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 1-800-462-5410 or access our website at www.DeltaDentalAR.com.

We look forward to serving you!

DELTA DENTAL PLAN OF ARKANSAS, INC.

BY: Ed Chrake

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.

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 1-800-462-5410 (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 15965, Attn: Civil Rights Coordinator, Little Rock, AR 72231; by phone at 1-800-462-5410 (TTY users call 711) or fax to 1-501-992-1864. 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.*

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل على الهاتف رقم 1-800-462-5410 (رقم الطابعة الهاتفية: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-462-5410 (TTY：711)。

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-462-5410 (ATS: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-462-5410 (TTY: 711).

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए नि:शुल्क उपलब्ध हैं। कॉल करें 1-800-462-5410 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-462-5410 (TTY：711) まで、お電話にてご連絡ください。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-462-5410 (TTY: 711) 번으로 전화해 주십시오.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-462-5410 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-462-5410 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-462-5410 (TTY: 711).

ધ્યાન આપો: જો તમે [ગુજરાતી] બોલતાં હો તો વિના મૂલ્ય ભાષાકીય સહાયતા સેવાઓ તમારે માટે ઉપલબ્ધ છે. કૉલ કરો 1-800-462-5410 (TTY: 711).

LALE: Ñe kwōj kōnono Kajin Ṃajō ļ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejje ļọk wōṇāān. Kaalọk 1-800-462-5410 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-462-5410 (TTY: 711).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-462-5410 (TTY: 711).

ໂປດ ຊາບ: ຖ້າວ່າ ທ່ານ ເວົ້າ ພາສາ ລາວ, ການ ບໍລິ ການ ຊ່ວຍ ເຫຼືອ ດ້ານ ພາສາ, ໂດຍບໍ່ ເສັ ຍ ຄ່າ, ແມ່ນມີ ພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-462-5410 (TTY: 711).

SCHEDULE OF BENEFITS

FREQUENCY OF SERVICES Your Certificate is on a Calendar Year Benefit Period	
Vision Exam:	Once every 12 Months
Eyeglass Lenses:	Once every 12 Months
Frames:	Once every 24 Months
Contact Lenses:	Once every 12 Months

CO-PAY (Per Person Per Benefit Period)		
	In-Network Provider:	Out-of-Network Provider:
Vision Exam:	$10	No co-pay
All Materials Combined:	$25	No co-pay
Contact Lens Fitting:	$25	No co-pay

BENEFITS AND ALLOWANCES [1]		
	In-Network Provider[6]:	Out-of-Network Provider[7]:
Vision Exam:		
By Ophthalmologist (M.D.)	Covered in Full after co-pay	$36 retail allowance
By Optometrist (O.D.)	Covered in Full after co-pay	$36 retail allowance
Materials - Frames[2]:	$130 retail allowance	$61 retail allowance
Materials - Eyeglass Lenses[2]:		
Single Vision	Covered in Full after co-pay	$28 retail allowance
Bifocals	Covered in Full after co-pay	$42 retail allowance
Trifocals	Covered in Full after co-pay	$56 retail allowance
Lenticular	Covered in Full after co-pay	$78 retail allowance
Progressives	Covered up to the providers retail trifocal amount after co-pay	$56 retail allowance
Materials - Contact Lenses[3]:		
Elective	$130 retail allowance	$100 retail allowance
Medically Necessary[4]	Covered in Full	$210 retail allowance
Contact Lens Fit[5]:		
Standard	Covered in Full after co-pay	$0 retail allowance
Specialty	$50 retail allowance	$0 retail allowance

[1] Where an "Allowance" is shown, you are responsible for paying any charges in excess of the Allowance.

[2] Eyeglass Lenses and Frames are paid in lieu of the Contact Lenses benefit.

[3] The Contact Lenses benefit is paid in lieu of Eyeglass Lenses and Frames. Contact Lenses allowance includes materials and fittings.

[4] Prior Authorization required.

[5] Standard Contact Lens Fitting is for an existing contact lens user who wears disposable, daily wear, or extended wear contact lenses. It includes 2 follow-up visits within 3 months. Specialty Contact Lens Fitting is for an Insured who has never worn contact lenses or who requires a more complex fit for toric, gas permeable, or multi-focal contact lenses. It includes 2 follow-up visits within 3 months.

[6] For In-Network Providers you may choose to use the insured benefit or take advantage of a sale or coupon, but not both.

