Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

DENTAL - PEDIATRIC

INDIVIDUAL DENTAL POLICY

COVERED BENEFITS RECEIVED FROM A NON-CONTRACTED DENTIST, EXCEPT IN CERTAIN CIRCUMSTANCES, ARE PAID AT A RATE LESS THAN THE SAME COVERED BENEFITS RECEIVED FROM A PREFERRED PROVIDER ORGANIZATION (PPO) DENTIST OR CONTRACTED DENTIST. (SEE YOUR SCHEDULE OF BENEFITS)

OTHER INSURANCE REDUCES BENEFITS - READ CAREFULLY

Attached is the Schedule of Benefits and Identification Card showing name of Policyholder, Policy number, premiums, and the effective date.

GUARANTEED RENEWABLE
CONDITIONED UPON RESIDENCE IN ARKANSAS
PREMIUMS SUBJECT TO CHANGE

ONLY COVERED PERSONS WHO ARE LESS THAN 19 YEARS OF AGE ARE ELIGIBLE FOR BENEFITS UNDER THIS POLICY

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. GAINES STREET
LITTLE ROCK, ARKANSAS 72201

ARKANSAS BLUE CROSS AND BLUE SHIELD

DENTAL EXPENSE POLICY

OUTLINE OF COVERAGE

If, after examination of your Policy, you are not satisfied with any of its terms or conditions, you may return it to the Company within thirty (30) days of its delivery to you and receive a full refund of all premiums.

READ YOUR POLICY CAREFULLY - This outline of coverage provides a very brief description of the important features of your Policy. The outline is not your Policy and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

DENTAL EXPENSE COVERAGE - Policies of this category are designed to provide to persons insured, coverage for dental expenses. Coverage is provided for periodic, limited, and comprehensive exams, routine prophylaxis, fluoride treatments, radiographic images, etc. subject to any Deductible and Coinsurance provision or other limitations which may be set forth in the Policy.

BENEFITS

COVERED SERVICES are limited to the services listed in Service Categories A., B., and C.

AGE LIMITATIONS: A Child under the age of 19 is covered in accordance with Policy guidelines.

IN-NETWORK OUT OF POCKET MAXIMUM: PLEASE CHECK YOUR SCHEDULE OF BENEFITS TO DETERMINE THE AMOUNT OF YOUR OUT-OF-POCKET MAXIMUM BENEFITS.

BENEFITS AND SERVICES NOT INCLUDED FOR:
Orthodontic services, procedures or supplies not Dentally Necessary; services or procedures not prescribed or rendered by a dentist; services or supplies collectible under Worker's Compensation; services that are provided without cost; accidental injuries; injuries or diseases caused by war; cosmetic services; prescription drugs; local or block anesthesia when billed separately; experimental or investigational services; services provided by an immediate relative.

Guaranteed Renewable/Conditioned upon Residence in Arkansas
This Policy is guaranteed renewable so long as you reside in Arkansas. The Company may change the established premium rate, but only if the rate is changed for all policies of the same form number and premium classification.

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(ATTACH SCHEDULE OF BENEFITS)

NON-DISCRIMINATION NOTICE

NOTICE: Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex to include discrimination on the basis of sexual orientation and gender identify.

We provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in various formats (large print, audio, accessible electronic formats, other formats), and language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. **If you need these services, contact our Civil Rights Coordinator.**

If you believe that we have 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:

Civil Rights Coordinator
601 Gaines Street,
Little Rock, AR 72201
Phone: 1-844-662-2276; TDD: 1-844-662-2275

You can file a grievance in person, by mail, or by email. If you need help filing a grievance our 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
Phone: 1-800-368-1019; TDD: 1-800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

LANGUAGE ASSISTANCE NOTICE

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-844-662-2276.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-662-2276.

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 1-844-662-2276.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-662-2276

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-662-2276 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-662-2276.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-662-2276.

ملاحظة: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية مجانا. دعوة 1-844-662-2276 العدد.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-662-2276.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-662-2276.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-662-2276.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-662-2276.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-662-2276.

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。1-844-662-2276 まで、お電話にてご連絡ください。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-662-2276.

