Dentistry

Minor Restorative Services

Services to rebuild and repair Your teeth damaged by disease, decay, fracture, or injury. This includes minor restorative services, such as amalgam (silver) fillings and composite resin (white) fillings.

Stainless steel crowns

Used as a restoration to natural teeth for a child when the teeth cannot be restored with a filling material.

Crowns

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.

Prosthodontic Services

Services and appliances that replace missing natural teeth. This includes bridges and full or partial dentures.

Relines and Repairs

Full or Partial Denture Reline Chair side or laboratory procedure to improve the fit of the appliance to the tissue (gums).

Implants

Coverage for an endosteal implant to support a crown.

4. EXCLUSIONS and LIMITATIONS

The following services or supplies are not a Covered Services unless otherwise specifically listed as a Covered Service in Your Schedule of Benefits. All charges for services or supplies that are exclusions or exceed these limitations will be Your responsibility.

Diagnostic and Preventive Services

Diagnostic and Preventive Services

- Routine periodic and specialty evaluations are Covered Services up to two (2) times in any twelve (12) month Calendar Year. This is inclusive of an initial, oral evaluation.
- An initial oral evaluation by the same Provider or Provider's office is a Covered Service one (1) time(s) in a thirty-six (36) consecutive month period.
- A Limited Oral Evaluation is a Covered Service for a specific oral health problem or complaint. Limited Oral Evaluations are not subject to the time limitation of routine periodic evaluations. Additional information may be required for consultant review.
- Full-mouth debridement is a Covered Service limited to once in a lifetime.
- Preventive control programs (e.g., oral hygiene instructions, dietary control, tobacco counseling, etc.) are not Covered Services.
- Diagnostic casts, photographs, and cephalometric films are Covered Services only if orthodontic services are Covered Services and are a Benefit at the orthodontic Maximum Plan Allowance. Prophylaxis (Cleaning) is a Covered Service two (2) time(s) in any Calendar Year. (*Please see information on Evidence Based Dentistry)
- Adult cleanings are a Covered Service for Participant(s) age fourteen (14) and older.
- Pulp vitality tests are Covered Services only for the diagnosis of emergency conditions as long as no other definitive procedure is performed on the same day. A pulp vitality test is a Covered Service available per visit, not per tooth.

Sealants

- A sealant is a Covered Service only for the first and second permanent molars when applied to a tooth with an unrestored occlusal surface.
- Sealants are Covered Services for Eligible Dependents prior to age sixteen (16).
- Sealants are Covered Services one (1) time(s) per sixty (60) consecutive month period.

Fluoride Treatments

- Topical application of fluoride is a Covered Service one (1) time per Calendar Year for Eligible Dependents to age nineteen (19).
- Fluoride rinses or self-applied fluorides are not Covered Services.
- One (1) additional fluoride application per Calendar Year is a Covered Service for Eligible Dependents prior to nineteen (19) who are identified at a moderate or high risk (as defined by the American Dental Association's Dental Procedure Codes) for developing caries.
- Application of silver diamine fluoride is a Covered Service two (2) times in a Calendar Year per tooth. Benefits for restorations within two (2) months of a silver diamine fluoride application are not a Covered Service. Sealants and preventive restorations are not Covered Services if silver diamine fluoride has been applied to the tooth. Silver diamine fluoride is not a covered service on the same day as a restoration of the same tooth.

Caries Risk Assessment

- A Caries Risk Assessment is a Covered Service once every twelve (12) months for Eligible Dependents to age three (3) to nineteen (19).

Bitewing Radiographs

- Bitewing x-rays are Covered Services as required.
- Bitewing x-rays are limited to two (2) films in any single visit for children under the age of ten (10).

Periapical Radiographs

- Periapical x-rays are Covered Services as required.

Full Mouth Radiographs

- A full mouth series x-ray or panoramic x-ray is a Covered Service one (1) time(s) within any sixty (60) consecutive month period.
- A combination of periapical and bitewing x-rays (fourteen (14) or more films) or a panoramic film and additional x-rays make up a full mouth series.

Space Maintainers

- A space maintainer is a Covered Service when used to replace prematurely lost or extracted teeth for Eligible Dependents prior to age fourteen (14).
- The cost of removal is included in the services of the Provider who provided the space maintainer. If the maintainer is removed by another Provider, the procedure is not a Covered Service
- A space maintainer is a Covered Service up to one (1) per space per lifetime.
- Recementation of a space maintainer is a Covered Service once per appliance. Recementation of a space maintainer within six (6) months of the seating date is part of the original procedure

Basic Services

Simple Extractions

No exclusions

Emergency Palliative Treatment

- Palliative treatment is a Covered Service once per visit as long as no other procedures, except for x-rays, exams, or any diagnostic service, are performed on the same date.

Minor Restorative Services

- Restorative benefits (filings) are Covered Services once per surface, per tooth in a twenty-four (24) month period. This is a Covered Service irrespective of the number of combinations of procedures requested or performed.
- A limited occlusal adjustment is not a Covered Service within six (6) months of a restoration or prosthetic appliance.
- An occlusal adjustment in conjunction with a restoration or prosthetic appliance is considered part

of the total fee of the restoration or appliance.

- A complete occlusal adjustment is not a Covered Service.

Occlusal Guard

- Repairs to Occlusal guards are not a Covered Service.
- Adjustments to Occlusal guards are Covered Services once per six (6) consecutive months during the six (6) months after initial placement.

Stainless Steel Crowns

- Replacement of a stainless steel crown within sixty (60) month period after the initial placement is not a Covered Service.
- Stainless Steel Crowns used as a restoration to natural teeth are Covered Services for Eligible Dependent(s) to age sixteen (16) when the teeth cannot be restored with a filling material.
- Prefabricated resin crowns are not Covered Services on posterior teeth. A stainless steel crown allowance will be made with any fee difference being the Participant's responsibility.
- Prefabricated porcelain/ceramic crowns are not Covered Services for primary teeth. Allowance will be given for a stainless steel crown on a molar tooth or a prefabricated resin crown on an anterior tooth with the fee difference the responsibility of the Participant.