[7] If you visit an Out-of-Network provider, you may be required to pay the provider for services rendered and then submit your expenses for reimbursement.

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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 Group 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 Group Health Plan and you should ignore the conflicting statement in this Certificate.

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"). This Certificate is part of the group Contract that is a legal document between Delta Dental and Your Group Sponsor to provide Benefits subject to the terms, conditions, exclusions and limitations described in this Certificate.

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.

Your coverage under this Certificate begins at 12:01 a.m. standard central time zone on the effective date determined by Your Group Sponsor and Delta Dental in the Contract. Coverage will end at 12:00 midnight standard central time zone on the date set out in Section 6.3. Delta Dental will continue Your coverage unless and until Your Group Sponsor or Delta Dental terminates it for any of the reasons described in this Certificate. Your Group Sponsor and Delta Dental determine Your eligibility for Benefits under this Certificate.

Delta Dental is delivering the Contract and this Certificate in the State of Arkansas. The Contract and this Certificate are governed by ERISA unless the Group Sponsor is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of Arkansas shall govern the Contract and this Certificate.

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 11, "Definitions".

2. HOW THE PLAN 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 Vision Provider?

The easiest and most accurate listing of Participating Providers is on Our website. Log into the Delta Dental Consumer Toolkit and then click on the Provider Directory link. Once at the web page, select the "Vision" icon and enter Your zip code. 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 1-800-462-5410.

2.2. Accessing Your Benefits

To utilize Your vision 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 Group Health Plan.

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 Our Consumer Toolkit. The Consumer Toolkit will also allow You to print ID cards, search Our Provider directories, and read health and wellness tips.

Make an appointment with Your Provider and tell him or her that You have vision benefits with Delta Dental. If Your Provider is not familiar with Delta Dental or has any questions, have him or her contact Us by writing to Customer Service at to be identified at a later date or calling at to be identified at a later date.

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 withinsix(6) - 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 will be required to submit an itemized invoice or receipt to Us.

2.4. Processing the Claim.

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

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

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.

2.5. 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 your Group Sponsor's Human Resources department, call Delta Dental, toll-free at 1-800-462-5410, or write Delta Dental at P.O. Box 15969, Little Rock AR 72231, to request a form to designate the person You wish to appoint as Your representative.

2.6. How Payment is Determined

Network Benefits

If your Provider is a Participating Provider, Delta Dental will base its payments on the in network Benefits shown in the Schedule of Benefits for Covered Services. You will pay any required co-pay and any charges above the Benefits to a Participating Provider.

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.

Some overages and out of pocket expenses on Covered Services may be subject to discounts offered by Participating Providers. Confirmation with your Provider regarding the amount and services covered should be discussed prior to services being rendered. Any discount is subject to change.

Note exception: If You use the services of a Participating Provider but take advantage of a sale, coupon, or other in store special, the Participating Provider may require that You pay in full and submit Your receipt to Us for reimbursement at the out of network reimbursement.

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. Any co-pay that applies should not be paid to the Non-Participating Provider, as it will be deducted by Us at the time the Claim is processed. You will be responsible for any difference between the amount of out-of-network Benefits shown in the Schedule of Benefits less any co-pay and the Provider's submitted amount.

2.7. Medically Necessary Services

Covered Services must be considered "Medically Necessary" in order to be Benefit under this Certificate. "Medically Necessary" or "Medical Necessity" means a Covered Service, which in the opinion of Our medical personnel:

(a) Is in accordance with generally accepted standards of vision practice;
(b) Is clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Participant's illness, injury or disease;
(c) Is not primarily for the convenience of the Participant, his or her family, his or her treating Provider, or other Provider; and
(d) Is not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Participant's illness, injury, or disease.

Not every service or supply that fits the definition for Medical Necessity is covered by this Certificate. Exclusions and limitations apply to certain services, supplies and expenses. For example, some Benefits are limited to a certain number of days, visits or a dollar maximum. Refer to the "Exclusions and Limitations" section of this Certificate and the Schedule of Benefits for Your Group Health Plan limits and maximums.

All determinations of Medical Necessity for Covered Services are made in accordance with the above definition at Our sole discretion.

2.8. Optional Services

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 Your Group Sponsor's Human Resources department or call Delta Dental, toll-free, at 1-800-462-5410. 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, Your Group Sponsor's name and group number, the Subscriber's member ID number, and Your daytime telephone number.