ملاحظة: إذا كنت تتحدث باللغة الفارسية، والخدمات اللغوية المقدمة مجانا بالنسبة لك. يرجى الاتصال 1-844-662-2276.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-662-2276.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-662-2276 पर कॉल करें।

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-662-2276.

انتباہ: آپ اردو بولتے ہیں تو، زبان کی مدد کی خدمات بلا معاوضہ دستیاب ہیں. کال کریں 1-844-662-2276

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-662-2276.

LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaaloḷọk 1-844-662-2276.

NOTICE OF PRIVACY PRACTICES

ARKANSAS BLUE CROSS AND BLUE SHIELD

THIS NOTICE DESCRIBES HOW CLAIMS OR MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, Arkansas Blue Cross and Blue Shield is required to protect the privacy of your protected health information. We also must give you this notice to tell you how we may use and release ("disclose") your protected health information held by us. Arkansas Blue Cross and Blue Shield is a business name of USAble Mutual Insurance Company.

Throughout this notice, we will use the name "Arkansas Blue Cross" as a shorthand reference for Arkansas Blue Cross and Blue Shield.

Arkansas Blue Cross must use and release your protected health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative)
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected, and
- Where required by law.

Arkansas Blue Cross has the right to use and release your protected health information to evaluate and process your health plan or health insurance claims, enroll and disenroll you and your dependents, and perform related business operations.

For example:

- We can use and disclose your protected health information to pay or deny your claims, to collect your premiums, or to share your benefit payment or status with other insurer(s).
- We can use and disclose your protected health information for regular healthcare operations. Members of our staff may use information in your personal health record to assess our efficiency and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of benefits and services we provide.
- We may disclose protected health information to your employer for health plan administration purposes, including healthcare operations of the health plan, if your employer arranges for your insurance or funds the health plan coverage and serves as plan administrator. If your employer meets the requirements outlined by the privacy law to ensure adequate separation between the employer and the health plan itself, we can disclose protected health information to the appropriate health plan administrative department of your employer to assist in obtaining coverage or processing a claim or to modify benefits, work to control overall plan costs, and improve service levels. This information may be provided to the appropriate health plan administrative department of your employer in the form of routine reporting or special requests.
- We may disclose to others who are contracted to provide services as business associates on our behalf. Some services are provided in our organization through contracts with others. Examples include pharmacy management programs, dental benefits, and a copy service we use when making copies of your health record. Our contracts require these business associates to appropriately protect your information in compliance with applicable privacy and security laws.
- Our health professionals and customer service staff, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. Examples of such releases of your protected health information could include your spouse calling to verify a claim was paid, or the amount paid on a claim, or an adult child inquiring about explanation of benefit forms received by an elderly parent who is ill or impaired and unable to address their own health insurance or health plan business.

Arkansas Blue Cross may use or give out your protected health information for the following purposes, under limited circumstances:

- To state and federal agencies that have the legal right to receive Arkansas Blue Cross data (such as to make sure we are making proper claims payments)
- For public health activities (such as reporting disease outbreaks)
- For government healthcare oversight activities (such as fraud and abuse investigations)
- For judicial and administrative proceedings (such as in response to a subpoena, law enforcement agency administrative request or other court order)
- For law enforcement purposes (such as providing limited information to locate a missing person or in response to any federal or state agency administrative request that is authorized by law)
- For research studies that meet all privacy law requirements (such as research related to the prevention of disease or disability)
- To avoid a serious and imminent threat to health or safety
- To contact you, either directly or through a business associate, using your postal or email addresses, telephone numbers or other personal information, regarding new or changed health plan benefits or new health benefits product offerings of Arkansas Blue Cross.
- To contact you, either directly or through a business associate, using your postal or email addresses, telephone numbers or other personal information, regarding health care providers participating in our networks, disease management, health education and health promotion, preventive care options, wellness programs, treatment or care coordination or case management activities of Arkansas Blue Cross.

By law, Arkansas Blue Cross must have your written permission (an "authorization") to use or release your protected health information for any purpose other than treatment, payment or healthcare operations or other limited exceptions outlined here or in the Privacy regulation or other applicable law. Once you have given your permission for us to release your protected health information you may take it back ("revoke") at any time by giving written notice to us, except if we have already acted based on your original permission. To the extent (if any) that we maintain or receive psychotherapy notes about you, most disclosures of these notes require your authorization. Also, to the extent (if any) that we use or disclose your information for our fundraising practices, we will provide you with the ability to opt out of future fundraising communications. In addition, most (but not all) uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of protected health information require your authorization.