Major Services

Oral Surgery Services

- General anesthesia/intravenous sedation is not a Covered Service except when administered in conjunction with covered oral surgery.
- General anesthesia/intravenous sedation is not a Covered Service for single tooth extractions (ADA procedure code 7140).
- General anesthesia/intravenous sedation is a Covered Service for Eligible Dependents three (3) years of age and under.
- Extractions, root removal, alveoplasty, and surgical exposure of impacted or unerupted tooth are Covered Services once per tooth in a lifetime.
- Oral surgery, except TMJ surgery, is a Covered Service.
- Treatment of complications (post-surgical) or unusual circumstances are not Covered Services 30 days following an extraction by the same Provider or Provider's office. Treatment by a Provider other than the Provider who performed the extraction is a Covered Service but is subject to consultant review.
- Analgesia, anxiolysis, inhalation of nitrous oxide, therapeutic drug injection, other drugs and/or medicines, and desensitizing medicines are not Covered Services.
- Removal of bone tissue is a Covered Service one (1) procedure(s) per lifetime.

Endodontic Services

- Root canal treatment is a Covered Service once in a lifetime, per tooth, by the same Provider or Provider's office that performed the root canal. Benefits for root canal treatment include charges for temporary restorations.
- Root canals on primary teeth are not Covered Services, unless there is no permanent successor. If there is no permanent successor the primary tooth is limited to pulpal therapy one (1) time(s) in a

lifetime.

- Retreatment of a root canal by the same Provider or Provider's office will be considered after twenty-four (24) consecutive months have lapsed since the initial treatment.

All Other Endodontic Services

- Hemisection is a Covered Service on multirooted teeth once per tooth per lifetime.

Surgical Periodontic Services

- 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.
- Curettage and osseous surgery are not Covered Services for Participants prior to age fourteen (14).

Non- Surgical Periodontic Services

- Non-surgical periodontics are Covered Services up to one (1) time(s) in a twenty-four (24) consecutive month period per quadrant.
- Root planing and scaling is not a Covered Service for Participant(s) prior to age fourteen (14).

Periodontal Maintenance Services

- Periodontal Maintenance is a Covered Service up to two (2) times per Calendar Year following active periodontal treatment. (*Please see information on Evidence Based Dentistry)
- Periodontal maintenance is a Covered Service after three (3) consecutive months following active periodontal treatment.

Prosthodontic Services

Fixed Partial Denture (Bridge)

- A fixed partial denture (Bridge) where a partial denture is constructed in the same arch is not a Covered Service.
- A posterior, fixed partial denture (bridge) and a removable partial denture in the same dental arch is not a Covered Service. The Benefit is limited to the allowance for the partial, removable denture.
- Replacement of a fixed partial denture (Bridge) that the Participant received in the previous sixty (60) consecutive months is not a Covered Service unless the loss of additional teeth requires the construction of a new appliance.
- Replacement of a fixed partial denture (bridge) is not a Covered Service unless the existing fixed partial denture (Bridge) cannot be made satisfactory.
- A fixed partial denture (bridge) is not a Covered Service for Eligible Dependents prior to age sixteen (16).
- Initial placement of full or partial removable dentures, fixed bridges (including crowns and inlays) which form a part thereof to replace a functioning natural tooth which is missing prior to the effective date of the Participant's coverage, is not a Covered Service unless the prosthetic appliance also includes the replacement of a natural tooth or teeth extracted while coverage was in effect.

Removable Full or Partial Dentures

- Benefits for a standard or partial denture shall include charges for any necessary adjustment within a six (6) consecutive month period. Adjustments after the post six (6) month delivery period are Covered Services up to two (2) times in any twelve (12) consecutive month period.

- Your Policy limits Benefits for dentures constructed by specialized techniques or features to the Maximum Plan Allowance for a standard full or partial denture. A standard denture means a removable appliance to replace missing natural, permanent teeth made by conventional means from acceptable materials. If a denture is constructed by specialized techniques or features and the fee is higher than the fee allowable for a standard full or partial denture, the Participant is responsible for the difference.
- Replacement of full or partial removable dentures that the Participant received in the previous sixty (60) consecutive months are not Covered Services except where the loss of additional teeth requires the construction of a new appliance.
- Replacement of a full or partial removable denture is not a Covered Service unless the existing full or partial removable denture cannot be made satisfactory.
- A full or partial removable denture is not a Covered Service for Eligible Dependents prior to age sixteen (16).
- Tissue conditioning is a Covered Service up to two (2) time(s) in a thirty-six (36) consecutive month period. Tissue conditioning is not a Covered Service if performed on the same day a denture is delivered or a reline/rebase is provided.
- Tissue conditioning performed within the first three (3) months of delivery of an immediate full or partial denture is not a Covered Service and is considered a part of the fee of the appliance.
- Overdentures as removable full or partial dentures are not a Covered Service. Allowance will be given for a standard full or partial denture with the fee difference the responsibility of the Participant.
- Initial placement of full or partial removable dentures, fixed bridges (including crowns and inlays) which form a part thereof to replace a functioning natural tooth which is missing prior to the effective date of the Participant's coverage, is not a Covered Service unless the prosthetic appliance also includes the replacement of a natural tooth or teeth extracted while coverage was in effect.

Denture Relines Rebase Repairs and Adjustments

- Reline or rebase of a full or partial denture is a Covered Service up to one (1) in a thirty-six (36) consecutive month period.
- Repair of a removable full or partial denture is a Covered Service up to one (1) time(s) in any sixty (60) consecutive month period.
- Repair of a fixed partial denture (Bridge) is a Covered Service up to one (1) time(s) in a sixty (60) consecutive month period.
- Adjustments made within the first six (6) consecutive month period after delivery of a standard full or partial denture are not Covered Services except in the case of an immediate full or partial denture which is not covered during the first three (3) consecutive months of delivery.
- Adjustments more than six (6) consecutive months after delivery of a standard full or partial denture are Covered Services up to two (2) time(s) per twelve (12) consecutive month period. In the case of an immediate denture, the adjustment is a covered service after three (3) consecutive months after delivery with the same frequency and time limitations of two (2) times per twelve (12) consecutive month period.
- The fee for relines and rebases, and repairs should be included in the cost of the initial placement of a standard full or partial denture new appliance within six (6) consecutive months of the seat date.
- In the case of an immediate denture, relines are included in the cost of the new appliance within three (3) consecutive months of the seat date.

Fixed Partial Denture (Bridge) Recementation

- Recementation of a fixed partial denture (bridge) within six (6) consecutive months of the seating date is part of the original procedure and is then a Covered Service once in a twelve (12) consecutive month period.