If You (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint You have been unable to resolve with Us, You may contact the Arkansas Insurance Department by mail, telephone, or e-mail:

State of Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
(501) 371-2640
(800) 852-5494
You can file a complaint electronically at http://insurance.arkansas.gov/csd-complaint.htm

3. BENEFIT CATEGORIES

A description of various vision services that can be selected as Covered Services are included below. Only the Covered Services listed in Your Schedule of Benefits are Covered Services under this Certificate. Covered Services are also subject to exclusions and limitations. You will want to review this section of this Certificate carefully.

Eye Exam

An eye examination is a series of tests performed by an ophthalmologist (medical doctor- MD) or optometrist (doctor of optometry –OD) assessing vision and ability to focus on and discern objects, as well as other tests and examinations pertaining to the eyes.

Lenses

Single Vision Lens is an eyeglass lens that corrects one field of vision, either for distance, intermediate (computer), or items up close (near vision). Single vision has the same optical focal point or correction over the entire area of the lens.

Bifocal Lens is an eyeglass lens with two distinct optical powers. Bifocals are commonly prescribed to people with presbyopia who also require a correction for myopia, hyperopia, and/or astigmatism.

Trifocal Lens is an eyeglass lens that has three regions which correct for distant, intermediate (arm's length), and near vision. Trifocals are mostly used by people with advanced presbyopia who have been prescribed 2 diopters or more of reading addition.

Lenticular Lens is an eyeglass lens sometimes used as corrective lenses for improving vision. A bifocal lens could be considered a simple example.

Progressive lens is an eyeglass lens that has a smooth transition between parts with different focal lengths, correct vision at all distances.

Frames

An optical instrument consisting of a frame that holds a pair of lenses for correcting defective vision

Contact Lenses

Elective Contact lenses are held in place over the cornea by surface tension and correct vision defects inconspicuously.

Medically Necessary contact lenses are non-elective contact lenses prescribed when certain medical conditions hinder vision correction through regular eyeglasses.

Contact Lenses Fitting (also called Contact Lens Exam) is an evaluation by an eye care Provider that measures the size and shape of the cornea in order to prescribe and dispense contact lenses. A contact lens fitting fee is in addition to an eye exam.

Standard Contact Lens Fittings is a fitting for existing contact lens users who wear disposable, daily wear or extended wear contact lenses. It includes two follow-up visits within three months.

Specialty Contact Lens Fitting is a fitting for a Participant who has never worn contact lenses or who requires a more complex fit for toric, gas permeable or multi-focal contact lenses. It includes two follow-up visits within three months.

4. EXCLUSIONS and LIMITATIONS

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

1. Services for injuries or conditions covered under Worker's Compensation or Employer's Liability laws or otherwise arising out of a work related injury.
2. Services available from any federal or state government agency, municipality, county, other political subdivision, or community agency, or from any foundation or similar entity.
3. Services or supplies received as a result of vision disease, defect, or injury due to an act of war, declared or undeclared.
4. 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 vision coverage.
5. Treatment by someone other than a Provider.
6. 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.
7. Services to correct congenital or developmental malformations.
8. Services for the purpose of improving appearance when form and function are satisfactory, and there is insufficient pathological condition evident to warrant the treatment.
9. Services or materials started prior to the date the Participant became eligible under this Certificate.
10. 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 vision 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.