Personal Health Record (PHR)

If you have a health benefit plan issued by Arkansas Blue Cross on or after October 1, 2007, you have a Personal Health Record (PHR). Your PHR contains a summary of claims submitted for services you received while you are or were covered by your health benefit plan, as well as non-claims data you choose to enter yourself. Your PHR will continue to exist, even if you discontinue coverage under your health benefit plan. You have access to your PHR through the Arkansas Blue Cross website. In addition, unless you limit access, your physician and other healthcare providers who provide you treatment have access to your PHR. Certain information that may exist in the claims records will not be made available to your physician and other healthcare providers automatically.

To protect your privacy, information about treatment for certain sensitive medical conditions, such as HIV/AIDS, sexually transmitted diseases, mental health, drug or alcohol abuse or family planning, will be viewable by you alone unless you choose to make this information available to the medical personnel who treat you. Similarly, non-claims data, such as your medical, family, and social history, will only appear in your PHR if you choose to enter it yourself. It is important to note that you have the option to prohibit access to your PHR completely, either by electronically selecting to prohibit access or by sending a written request to prohibit access to the Privacy Office at the address below.

Special Note on Genetic Information

We are prohibited by law from collecting or using genetic information for purposes of underwriting, setting premium, determining eligibility for benefits, or applying any pre-existing condition exclusion under an insurance policy or health plan. Genetic information means not only genetic tests that you have received, but also any genetic tests of your family members, or any manifestations of a disease or disorder among your family members. Except for pre- existing condition exclusions, we may obtain and use genetic information in making a payment or denial decision, or otherwise processing a claim for benefits under your health plan or insurance policy, to the extent that genetic information is relevant to the payment or denial decision or proper processing of your claim.

Your Rights Regarding Information About You

You have the right to:

- See and obtain a copy of your protected health information that is contained in a designated record set that was used to make decisions about you. This may include an electronic copy, in certain circumstances, if you make this request in writing.
- Have your protected health information amended if you believe that it is wrong, or if information is missing, and Arkansas Blue Cross agrees. If Arkansas Blue Cross disagrees, you may have a statement of your disagreement added to your protected health information.
- Receive a listing of those receiving your protected health information from Arkansas Blue Cross. The listing will not cover your protected health information that was released to you or your personal representative, or that was released for payment or healthcare operations, or that was released for law enforcement purposes.
- Ask Arkansas Blue Cross to communicate with you in a different manner or at a different place (for example, by sending your correspondence to a P.O. Box instead of your home address) if you are in danger of personal harm if the information is not kept confidential.
- Ask Arkansas Blue Cross to limit how your protected health information is used and released to pay your claims and perform healthcare operations. Please note that Arkansas Blue Cross may not be able to agree to your request.
- Get a separate paper copy of this notice.
- For purposes of obtaining our company's assistance with your application for coverage of associated subsidies through ARHOME (the federal Affordable Care Act Exchange), you have the right in so doing to request that we limit further collection, creation, disclosure, access, maintenance, storage, and use of your personally identifiable information.

Breach Notification

In the event of a breach of your health information, we will provide you notification of such a breach as required by law or where we otherwise deem such notification appropriate.

To Exercise Your Rights

If you would like to contact Arkansas Blue Cross for further information regarding this notice, or exercise any of the rights described in this notice, you may do so by contacting Customer Service at the following toll-free telephone numbers:

Arkansas Blue Cross **800-238-8379**

You also may access complete instructions and request forms from our companies' website:

arkansasbluecross.com

Changes to this Notice

We are required by law to abide by the terms of this notice. We reserve the right to change this notice and make the revised or changed notice effective for claims or medical information we already have about you as well as any future information we receive. When we make changes, we will notify you by sending a revised notice to the last known address we have for you or by alternative means allowed by law or regulation. We also will post a copy of the current notice on Arkansas Blue Cross website.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Arkansas Blue Cross by writing to the following address:

Privacy Office
ATTN: Privacy Officer
P.O. Box 3216
Little Rock, AR 72201
Telephone: 866-254-4001
Email: privacyofficeinquiries@arkbluecross.com

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must:

1. be in writing;
2. contain the name of the entity against which the complaint is lodged;
3. describe the relevant problems; and
4. be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or in any other way retaliate against you for filing a complaint with the Secretary or with us.