Crown Service

- Crowns, inlays, onlays, and veneers are Covered Services 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.
- Crowns, inlays, onlays, and veneers and fixed partial denture recements within the first six (6) consecutive months of the seating date is part of the original procedure. Recements are limited to one (1) per tooth in twelve (12) consecutive months.
- Replacement of a crown, inlay, onlay, or veneer is a Covered Service only after sixty (60) months of the previous prosthetic.
- Payment for crowns, inlays, onlays, and veneers shall include charges for preparations of tooth, gingival, and impression.
- Porcelain, ceramic or cast crowns are not Covered Services for Participants prior to age twelve (12).
- Temporary and provisional crowns and partial dentures are not Covered Services.
- Repair of crowns, inlays, onlays, and veneers within twenty-four (24) consecutive months of the seating date is part of the original restoration and is then a Covered Service up to one (1) time in twenty-four (24) consecutive months per tooth.

Implant Services

- Endosteal implants are Covered Services once in a lifetime per tooth.
- Implant maintenance procedure is a Covered Service one (1) time(s) in any twelve (12) consecutive months.
- An implant supported abutment crown is a Covered Service one (1) time(s) in any sixty (60) consecutive month period.
- An implant supported abutment retainer is a Covered Service (1) time(s) in any sixty (60) consecutive month period.
- An implant supported prosthesis is a Covered Service (1) time(s) in any sixty (60) consecutive month period.
- Implant removal is a Covered Service one (1) time(s) in a lifetime per tooth.
- Recementation of implant /abutment supported crown or fixed partial denture is a Covered Service one time in any twelve (12) consecutive month period after six (6) months have elapsed since initial placement.
- Repair of implant supported prosthesis or implant abutment is a Covered Service one (1) time(s) in any sixty (60) consecutive month period.
- Scaling and debridement in the presence of inflammation of a single implant, including cleaning of the implant surface is a Covered Service once per tooth in any twenty-four (24) consecutive month period after twelve months have passed from the placement of the implant supported restoration. This procedure is not allowed on the same date of service as a prophylaxis (cleaning) or a periodontal

procedure which includes periodontal maintenance, root planing and scaling, gingival flap procedure, and osseous surgery.

- Initial placement of an implant (including crowns to cover the implant) which replace a functioning natural tooth which is missing prior to the effective date of the Participant's coverage, is not a Covered Service.

General

- The following are not Covered Services:
  - Services for injuries or conditions covered under Worker's Compensation or Employer's Liability laws or otherwise arising out of a work related injury.
  - Services available from any federal or state government agency, municipality, county, other political subdivision, or community agency, or from any foundation or similar entity.
  - Services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.
  - Services or supplies for which no charge is made that the Participant is legally obligated to pay, including services for which no charge would be made in the absence of dental coverage.
  - Treatment by someone other than a Provider, except that a licensed hygienist may perform services in accordance with applicable law. Services must be under the supervision and guidance of the Provider in accordance with generally accepted dental standards.
  - Completion of forms and/or submission of supportive documentation required by Delta Dental for a benefit determination. A charge for these services is not to be made to a You by a Participating Provider.
  - Services to correct congenital or developmental malformations.
  - 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).
  - Services or appliances started prior to the date the Participant became eligible under this Certificate, including, but not limited to, restorations, prosthodontics, and orthodontics.
  - Services with respect to diagnosis and treatment of disturbances of the temporomandibular joint (TMJ), unless optional coverage is purchased.
  - Orthodontic services, including medically necessary orthodontia regardless of the individual Participant's age.
  - 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.
  - Experimental and/or investigational services, supplies, care and treatment which do 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. Delta Dental must make an independent evaluation of the experimental or non-experimental standings of specific technologies. Delta Dental's decision will be final and binding. 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.
  - Replacement of lost, missing, or stolen appliances/devices.
  - Services when a Claim is received for payment more than twelve (12) months after services are

rendered.

- Complete occlusal adjustments, occlusal guards, occlusion analysis, enamel microabrasion, odontoplasty, bleaching, and athletic mouthguards.
- Specialized techniques that entail procedure and process over and above that which is normally adequate. Any additional fee is the Participant's responsibility.
- Behavior management.
- Those services and Covered Services excluded by the rules and regulations of Delta Dental, including Delta Dental's processing policies.
- Removable appliances for control of harmful habits, including but not limited to tongue thrust appliances.
- Charges for general anesthesia/intravenous sedation are not covered except when administered in conjunction with covered oral surgical procedures, excluding simple tooth extractions and for children three (3) and under.
- Procedures that do not comply with Delta Dental's guidelines.
- 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.
- Implant techniques and procedures related to implants.
- Any other Benefits and services not specifically covered in the Certificate, Schedule of Benefits, and/or Exclusions and Limitations.

Carry-over Benefit Feature

- Orthodontic Lifetime Maximums are not a Carry-over Benefit.
- Carry-over Amount is the amount a Participant may earn per benefit year if they meet the criteria noted below.
- Claims Threshold is the total paid Claims amount during the Calendar Year.
- Carry-over Benefit Maximum is the maximum amount of Carry-over benefit each Participant can accumulate.
- Once the Carry-over Amount has reached the maximum, no further amounts will accumulate toward the Participant's Carry-over Benefit Maximum until the Claims Threshold balance falls below the Carry-over Benefit Maximum amount.
- Carry-over accounts will be utilized to pay Benefits only after the benefit year maximum is fully exhausted.

Carry-over Criteria:

1. The Participant must have submitted at least one Claim for a Covered Service during the benefit year; and
2. The total amount paid by Us and applied to Your benefit year maximum during the benefit year must not exceed the claims threshold.

If coverage is terminated for any reason, the entire balance in your Carry-over account will be reduced to zero on the effective date of your termination from this Certificate.

5. CLAIMS APPEAL PROCEDURE

5.1. Informal Request for Review

If You receive an explanation of benefits that indicates an Adverse Benefit Determination and You think that Delta Dental incorrectly denied all or part of Your Claim, You or Your Provider may, but are not required to, contact Delta Dental and ask Us to check the Claim to make sure it was processed correctly. You may do this by calling Delta Dental at 1-844-368-6484 or mailing Your inquiry to Delta Dental Attn: Customer Service Department at P.O. Box 15965, Little Rock, Arkansas, 72231.

When writing, please enclose a copy of Your explanation of benefits and describe the problem. Be sure to include Your name, telephone number, the date, and any information You would like considered about Your Claim. This inquiry is not required and will not be considered a formal appeal of an Adverse Benefit Determination. Delta Dental provides this opportunity for You to describe problems, or submit an explanation or additional information that might indicate Your Claim was improperly denied, and allow Delta Dental to correct any errors.

Whether or not You have asked Delta Dental informally to recheck its initial determination, You can request a formal appeal using the formal claims appeal procedure described below.