11. Replacement of lost, missing, broken, or stolen frames or lenses, except at normal intervals when Benefits are otherwise available (see discount section for more information).
12. Services when a Claim is received for payment more than six(6) - twelve (12) months after services are rendered.
13. Fees charged by a Provider for services other than a vision examination or vision materials must be paid in full by the Participant to the Provider. Such fees or materials are not covered under this Certificate.
14. Specialized techniques that entail procedure and process over and above that which is normally adequate. Any additional fee is the Participant's responsibility.
15. Behavior management.
16. Those services and Covered Services excluded by the rules and regulations of Delta Dental, including Delta Dental's processing policies.
17. Procedures that do not comply with Delta Dental's guidelines.
18. Any vision examination or any corrective eyewear required by an employer as a condition of employment and safety eyewear.
19. Benefits provided under Your medical insurance or another vision plan, except in the case of coordination of benefits.
20. Plano or non-prescription lenses or non-prescription, pre-fabricated sunglasses.
21. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing.
22. Frame cases.
23. Two (2) pairs of glasses, in lieu of bifocals, trifocals or progressives.
24. Low (subnormal) vision aids or aniseikonic lenses.
25. Medical and/or surgical treatment of the eye, eyes, or supporting structures.
26. Blended bifocal lenses.
27. Groove, drill or notch, and roll and polish.
28. Coating on lenses (Factory scratch coat, anti- reflective, sunglass colors, ect.).
29. Faceted lenses, high-index lenses, laminated lenses, photochromic (Transition) lenses, polaroid lenses, polished bevel lenses, polycarbonate lenses, prism lenses, or slab-off lenses.
30. Oversized lenses –any lenses with an eye size of 61mm or greater.
31. Tints (except Pink tint #1 and #2).
32. Ultra-violet tint or coating.
33. Additional cost for contact lenses over the allowance in Your Schedule of Benefits (see discount section for more information).
34. Additional cost for a frame over the allowance in Your Schedule of Benefits (see discount section for more information).
35. Progressive Power lenses (if this type of lens is not a Benefit under Your Certificate, the Provider will apply the retail charge for standard trifocal lenses against the charges for the style of progressive lenses You have selected. You pay the Provider the difference, if any, between the two).
36. Any other Benefits and services not specifically covered in the Certificate, Schedule of Benefits and/or Exclusions and Limitations.

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 1-800-462-5410 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. You also have the right to review the Contract between Delta Dental and the Group Sponsor and any documents related to it. 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. Employee Coverage

All active Employees of the Group Sponsor working the designated number of hours per week as defined in the Contract will be eligible to enroll for coverage under the Contract. Coverage will start as described in Section 6.3 below. Employees classified by the Group Sponsor as temporary, seasonal, or leased, are not be eligible to enroll for coverage under the Contract.

6.2. Dependent Coverage

You must be covered under the Contract as an Employee of the Group Sponsor in order for Your Eligible Dependents to be covered. No dependent shall be covered hereunder prior to the Employee's eligibility date.

An individual may not be covered under this Certificate as both a Subscriber and a Covered Dependent. Also, an individual may not be considered an Eligible Dependent of more than one Subscriber.

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 children under the limiting age specified in the Contract.
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. If Delta Dental asks You to do so, you must submit medical reports confirming the child's initial or continuing total disability.
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 the Eligible Employee is the legal guardian, or e) Child for whom the Eligible Employee is 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 attains the limiting age as defined by the Contract. 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.

6.3. When Does Coverage Start

In order for Your coverage to take effect, You must submit an enrollment form for coverage for Yourself and Your Eligible Dependents. It is important that Your enrollment form is received by Delta Dental in a timely manner. Your coverage begins upon the effective date of this Certificate as determined by your Group Health Plan. You should contact your Group Sponsor for information concerning Your eligibility requirements and effective date.

If You apply for coverage and pay any required premium for Yourself and Your Eligible Dependents, Your coverage will be effective in accordance with one of the following:

1. If You are eligible on the effective date of Your Group Health Plan's Contract and Your enrollment form is received by Delta Dental prior to or within 31 days following such date, Your coverage will become effective on the effective date.
2. The first day of the calendar month after You and Your Eligible Dependents, complete the probation period, if any, as defined in the Contract or as amended by the Group Sponsor.
3. If You enroll for coverage for Yourself or any Eligible Dependents during an open enrollment period, Your coverage shall become effective on the first day of the new open enrollment period assigned by Your Group Sponsor.
4. Employees and Eligible Dependents who do not enroll for coverage on a timely basis upon initial eligibility or upon an Enrollment Qualifying Event will be permitted to enroll for coverage under the Contract during open enrollment or as allowed by the Group Sponsor pursuant to Late Entry restrictions, as applicable. Late Entry restrictions, as applicable, include Benefit reductions as set forth in the Schedule of Benefits.