Last material revision 05/2013 **Last general revision 01/2023**

Y0083_22BM_PN_C

ARTICLE I. STATEMENT OF COVERAGE

A. This Policy contains the insurance benefits provided by Arkansas Blue Cross and Blue Shield, (the Company) to you and is subject to its terms. Payment for dental services will be made in accordance with this Policy; however, only services specifically listed herein for the individual listed on the Schedule of Benefits are covered.

B. This coverage is most effective and advantageous when the services of Dentists in the Preferred Provider Organization (PPO Dentist) are used.

C. PPO Dentists and Contracting Dentists are paid directly by the Company and have agreed to accept the Company's payment for Covered Services as payment in full except for your Deductible and Coinsurance, if applicable. You are responsible for your Deductible and Coinsurance, if applicable, and any charges beyond the policy payment when you receive services from a Non-Contracting Dentist. The determination of whether a Dentist is a PPO Dentist, Contracting Dentist, or Non-Contracting Dentist is the responsibility of the Company. The Company can provide a list of PPO Dentists and Contracting Dentist, or you may also access our website at WWW.ARKANSASBLUECROSS.COM. You should always ask your chosen provider if he/she participates. We also recommend that you take this Policy with you to your provider's office.

D. The decision about whether to use a PPO Dentist or Contracting Dentist is the sole responsibility of the Covered Person. Neither PPO Dentists nor Contracting Dentists are employees or agents of the Company. The Company makes no representations or guarantees regarding the qualification or experience of any dentist with respect to any service. The evaluation of such factors and the decision about whether to use any dentist is the sole responsibility of the Covered Person.

E. The effective date of your coverage is indicated in the Schedule of Benefits.

F. Continuance of coverage under this Certificate shall be contingent upon receipt of premiums remitted in advance by the Policyholder.

G. Under this Policy, notice is effectively delivered when it is mailed to your most recent address as recorded in our records.

H. The Company reserves the right to amend the premiums required for this Policy. If we do so, we will give thirty (30) days' written notice to the Policyholder and the change will go into effect on the date indicated in the notice.

I. No agent or employee of the Company may change or modify any benefit, term, condition, limitation, or exclusion of this document. Any change or amendment must be in writing and signed by an Officer of the Company.

ARTICLE II. DEFINITIONS

A. Charge, when used in connection with dental services or supplies covered in this contract, will be the amount deemed by the Company to be reasonable. An amount equaling the lesser of the charge billed by the dentist or the Arkansas Blue Cross and Blue Shield allowance is the basic Charge. However, this Charge may vary, given the facts of the case and the opinion of the Company's Dental Advisor.

B. Child means the Policyholder's natural Child, legally adopted Child or Stepchild. "Child" also means a Child that has been placed with the Policyholder for adoption. "Child" also means a Child for whom the Policyholder must provide medical support under a qualified medical Child support order or for whom the Policyholder has been appointed the legal guardian.

C. Coinsurance means the obligation of a Covered Person to pay a certain portion of a Charge. Coinsurance is expressed as a percentage in the Schedule of Benefits. The Schedule of Benefits sets forth the Coinsurance for Covered Services received from a PPO Dentist or a Contracting Dentist (In-Network) and the Coinsurance for Covered Services from a Non-PPO Dentist (Out-of-Network).

D. Company means Arkansas Blue Cross and Blue Shield.

E. Contracting Dentist means a dentist who has signed a contract with the Company to provide Covered Services. The Company will pay a Contracting Dentist directly. Covered Services provided by a Contracting Dentist are subject to the In-Network Coinsurance as specified in the Schedule of Benefits.

F. Cosmetic Treatment means a procedure which is not Dentally Necessary, and which is undertaken primarily, in the opinion of the Company, to improve or otherwise modify the Covered Person's appearance.

G. Covered Person means the Policyholder, Individual Insured under a "Child Only" Policy or Dependent who is insured under this Policy.