5.2. Formal Claims Appeal Procedure

If You receive notice of an Adverse Benefit Determination, You or Your authorized representative should seek an appeal as soon as possible, but You must file your appeal within 180 days of the date that You received the explanation of benefits that indicates an Adverse Benefit Determination.

To request a formal appeal of Your claim, send Your request in writing to:

Appeals Department
Delta Dental
P.O. Box 15965
Little Rock, AR 72231

Please include Your name and address, the Subscriber's member ID, the reason why You believe Your Claim was wrongly denied, and any other information You believe supports Your Claim. If You would like a record of Your request and proof that Delta Dental received it, mail Your request by certified mail, return receipt requested.

The Professional Relations Director or any person reviewing Your Claim will not be the same as, nor subordinate to, the person who initially decided Your claim. The reviewer will grant no deference to the prior decision about Your Claim. The reviewer will assess the information, including any additional information that You have provided, as if he or she were deciding the Claim for the first time. The reviewer's decision will take into account all comments, documents, records and other information relating to Your Claim even if the information was not available when Your Claim was initially decided.

If the decision is based, in whole or in part, on medical judgment (including determinations with respect to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate), the reviewer will consult a health care professional with appropriate training and experience, if necessary. The health care professional will not be the same individual or that person's subordinate consulted during the initial determination.

The reviewer will make a determination within 60 days of Our receipt of Your appeal. If Your Claim is denied on appeal (in whole or in part), You will be notified in writing. The notice of an Adverse Benefit Determination during the formal claims appeal procedure will meet the requirements described below.

5.3. Manner and Content of Notice

If Your Claim is denied on appeal, You will receive a notice that will inform You of the specific reasons for the denial, the pertinent provisions on which the denial is based, the applicable review procedures for claims, including time limits and that, upon request, You are entitled to access all documents, records and other information relevant to Your Claim free of charge.

Your notice will also contain a description of any additional materials necessary to complete Your Claim, an explanation of why such materials are necessary, and a statement that You have a right to bring a civil action in court if You receive an Adverse Benefit Determination after Your Claim has been completely reviewed according to this claims appeal procedure. The notice will also reference any internal rule, guideline, protocol, or similar document or criteria relied on in making the Adverse Benefit Determination, and will include a statement that a copy of such rule, guideline or protocol may be obtained upon request at no charge.

If the Adverse Benefit Determination is based on a matter of medical judgment or medical necessity, the notice will also contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge.

6. WHO GETS BENEFITS

6.1. Eligible Individual

You must a resident of the State of Arkansas to apply for dental coverage for himself/herself with Us.

Subject to any requirements, restrictions, or limitations pursuant to applicable law that define when an individual is eligible to enroll for coverage, for example, an open enrollment period provided for pursuant to a health insurance marketplace exchange created pursuant to PPACA. Note: If You terminate Your coverage under this Certificate, You must wait twelve months from the date of termination to be eligible to enroll with Us again.

6.2. Dependent Coverage

Coverage for Your Eligible Dependents will start as described in Section 6.3 below.

Your Eligible Dependents include:

1. Your legally married spouse (not legally separated).
2. Your child until he or she reaches the age of 26.
3. Your children who have reached the end of the Calendar Year of their nineteenth (19) birthday, but who were at that time (and continue to be) totally and permanently disabled by a physical or mental condition. Those children must also be eligible to be

claimed by You or Your legal spouse as dependents under the U. S. Internal Revenue Code during the current Calendar Year. Delta Dental may request, at Delta Dental's expense, that You submit a medical report confirming the child's initial or continuing total disability. Once total disability has been confirmed, Premium for the dependent will remain at the dependent child rate.

4. A child of your child who is your dependent for federal income tax purposes at the time application for coverage of the child is made.

The term "child" means a/an: a) Natural born child, b) Stepchild, c) Adopted child, d) Child for whom You are the legal guardian, or e) Child for whom You are legally required to provide coverage.

An Eligible Dependent who is a full time student will continue to be an Eligible Dependent until the day such child reaches the age of 26. 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. You may be required to provide Delta Dental with written evidence of the child's full time student status.

In order to be an Eligible Dependent the individual must reside in the United States. Under certain circumstances, You may be required to provide Us with proof of the relationship between Yourself and the Eligible Dependent.

6.3. When Does Coverage Start

In order for Your coverage to take effect, requirements described in Section 6.1 and 6.2 must be met, submit an Application for coverage for Yourself and Your Eligible Dependents, and pay any required Premium.

If You are eligible and You apply for coverage and submit any required Premium for Yourself and Your Eligible Dependents, Your coverage will be effective the first day of the month following the date that the Premium was paid.

You must complete an Application to enroll any newly Eligible Dependents even if coverage under the Certificate already includes Eligible Dependents. Additional Premium may also be required to be paid prior to coverage under the Certificate becoming effective. If an Application is not submitted to Us within thirty-one (31) days from the satisfaction of the enrollment provisions set forth above, no coverage will be provided under the Certificate on behalf of that otherwise Eligible Dependent.

6.4. Individual Change Form

You may obtain an Individual Change Form by calling Delta Dental at 1-844-368-6484 or by visiting Delta Dental's website at www.dentaldentalar.com. After You have completed the Individual Change Form, return it to Delta Dental.

Use this form to:

- Notify Delta Dental of a change to Your name

- Add Eligible Dependents
- Remove Eligible Dependents
- Cancel all or a portion of Your coverage
- Notify Delta Dental of all changes in address for yourself and Your Eligible Dependents
- Change Your payment information.

7. COORDINATION OF BENEFITS

7.1. When Coordination of Benefits applies

Coordination of Benefits ("COB") applies to this Certificate when a Participant has benefits under more than one plan. The objective of COB is to eliminate duplication of payment for services. COB rules establish whether this Certificate's Benefits are determined before or after another plan's benefits.

You must submit your bills to the primary plan first. The primary plan must pay its full benefits as if You had no other coverage. If the primary plan denies Your claim or does not pay the full bill, You may then submit the remainder of the bill to the secondary plan.

7.2. Which Plan Pays First?

To decide which plan is primary, Delta Dental will consider both the COB provisions of the other plan and the relationship of the Participant to You, as well as other factors. The primary plan is determined by the first of the following rules that applies:

1. Subscriber's Plan
   The plan covering the patient as a subscriber is primary over a plan covering the patient as a dependent.

2. Non-coordinating Plan
   If the Participant has another plan that does not coordinate benefits, it will always be primary.

3. Children (Parents Divorced or Separated)
   If a court decree makes one parent responsible for health care expenses, that parent's plan is primary.