6.4. Qualifying Events that Change Coverage

Your Benefits are intended to remain the same for the entire Contract Year. During the Contract Year, You will be allowed to change your Benefits only if You experience one of the following Enrollment Qualifying Events:

- Change in legal marital status such as marriage or divorce.
- Change in number of Eligible Dependents in the event of birth up to first of the month following the child's third birthday, adoption, or death.
- Change in Your or Your spouse's employment - either starting or losing a job.
- Change in Your or Your spouse's work schedule, such as going from full-time to part-time or part-time to full-time, or beginning or ending an unpaid leave of absence.
- Change in Eligible Dependent status, such as if a child reaches the limiting age under the Contract.
- Becoming eligible for Medicare, Medicaid or Children's Health Insurance Program (CHIP).
- Termination of Medicare, Medicaid or Children's Health Insurance Program (CHIP) coverage.
- Change in You or Your dependent's eligibility.
- Loss of other coverage.

Eligible Dependents: An enrollment form must be received within 31 days of the date that a spouse or child first qualifies as an Eligible Dependent. If the enrollment form is received within 31 days, coverage will become effective on the date the spouse or child first becomes an Eligible Dependent.

Court-ordered Coverage: If You divorce, legally separate, or annul Your marriage, Your spouse's coverage automatically terminates on the date of the divorce, legal separation, or annulment. A court order requiring You to provide coverage for the former spouse does not change the termination of coverage. However, see Section 9 for information about how Your former spouse can elect to continue coverage.

6.5. Enrollment Application/Change Form

You may obtain an Enrollment Application or Change Form from Your Group Sponsor, by calling Delta Dental at 1-800-462-5410, or by visiting Delta Dental's website at www.dentaldentalar.com. After You have completed the application or form, return it to Your Group Sponsor.

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.

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. Non-coordinating Plan

   If the Participant has another plan that does not coordinate benefits, it will always be primary.

2. Employee or Subscriber

   The plan that covers the Participant as an employee is 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. Laid Off or Retired Employees

   The plan that covers You as a laid off or retired employee or as a dependent of a laid off or retired employee is primary.

6. COBRA Coverage

   The plan that is provided under a right of continuation pursuant to federal law is primary.

7. Other Plans

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

   If the other plan does not have Rule 5 and/or Rule 6 (above) and decides the order of benefits differently from this Certificate, Delta Dental may ignore either of those rules.

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 the Group Health Plan.

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 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;
3. Immediately when You do not make any required contributions for Your coverage as required by the Group Sponsor.

4. If You stop working for the Group Sponsor for any reason, including a job elimination or being placed on severance, Your coverage will end on the last day of the month in which You stop working, unless you qualify for and pay for COBRA which is further described in Section 9.
5. When the Contract between Delta Dental and the Group Sponsor is terminated.
6. If Your Group Sponsor fails to pay the Premium, Your coverage will end on the first day of the month for which Delta Dental did not receive payment.
7. Immediately when You exhaust Your overall maximum lifetime benefit under Your Plan, if Your Plan has a maximum benefit.

It is the Group Sponsor's responsibility to let Delta Dental know when Your employment ends. The limits above may be extended only if Delta Dental and the Group Sponsor agree, in writing, to extend them.

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, unless they are eligible to and in fact elect to continue coverage under COBRA which is further described in Section 9.
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 Contract to be a Covered Dependent.
3. Immediately when You do not make Your contribution for the cost of dependent coverage.

If these events occur, then You and/or Your Covered Dependents may be eligible for continuation of coverage under COBRA as described in Section 9 of this Certificate.

9. CONTINUATION OF COVERAGE

If Your Group Sponsor is subject to COBRA requirements, continuation of coverage is governed by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requirements. With COBRA, You and Your Covered Dependents can continue health coverage, subject to certain conditions and Your payment of premium to the Group Sponsor. Continuation coverage rights are available after a "qualifying event" that would cause You or Your Covered Dependents to otherwise lose coverage.

When You and/or Your Covered Dependents become eligible for coverage under COBRA because of a qualifying event, the Group Sponsor will provide You with detailed information on continuing coverage through COBRA.

If You have questions about COBRA continuation coverage for You and/or Your Covered Dependents, including election of coverage, payment of premium, and when it ends, please contact the Group Sponsor.

10. 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 Group Sponsor 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 or Group Sponsor 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, assistants, 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 Contract.

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 1-800-462-5410 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. Neither Delta Dental (including its agents, directors, officer, and employees) nor Group Sponsor shall 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 Group Sponsor is 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 Group Sponsor 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 Federal and Arkansas law. The Contract and this Certificate are governed by ERISA unless the Group Sponsor is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of Arkansas shall govern this Contract and this Certificate.