H. Covered Services mean a service or supply specified in this Policy or specifically approved by the Company for which the Company will reimburse charges.

I. Date of Service is the date that treatment is completed.

J. Deductible means the amount shown in the Schedule of Benefits that must be paid by the Covered Person before the Company will assume liability, if applicable.

K. Dental Advisor is a dentist, group of dentists, or another qualified person or persons utilized by the Company to review claims for treatment.

L. Dentally Necessary means a dental service or procedure required to establish or maintain a patient's dental health. The determination as to when a dental service is necessary shall be governed in accordance with guidelines established by the Company. In the event of a conflict of opinion between the treating dentist and the Company as to if a dental service or procedure is Dentally Necessary, the opinion of the Company shall be final.

M. Dental Xtra is a program that provides additional dental benefits for Covered Persons with certain conditions such as diabetes, coronary artery disease, stroke, Sjögren's syndrome, oral cancer, head & neck cancers, pregnancy, chronic obstructive pulmonary disease (COPD), end-stage renal disease (ESRD), and metabolic syndrome (MetS). (See Article IV. F.)

N. Essential Health Benefit Plan ("EHP") means a Qualified Health Benefit Plan or a health benefit plan meeting the certification requirements of a Qualified Health Plan but is offered off the Exchange.

O. Exchange means a governmental agency or non-profit entity, which meets the applicable standards of the federal Affordable Care Act of 2010 and implementing rules, that makes Qualified Health Plans available to Qualified Individuals.

P. Integral Service means a service or procedure that is considered part of another procedure. No additional allowances are given for Integral Services.

Q. In-Network Out-of-Pocket Maximum means each calendar year; a Covered Person must pay the In-Network Coinsurance for covered services up to the In-Network Out-of-Pocket Maximum specified in the Schedule of Benefits. If the Plan provides family coverage, any number of Covered Persons in the family must collectively pay the cost of covered services equal to the In-Network Out-of-Pocket Maximum specified in the Schedule of Benefits. For example, if the Plan covers one Covered Person, the In-Network Out-of-Pocket Maximum will be satisfied when In-Network Coinsurance payments for that Covered Person equal $400. If the Plan covers more than one Covered Person, the In-Network Out-of-Pocket Maximum will be satisfied when In-Network Coinsurance payments for all Covered Persons equal $800. After such payments are made, no further In-Network Coinsurance will be required for the balance of the calendar year, regardless of which Covered Person incurs a claim.

R. Non-Diseased Tooth is a tooth that is whole or properly restored and is free of decay and/or periodontal conditions.

S. Non-Contracting Dentist means a dentist who does not have a contract with the Company to provide Covered Services. Covered Services provided by a Non-Contracting Dentist are subject to the Out-of-Network Coinsurance as specified in the Schedule of Benefits. Non-Contracting Dentists are free to bill you charges for Covered Services which are in excess of the Company's payment.

T. Member means the Policyholder (See Article W.)

U. Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a Child by a person with whom the Child has been placed in anticipation of the Child's adoption. The Child's Placement for adoption with such person terminates upon the termination of such legal obligation.

V. Policy means this document, your Schedule of Benefits, the application and any amendments or endorsements signed by an Officer of the Company.

W. Policyholder means the person with whom the Company has agreed to provide coverage and whose name appears on the Schedule of Benefits. Policyholder also means Covered Person.

X. PPO Dentist means a Contracting Dentist who has agreed to participate in the Preferred Provider Organization and meets all applicable credentialing and contractual standards associated with the Preferred Provider Organization. The Company will pay a PPO Dentist directly. Covered Services

provided by a PPO Dentist are subject to the In-Network Coinsurance as specified in the Schedule of Benefits.

Y. Preferred Provider Organization (PPO) means a panel of dentists who have agreed to accept reimbursement for their services covered under this Plan at reduced charges.

Z. Qualified Health Plan or QHP means a health plan that has in effect a certification issued by the Exchange.

AA. Qualified Individual means an individual enrolled through the Exchange and determined by the Exchange to be a citizen or national of the United States or an alien lawfully present in the United States residing in the service area of the Exchange and is current on his or her premiums.

AB. The masculine gender when used herein shall include the feminine gender.

AC. Treatment Plan means a written report of a series of procedures recommended for the treatment of a specific dental problem, prepared by the dentist as a result of an examination of the Covered Person.