   If a court decree states that the parents have joint custody without stating that one of the parents is responsible for the child's health care expenses, Delta Dental follows the birthday rule (see rule 4 below).

   If neither of these rules applies, the order will be determined as follows:
   - First, the plan of the parent with custody of the child;
   - Then, the plan of the spouse of the parent with custody of the child;
   - Next, the plan of the parent without custody of the child; and
   - Last, the plan of the spouse of the parent without custody of the child.

4. Children and the Birthday Rule

The plan of the parent whose birthday is earliest in the Calendar Year is always primary for children. For example, if Your birthday is in January and Your spouse's birthday is in March, Your plan will be primary for all of Your Children. If both parents have the same birthday, the plan that has covered the parent for the longer period will be primary.

5. Other Plans
   If none of the rules above determines the order of benefits, the plan that has covered the Participant for the longer period will be primary.

   In the event that these rules do not determine how Delta Dental should coordinate benefits with another plan, Delta Dental will follow its internal policies and procedures, unless prohibited by applicable law.

7.3. How Delta Dental Pays as Primary Plan
When Delta Dental is the primary plan, it will pay Benefits as if the Participant had no other coverage.

7.4. How Delta Dental Pays as Secondary Plan
When Delta Dental is the secondary plan, it will pay Benefits based on the amount left after the primary plan has paid. It will not pay more than that amount, and it will not pay more than it would have paid as the primary plan. However, Delta Dental may pay less than it would have paid as the primary plan.

When Benefits are reduced as described above, each Benefit is reduced in proportion. Benefits are then charged against any applicable benefit limit of Your Policy.

7.5. Right to Receive and Release Needed Information
Delta Dental needs certain facts to apply these COB rules, and it has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Delta Dental need not tell or get the consent of any person to do this. Each person claiming Benefits under this Certificate must give Delta Dental any facts it needs to process the Claim.

7.6. Facility of Payment
A payment made under another plan may include an amount that should have been paid under this Certificate. If it does, Delta Dental may pay that amount to the organization that made the payment. That amount will then be treated as though it were a Benefit paid under this Certificate, and Delta Dental will not have to pay that amount again. The term "payment made" includes providing Benefits in the form of services, in which case "payment made" means reasonable cash value of the Benefits provided in the form of services.

8. WHEN COVERAGE ENDS

Coverage under Your Health Plan can end for a variety of reasons. You will find below details on how, why, and when Your coverage or coverage of Your dependents will end.

8.1. When Your Coverage Ends

1. Immediately when You voluntarily stop Your coverage;
2. Immediately when You are no longer eligible for coverage (for example, if You are no longer a citizen of the state of Arkansas);
3. If You fail to pay the Premium, Your coverage will end on the first day of the month for which Delta Dental did not receive payment in accordance with the Premium Due Date and Grace Period rules outlined below.

8.2. When Covered Dependent's Coverage Ends

1. Your Covered Dependent's coverage ends when Your own coverage ends for any reason listed above.
2. Your Covered Dependent's coverage ends when they no longer meet the definition of an Eligible Dependent effective at the end of the calendar month when Your Covered Dependent no longer meets the requirements under the Certificate to be a Covered Dependent.
3. Immediately when You do not pay Premium for the cost of dependent coverage.

8.3 Premium Due Date and Grace Period

Premium for coverage under this Certificate is due no later than the first (1st) day of the month for which the coverage applies. For example, if coverage is for the month of July, premium for the month of July must be paid no later than July 1st. All Participants lose coverage when the applicable Premium is not timely received by Us.

Except as otherwise provided in this Section 8.3, a grace period of thirty (30) days will be granted for the payment of each Premium falling due after the first Premium during which grace period the Certificate shall continue in force. However, during this period of time We will pend any and all Claims received. If Premium is not paid within thirty-one (31) days after it becomes due and payable, this Certificate is terminated as of the date on which the Premium was due and payable and We will seek to recoup amounts paid to Providers during the grace period.

8.4 Reinstatement.

If any renewal Premium is not paid within the time granted by Delta Dental to You for payment, a subsequent acceptance of Premium by Delta Dental or by an agent authorized by Delta Dental to accept such Premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Certificate; provided, however, that if Delta Dental or such agent requires an application for reinstatement and issues a conditional receipt for the Premium tendered, the Premium will be reinstated upon approval of such application by Delta Dental, or lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless Delta Dental has previously notified You in writing of its disapproval of such application. In all other respects, You and Delta Dental shall have the same rights thereunder as they had under the Certificate immediately before the due date of the defaulted Premium, subject to any provisions enjoyed hereon or attached hereto in connection with the reinstatement. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement. To reinstate the Certificate for non-payment of Premium, Delta Dental may to the extent allowed by applicable law require a payment in the amount equal to the annual Premium for the Certificate.

9. GENERAL PROVISIONS

1. Assignment of Benefits. Benefits to Participants are for the personal benefit of those individuals and cannot be transferred or assigned; provided, however, that Delta Dental may pay a Participating Provider directly on behalf of Participants.

2. Subcontractors and Agents. Delta Dental may subcontract certain functions or appoint an agent or agents to act on Delta Dental's behalf and fulfill expressed, limited duties under this Certificate. Such agents have no authority to change or amend this Certificate.

3. Assignment. Delta Dental shall have the discretion to assign its rights and responsibilities under this Certificate to an affiliated entity. If Delta Dental chooses to assign its rights and responsibilities, it shall assign them to an appropriately licensed entity capable of performing similar functions at similar levels as Delta Dental. Delta Dental will provide written notice of the assignment to You and said notice shall provide the name and address of the assignee. Neither this Certificate nor any part of it shall be assigned by You without the prior written consent of Delta Dental, and any attempt at assignment without such consent by Delta Dental shall be null and void. Subject to the foregoing limitation, this Certificate shall be binding on the parties and their respective successors and assigns.

4. Delta Dental Liability. Delta Dental shall have no liability for any wrongful conduct, including, but not limited to, tortious conduct, negligence, wrongful acts or omissions, or any other act of any person. This includes, but is not limited, to Providers, dental assistants, dental hygienists, dental employees, hospitals, or hospital employees receiving or providing services. Delta Dental shall have no liability for any services, equipment, or facilities.

5. Endorsements/Amendments. This Certificate is subject to amendment by Delta Dental. Nothing contained in any endorsement shall affect any of the conditions, provisions, or limitations of this Certificate except as expressly provided in the endorsement. All conditions, provisions, and limitations of this Certificate shall apply to any endorsement if they are not in conflict.