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, through the Group Sponsor, 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. Request for Evidence of Creditable Coverage. Participant(s) may request a Certificate of Credible Coverage by contacting Delta Dental at 1-800-462-5410.

25. 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).

11. Definitions

11.1. "Adverse Benefits Determination" means any denial, reduction or termination of Benefits by Delta Dental for which a Claim has been filed.

11.2. "Benefit" means the sums that Delta Dental will pay for limited-scope vision services under Group Sponsor's Contract as set out in this document, subject to the conditions, limitations, and restrictions set forth herein.

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

11.4. "Certificate of Coverage (Certificate)" is this document evidencing that certain insurance coverage/protection is provided to a Group Sponsor for the benefit of its subscribing Eligible Employees. This insurance protection is more specifically set out pursuant to the terms and conditions set out in the Contract by and between the Group Sponsor and Delta Dental.

11.5. "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.

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

11.7. "Contract" is the agreement between Delta Dental and Group Sponsor, including the Application and Agreement for Employers, all schedules, endorsements, and amendments as issued by Delta Dental.

11.8. "Contract Year" is the twelve (12) months starting on the effective date of the Contract and each subsequent twelve (12) months while the Contract is in effect.

11.9. "Covered Dependent" means an Eligible Dependent who is enrolled for Benefits under this Certificate and for whom Delta Dental has received Premium.

11.10. "Covered Services" is the unique vision services selected for coverage as described in the Schedule of Benefits and subject to the terms of this Certificate.

11.11. "Eligible Dependent" is an individual who meets the eligibility requirements as set forth in Section 6.2.

11.12. "Employee" is an individual employed by the Group Sponsor. If the Group Sponsor is an association, an Employee will mean an individual who is a current member of that association.

11.13. "Enrollment Qualifying Event" means the occurrence of a specified event that would allow an Eligible Dependent to enroll under this Certificate after being first eligible.

11.14. "Group Health Plan" is the group vision Benefits program to which the Certificate applies.

11.15. "Group Sponsor" is any individual, partnership, association, corporation, or organization that establishes a Group Health Plan for its Employee or members and their Eligible Dependents. It will pay to Delta Dental the Premiums. It will also receive notice, identification card, Certificate, or rider from Delta Dental on behalf of such Participants. The Group Sponsor shall not be the agent of Delta Dental for any purpose.

11.16. "Late Entry" is when an Employee or Eligible Dependent enrolls in the Group Health Plan after his or her initial eligibility period and not as a result of an Enrollment Qualifying Event, if applicable as described in this Certificate. Waiting periods may apply.

11.17. "Non-Participating Provider" is any Provider other than a Participating Provider.

11.18. "Participant" is an Eligible Employee or an Eligible Dependent who is enrolled for Benefits under this Certificate and for whom Delta Dental has received Premium.

11.19. "Participating Provider" is a Provider who has contracted with or for the benefit of Delta Dental.

11.20. "Premium" is the monthly amount to be paid by the Group Sponsor to Delta Dental for coverage under the Certificate.

11.21. "Provider" means an Ophthalmologist, Optometrist or Optician who is operating within the scope of his or her license or a dispensing optician.

11.22. "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 vision Premiums are remitted at the time vision care is provided.

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

NOTICE OF PRIVACY PRACTICES

Date of this notice: February 12, 2016

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 Michigan, Inc., Delta Dental Plan of Ohio, Inc., Delta Dental Plan of Indiana, Inc., Delta Dental Plan of Arkansas, Inc., Delta Dental of Kentucky, Inc., Delta Dental Plan of New Mexico, Inc., Delta Dental of North Carolina, Delta Dental of Tennessee, Renaissance Life & Health Insurance Company of America, Renaissance Health Insurance Company of New York, and Renaissance Systems & Services, LLC (collectively, "we" or "us" or the "Plan"). These entities have designated themselves as a single affiliated covered entity for purposes of the privacy rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and each has agreed to abide by the terms of this notice and may share protected health information with each other as necessary for treatment, payment or to carry out health care operations, or as otherwise permitted by law.

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. You may also obtain a copy of this notice at one of our websites:

www.deltadentalmi.com,
www.deltadentaloh.com,
www.deltadentalin.com,
www.deltadentalar.com
www.deltadentalky.com,
www.deltadentalnc.com,
www.deltadentalnm.com,
www.deltadentaltn.com,
www.renaissancedental.com, or
www.rss-llc.com.

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.

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

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

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