AD. We, Our and Us means the Company, Arkansas Blue Cross and Blue Shield.

AE. You and Your means a Covered Person.

ARTICLE III. ELIGIBILITY STANDARDS

Even if a service you receive would be covered under the other coverage standards set out in this Policy, you must be eligible under the Policy and the Policy must be in force at the time you receive such service in order to receive benefits. This section sets out the standards for eligibility under the Policy, Subsection A, and the provisions governing termination of coverage under this Policy, Subsection B.

A. **Eligibility for Coverage.** In order to be covered by the Policy, you must meet the eligibility requirements for a Policyholder, an individual insured under a "Child Only" Policy or the Policyholder's Dependent.

1. **Policyholder Eligibility.** An eligible Policyholder is a Covered Person under an Essential Health Benefit Plan ("EHP") and is:
   a. a Qualified Individual; enrolled through the Exchange and current on all premiums or
   b. an individual who resides in the State of Arkansas and who completed and submitted to the Company an application for coverage.
2. **Individual Insured under a "Child Only" Policy** is a Covered Person under an Essential Health Benefit Plan ("EHP") and is an individual under the age of 19, who resides in the State of Arkansas and whose parent or legal guardian has completed and submitted to the Company an application for coverage.
3. **Dependent** is a Covered Person under an Essential Health Benefit Plan ("EHP") and is a Spouse or Child of the Policyholder.

B. **Term, Renewal and Termination of the Policy.** This Policy shall be in effect until terminated by its terms.

1. **At the Option of the Policyholder.** The Policyholder may terminate this Policy at his or her option on the date the Policyholder specifies by giving the Company at least fourteen (14) days' notice.
2. **Termination by the Exchange**. If the Policyholder is a Qualified Individual, his or her coverage may be terminated on a date specified by the Exchange.
3. **Death of Policyholder.** This Policy shall terminate upon the death of the Policyholder. In such event, the Company shall return all unearned premiums beyond the Policy Month in which the death occurred to your estate or other appropriate party. Contact Customer Service to set up a new Policy for family Covered Persons currently covered on this Policy.
4. **Change of Residence.** If the Policyholder moves permanently to another state, this Policy shall terminate at the end of the period for which premiums have been paid.
   a. A Policyholder moving to another state can obtain insurance coverage from the Blue Cross and Blue Shield Plan located in the new state of residence by requesting a transfer of coverage authorization from the Company. The rates and benefits of the policy issued in the new state of residence may be substantially different.
   b. To obtain a transfer of coverage authorization, contact our Customer Service, Attention Transfer Representative.

5. **Guaranteed Renewable, Premiums May Change.** Unless you change residence from Arkansas (See ARTICLE III, B. 4.), this Policy and any amendments or riders to it are guaranteed renewable. This means that the Policy shall remain in force, so long as the Policyholder complies with its terms and so long as the premiums are paid in a timely manner. Your premium rate may change upon renewal if your age increases, if you relocate into a different rating area or the Company changes the established premium rate for all policies and riders of the same form number and premium classification as this Policy.

6. **Payment of Premiums.** Premium payment due dates are the first day of the month. The premium payment mode is monthly. Premium payments are due in advance of the premium due date regardless of the premium payment mode selected, subject to the Grace Period provision below. "Pay," "Paid" or "Payment," when used herein reference to premium, premium due dates or the Grace Period shall mean that the full amount of all funds due are actually received by the Company at its principal offices in Little Rock, Arkansas. Placing a check into the U.S. mail or with any courier service shall not constitute payment under this Policy unless or until the check is actually received by the Company at its principal office. Nor shall any invalid or dishonored check constitute payment.

7. **Grace Period.**

   a. For a Policyholder who is a Qualified Individual receiving advance payments of premium tax credits, a grace period of three consecutive months will be granted for the payment of premiums becoming payable after the first premium payment. During the grace period the Policy shall continue in force. The Company shall pay appropriate claims for services rendered during the first month of the grace period and shall suspend payment of claims for services rendered during the second and third month of the grace period. If all outstanding premiums are not paid within the three-month period after they become due and payable, this Policy shall terminate as of the last day of the first month of the grace period.

   b. For a Policyholder who is not a Qualified Individual receiving advance payments of premium tax credits, a grace period of thirty-one (31) days will be granted for the payment of premiums becoming payable after the first premium payment. During the grace period the Policy shall continue in force. If premiums are not paid within thirty-one (31) days after they become due and payable, this Policy shall terminate as of the date on which the premiums were due and payable.