6. 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 Certificate.

7. Headings. Section and subsection headings contained in this Certificate are inserted for convenience of reference only. They shall not be deemed to be part of this Certificate for any purpose. They shall not in any way define or affect the meaning, construction or scope of any of the provisions hereof.

8. Right to Develop Policies and Guidelines. We reserve the right to develop or adopt policies and guidelines for the administration of Benefits under this Certificate. These policies and guidelines will be interpretive only and will not be contrary to any terms of this Certificate. If you have a question about the policies or guidelines used to apply to a particular Benefit, you may contact Delta Dental at 1-844-368-6484 or www.deltadentalar.com.

9. Waiver. The waiver by Us or any Participant hereunder of a breach of or a default under any of the provisions of this Certificate shall not be construed as a waiver of any subsequent breach or default of a similar nature. The failure of any of such parties, on one or more occasions, to enforce any of the provisions of this Certificate or to exercise any right or privilege hereunder, shall not be a waiver of any of such provisions, rights or privileges hereunder.

10. Your Medical Records. We may need to obtain copies of Your medical records from any of Your treating Providers. This may be necessary to properly administer Your Benefits. You, or Your legal representative, agree to sign an appropriate authorization for release of medical records upon Our request. If You elect not to consent to the release of medical records, We may be unable to properly administer Your coverage. If this occurs, We have the right to deny payment for impacted Covered Services.

11. Notice of Claim. We must receive Your Claim for Benefits within no more than 12 months from the date You receive the service. Failure to meet this requirement will result in payment denial.

12. Who Receives Payment Under This Certificate. We will make payments under this Certificate directly to the Network Providers providing care. If You receive Covered Services from any Non-Participating Provider, we reserve the right to pay either You or the Provider.

13. Loss of Eligibility During Treatment. If a Participant loses eligibility while receiving treatment, only Covered Services received while that person was covered under this Certificate will be payable. Certain services begun before the loss of eligibility may be covered if they are completed within 60 days from the date of termination. In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by Delta Dental. The difference between Delta Dental's payment and the total fee for those services is Your responsibility.

14. Force Majeure. Delta Dental (including its agents, directors, officer, and employees) shall not be liable for delays in performance due to circumstances beyond their reasonable control. Each party shall be excused from performance under this Certificate and shall have no liability to the other party for any period during which it is prevented from performing any of its obligations (other than payment obligations), in whole or in part, as a result of delays caused by the other party or by an act of God, war, terrorism, civil unrest, civil disturbance, court order, labor dispute, or other cause beyond its reasonable control, including failures or fluctuations in electrical power, heat, light, or telecommunications, and such nonperformance shall not be a default under or grounds for termination of this Certificate. In the event You are unable to make payment due to circumstances beyond its reasonable control as identified in this Force Majeure section, Delta Dental will accept delayed payment from You within a reasonable period of time which shall not exceed thirty (30) days.

15. Governing Law. This Certificate, any rights and obligations under this Certificate, and any claims or disputes relating thereto, shall be governed by and construed in accordance with Arkansas law.

16. 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.

17. 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.

18. Does Not Replace Workers' Compensation. This Certificate does not affect any requirements for coverage by Worker's Compensation Insurance.

19. Change of Status. You must notify Delta Dental of any event that changes the status of a Participant.

20. Legally Mandated Benefits. If any applicable law requires broader coverage or more favorable treatment for Participants than is provided by this Certificate, then that law shall control over the language of this Certificate.

21. Right to Recovery. Whenever Benefits greater than the maximum amount of allowable Benefits are provided, Delta Dental will have the right to recover any excess. Delta Dental will recover the excess from any persons, insurance companies, or other organizations involved to whom the payment was made. Any Participant will execute and deliver any necessary documents and do what is necessary to secure such rights to Delta Dental.

22. Right to Recovery Due to Fraud. If Delta Dental pays Benefits that were sought or received under fraudulent, false, or misleading pretenses or circumstances, pays a Claim that contains false or misrepresented information, or pays a Claim that is determined to be fraudulent due to Participant actions, Delta Dental may recover that payment from Participant. Participant authorizes Delta Dental to recover any payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to Participant.

23. Subrogation and Right to Reimbursement. Delta Dental acquires the Participant's legal rights to recovery for payment for Covered Services the Participant required because of the action or fault of another. Delta Dental has the right to recover from the Participant any payments made by or for the other party. Delta Dental is entitled to recovery only after the Participant has been fully compensated for the loss or damage sustained. In such cases, Delta Dental has the right to recover amounts equal to the Benefits paid by Delta Dental. Delta Dental also has the right to recover collection costs and attorney's fees in the proportion each benefits from the recovery.

    Delta Dental has the right to make the recovery by suit, settlement, or otherwise from the person who caused the 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 Delta Dental recover from other sources. Participant must provide all requested information and sign necessary documents. If the Participant fails to help Delta

Dental or settles any Claim without Delta Dental's written consent, Delta Dental may recover from the Participant. Delta Dental will be entitled to any recovery received by the Participant and reasonable attorney's fees and court costs.

24. DeltaUSA. The parties acknowledge that Delta Dental 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).

25. Refund of Unearned Premiums Upon Death of Insured. Upon the death of the Subscriber, the proceeds payable to the insured or his or her estate under this Policy, shall include premium for any period beyond the end of the Policy month in which the death occurred. Unearned premium shall be paid in lump sum on a date not later than thirty (30) days after the proof of the insured's death has been furnished to Delta Dental.

10. Definitions

10.1. "Adverse Benefits Determination" means any denial, reduction or termination of Benefits by Delta Dental for which a Claim has been filed.
10.2. "Application" means the Delta Dental Individual and Family application You submit to Delta Dental in order to enroll in a policy.
10.3. "Benefit" means the sums that Delta Dental will pay for limited-scope dental services under Your Policy as set out in this document, subject to the conditions, limitations, and restrictions set forth herein.
10.4. "Certificate of Coverage (Certificate)" is this document evidencing that certain insurance coverage/protection is provided to Participants.
10.5. "Claim" means a request for Benefits under this Certificate by the Participant, a Provider, or an authorized representative of the Participant which is submitted in accordance with Delta Dental's standard procedures for filing a Claim. A Claim includes a request for payment for a service, supply, prescription drug, equipment or treatment. A Claim does not include any Benefit inquiries where such inquiries do not follow the requirements established in the Claim procedures.
10.6. "Calendar Year" means the twelve (12) months beginning on January 1 and ending on December 31 of each year.
10.7. Contract Year" is the twelve (12) month period beginning on the first day of the calendar month in which Your Premium has been paid and each subsequent twelve (12) months while this Certificate is in effect.
10.8. "Covered Dependent" means an Eligible Dependent who is enrolled for Benefits under this Certificate and for whom Delta Dental has received Premium.
10.9. "Covered Services" is the unique dental services selected for coverage as described in the Schedule of Benefits and subject to the terms of this Certificate.
10.10. "Eligible Dependent" is an individual who meets the eligibility requirements as set forth in Section 6.2.
10.11. "Policy" is the dental Benefits to which the Certificate applies.
10.12. "Maximum Plan Allowance" is the maximum payment allowed by Delta Dental for the applicable Covered Service(s) provided by the Provider(s).
10.13. "Non-Participating Provider" is any Provider other than a Participating Provider.
10.14. "Participant" is You and an Eligible Dependent who enrolled for Benefits under this Certificate and for whom Delta Dental has received Premium.
10.15. "Participating Provider" is a licensed Dentist who has contracted with and agreed to abide by the rules and regulations of Delta Dental or any other organization that is a member of Delta Dental Plans Association, DeltaUSA, or its affiliates.

10.16. "Premium" is the monthly amount to be paid by You to Delta Dental for coverage under the Certificate.

10.17. "Provider" means a legally licensed dentist or any other legally licensed dental practitioner rendering services. Services must be covered under the Certificate and be within the scope of the dentist or other legally licensed dental practitioner's license.

10.18. "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.

10.19. "Subscriber" means the individual to whom this Certificate is issued.

10.20. "Urgent Care" involves treatment that is necessary and reasonable and if not provided:

a) Could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function; or

b) In the opinion of a licensed medical professional with knowledge of the Participant's medical condition would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

GRAMM-LEACH-BLILEY PRIVACY NOTICE

What Does Delta Dental Do With Your Personal Information?

Why?: Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.

What?: The types of personal information we collect and share depend on the product or service you have with us. This information can include:

- Social Security number and Insurance claim information
- Transaction history and Medical information
- Credit card payments and Employment information

When you are *no longer* our customer, we continue to share your information as described in this notice.

Why?: All financial companies need to share members' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their members' personal information; the reasons Delta Dental chooses to share; and whether you can limit this sharing.

Reasons We Can Share Your Personal Information	Does Delta Dental Share?	Can You Limit This Sharing?
For our everyday business purposes – such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes – to offer our products and services to you	Yes	No
For joint marketing with other financial companies	No	We do not share
For our affiliates' everyday business purposes – information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes – Information about your creditworthiness	No	We do not share
For nonaffiliates to market to you	No	We do not share

What We Do?	
How does Delta Dental protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings.
How does Delta Dental collect my personal information?	We collect your personal information, for example, when you: • Apply for insurance • Pay insurance claims • File an insurance claim • Use your credit or debit card • Give us your contact information
Why can't I limit all sharing?	Federal law gives you the right to limit only: • Sharing for affiliates' everyday business purposes– information about your creditworthiness • Affiliates from using your information to market to you

	• Sharing for non-affiliates to market to you State laws may give you additional rights to limit sharing.

Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. Our affiliates include companies with the Delta Dental name in Michigan, Ohio, Indiana, Kentucky, Tennessee, New Mexico, and North Carolina; insurance companies such as Renaissance Life & Health Insurance Company of America and Renaissance Health Insurance Company of New York; and others such as Renaissance Systems & Services, LLC.
Non-affiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. Delta Dental does not share your personal information with non-affiliates so they can market to you.
Joint Marketing	A formal agreement between non-affiliated financial companies that together market financial products or services to you. Delta Dental does not jointly market with non-affiliated financial companies.

Other Important Information
For customers in AZ, CA, CT, GA, IL, ME, MA, MN, MT, NV, NJ, NC, OH, OR and VA: To review your personal information, write to Privacy Officer, 1516 Country Club Road, Sherwood, Arkansas 72120. You must state your full name, address, policy number (if applicable) and the information you would like to see. We will tell you what information we have, and you may review and copy it at our office or ask that we mail a copy to you for a fee. If you think that personal information that we have about you is wrong, you may write to us. We will tell you what actions we take because of your letter. If you do not agree with our actions, you may send us a statement.

Questions?: Send all requests regarding this Privacy Notice to:

Delta Dental Plan of Arkansas, Inc.
Attn: Chief Privacy Officer
1513 Country Club Road
Sherwood, Arkansas 72120

Para asistencia en español, llame al número de servicio al cliente (customer service) que aparece en el reverso de su tarjeta para miembros.

This document is also available in alternative formats upon request and at no cost to persons with disabilities.

NOTICE OF PRIVACY PRACTICES

Date of this notice: October 13, 2017

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.

This notice describes the privacy practices of Delta Dental Plan of Arkansas, Inc.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information" ("PHI"). Generally, PHI is individually identifiable health information, including demographic information, collected from you or received by a health care provider, a health care clearinghouse, a health plan or your employer on behalf of a group health plan that relates to:

1. your past, present or future physical or mental health or condition;
2. the provision of health care to you; or
3. the past, present or future payment for the provision of health care to you.

We are required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information. We are committed to protecting your health information.

We comply with the provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act. We maintain a breach reporting policy and have in place appropriate safeguards to track required disclosures and meet appropriate reporting obligations. We will notify you promptly in the event a breach occurs that may have compromised the security or privacy of your PHI. In addition, we comply with the "Minimum Necessary" requirements of HIPAA and the HITECH amendments.

For more information concerning this notice please see: www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we may use or disclose your PHI.

For treatment—We may use or disclose your PHI to facilitate medical treatment or services by providers. We may disclose PHI about you to providers, including dentists, doctors, nurses, or technicians, who are involved in taking care of you. For example, we might disclose information about your prior dental X-ray to a dentist to determine if the prior X-ray affects your current treatment.

For payment—We may use or disclose PHI about you to obtain payment for your treatment and to conduct other payment-related activities, such as determining eligibility for Plan benefits, obtaining customer payment for benefits, processing your claims, making coverage decisions, administering Plan benefits and coordinating benefits.

For health care operations—We may use and disclose PHI about you for other Plan operations, including setting rates, conducting quality assessment and improvement activities, reviewing your treatment, obtaining legal and audit services, detecting fraud and abuse, business planning and other general administration activities. In accordance with the Genetic Information and Nondiscrimination Act of 2008, we are prohibited from using your genetic information for underwriting purposes.

To Business Associates—We may contract with individuals or entities known as Business Associates to perform various functions or to provide certain types of services on the Plan's behalf. In order to perform these functions or provide these services, Business Associates may receive, create, maintain, use and/or disclose your PHI, but only if they agree in writing with the Plan to implement appropriate safeguards regarding your PHI. For example, the Plan may disclose your PHI to a Business Associate to administer claims or provide support services, such as utilization management, quality assessment, billing and collection or audit services, but only after the Business Associate enters into a Business Associate Agreement with the Plan.

Health-related benefits and services—We may use or disclose health information about you to communicate to you about health-related benefits and services. For example, we may communicate to you about health-related benefits and services that add value to, but are not part of, your health plan.

To avert a serious threat to health or safety—We may use and disclose PHI about you to prevent or lessen a serious and imminent threat to the health or safety of a person or the general public.

Military and veterans—If you are a member of the armed forces, we may release PHI about you if required by military command authorities.

Worker's compensation—We may release PHI about you as necessary to comply with worker's compensation or similar programs.

Public health risks—We may release PHI about you for public health activities, such as to prevent or control

disease, injury or disability, or to report child abuse, domestic violence, or disease or infection exposure.

Health oversight activities—We may release PHI to help health agencies during audits, investigations or inspections.

Lawsuits and disputes—If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We also may 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; 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.

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.

To Plan Sponsor—We may disclose your PHI to certain employees of the Plan Sponsor (i.e., the company) for the purpose of administering the Plan. These employees will only use or disclose your PHI as necessary to perform Plan administrative functions or as otherwise required by HIPAA.

Disclosure to others—We may use or disclose your PHI to your family members and friends who are involved in your care or the payment for your care. We may also disclose PHI to an individual who has legal authority to make health care decisions on your behalf.

REQUIRED DISCLOSURES

The following is a description of disclosures of your PHI the Plan is required to make:

As required by law—We will disclose PHI about you when required to do so by federal, state or local law. For example, we may disclose PHI when required by a court order in a litigation proceeding, such as a malpractice action.

Government audits—The Plan is required to disclose your PHI to the secretary of the United States Department of Health and Human Services when the secretary is investigating or determining the Plan's compliance with HIPAA.

Disclosures to you—Upon your request, the Plan is required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits.

WRITTEN AUTHORIZATION

We will use or disclose your PHI only as described in this notice. **It is not necessary for you to do anything to allow us to disclose your PHI as described here.** If you want us to use or disclose your PHI for another purpose, you must authorize us in writing to do so. For example, we may use your PHI for research purposes if you provide us with written authorization to do so. You may revoke your authorization in writing at any time. When we receive your revocation, it will be effective only for future uses and disclosures. It will not be effective for any PHI that we may have used or disclosed in reliance upon your written authorization. We will never sell your PHI or use it for marketing purposes without your express written authorization. We cannot condition treatment, payment, enrollment in a health plan, or eligibility for benefits on your agreement to sign an authorization.

ADDITIONAL INFORMATION REGARDING USES OR DISCLOSURES OF YOUR PHI

For additional information regarding the ways in which we are allowed or required to use of disclosure your PHI, please see www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

YOUR RIGHTS REGARDING PHI THAT WE MAINTAIN

You have the following rights regarding PHI we maintain about you:

Your right to inspect and copy your PHI—You have the right to inspect and copy your PHI. You must submit your

request in writing and if you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request. A copy will be provided within 30 days of your request.

The Plan may deny your request to inspect and copy PHI in certain limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed by submitting a written request to the contact person listed below.

Your right to amend incorrect or incomplete information—If you believe that the PHI the Plan has about you is incorrect or incomplete, you may request that we change your PHI by submitting a written request. You also must provide a reason for your request. We are not required to amend your PHI but if we deny your request, we will provide you with information about our denial and how you can disagree with the denial within 60 days of your request.

Your right to request restrictions on disclosures to health plans—Where applicable, you may request that restrictions be placed on disclosures of your PHI.

Your right to an accounting of disclosures we have made—You may request an accounting of disclosures of your PHI that we have made, except for disclosures we made to you or pursuant to your written authorization, or that were made for treatment, payment or health care operations. You must submit your request in writing. Your request may specify a time period of up to six years prior to the date of your request. We will provide one list of disclosures to you per 12-month period free of charge; we may charge you for additional lists.

Your right to request restrictions on uses and disclosures—You have the right to request restrictions or limitations on the way that we use or disclose PHI. You must submit a request for such restrictions in writing, including the information you wish to limit, the scope of the limitation and the persons to whom the limits apply. We may deny your request.

Your right to request confidential communications through a reasonable alternative means or at an alternative location—You may request that we direct confidential communications to you in an alternative manner (i.e., by facsimile or email). You must submit your request in writing. We are not required to agree to your request, however, we will accommodate your request if doing otherwise would place you in any danger.

Your right to a paper copy of this notice—To obtain a paper copy of this notice or a more detailed explanation of these rights, send us a written request at the address listed below.

Your right to appoint a personal representative—Upon receipt of appropriate documentation appointing an individual as your personal representative, medical power of attorney or legal guardian, that individual will be permitted to act on your behalf and make decisions regarding your health care.

CHANGES TO THIS NOTICE

We may amend this Notice of Privacy Practices at any time in the future and make the new notice provisions effective for all PHI that we maintain. We will advise you of any significant changes to the notice. We are required by law to comply with the current version of this notice.

COMPLAINTS

If you believe your privacy rights or rights to notification in the event of a breach of your PHI have been violated, you may file a complaint with us or with the Office of Civil Rights. Complaints about this notice or about how we handle your PHI should be submitted in writing to the contact person listed below.

A complaint to the Office of Civil Rights should be sent to Office of Civil Rights, U.S. Department of Health & Human Services, 200 Independence Ave., SW, Washington, D.C. 20201, 877-696-6775. You also may visit OCR's website at www.hhs.gov/hipaa/filing-a-complaint/index.html for more information.

You will not be penalized, or in any other way retaliated against for filing a complaint with us or the Office of Civil Rights.

SEND ALL WRITTEN REQUESTS REGARDING THIS PRIVACY NOTICE TO:

Delta Dental Plan of Arkansas, Inc., Attn: Privacy Officer, P.O. Box 15965, North Little Rock, AR 72231, 1-800-462-5410.

Para asistencia en español, llame al número de servicio al cliente (customer service) que aparece en el reverso de su tarjeta para miembros.

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Inquiries, Review
Customer Service
P.O. Box 15965
Little Rock, AR 72231

(844) 368-6484

An Equal Opportunity Employer

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