8. **Reinstatement**. If any renewal premium is not paid within the grace period, a subsequent acceptance of premium by the Company or by any agent authorized by the Company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if the Company or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by the Company or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the Company has previously notified the Covered Person in writing of its disapproval of such application. In all other respects, the Covered Person and Company shall have the same rights hereunder as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed 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.

9. **Termination of a Covered Person's Coverage For Cause.**

   a. The Company may terminate coverage under this Policy upon thirty (30) days' written notice for:

      (1) concealment of information, misrepresentation (whether intentional or not, subject to the provision entitled "Time Limit on Certain Defenses," See ARTICLE IX, B.) or fraud in obtaining coverage; or

      (2) concealment of information, misrepresentation (whether intentional or not) or fraud in the filing of a claim for services, supplies, or in the use of services or facilities.

   b. For purposes of this termination for cause provision, concealment of information or a

misrepresentation occurs if (i) information is withheld or if incorrect information is provided and (ii) the Company would not have issued this Policy, would have charged a higher premium, would have required the Policy to be amended, or would not have paid a claim in the manner it was paid had the Company known the facts concealed or misrepresented.

c. Termination for cause shall be effective upon the later of (i) thirty (30) days after a written notice of termination for cause is posted in the U.S. Mail, addressed to the Policyholder at his or her last known address as provided by Policyholder to Company; or (ii) the date stated in the termination notice letter to Policyholder.

d. A Covered Person may appeal a termination for cause action. Such an appeal must be submitted in writing, addressed to the Appeals Coordinator of Arkansas Blue Cross and Blue Shield, 601 S. Gaines Street, Little Rock, Arkansas 72203. In order for the appeal to be considered the Appeals Coordinator must receive the appeal prior to the later of (i) thirty (30) days after a written notice of termination for cause is posted in the U.S. Mail, addressed to the Policyholder at his or her last known address as provided by Policyholder to Company; or (ii) the termination effective date stated in the termination notice letter to Policyholder.

10. **Termination of Benefits.** Upon termination of this Policy all benefits, except for Covered Services that were incurred prior to termination, shall cease.

ARTICLE IV. COVERED SERVICES

A. **Payment for Covered Services.** Payment for dental services will be made in accordance with this Policy. Such payments are subject to Deductible and Coinsurance, if applicable, and Limitations specified in this Policy. Only Covered Persons under the age of nineteen (19) years are eligible for benefits under this Policy. No other Covered Persons are eligible for benefit payment under this Policy.

B. **PPO Dentists and Contracting Dentists.** PPO Dentists and Contracting Dentists have agreed to accept the Charge as payment in full for Covered Services except for the Deductible and In-Network Coinsurance if applicable. Covered Services performed by a PPO Dentist or Contracting Dentist are subject to the In-Network Coinsurance percentage of the Charge for the Covered Service stated in the Schedule of Benefits. The Covered Person is responsible for the payment of the applicable Deductible and In-Network Coinsurance as stated in the Schedule of Benefits.

C. **Non-Contracting Dentists.** Covered Services performed by a Non-Contracting Dentist are subject to the Out-of-Network Coinsurance percentage of the Charge for the Covered Service stated in the Schedule of Benefits. When Covered Services are performed by a Non-Contracting Dentist, the Company will pay contract benefits directly to the Policyholder. Any difference between the Non-Contracting Dentist's billed charge and the contract benefits paid by the Company shall be the responsibility of the Covered Person.

D. **Treatment Plan/Predetermination/Prior Authorization**

1. The Company requires a Treatment Plan for services for which the dentist expects to bill $300.00 or more. When a Treatment Plan is required, the dentist must submit such Treatment Plan to the Company for predetermination prior to the performance by the dentist for any Covered Service. Substantiating material such as radiographic images and periodontal charting must be submitted with the Treatment Plan when requested by the Company.

2. If a Treatment Plan or substantiating material requested by the Company is not submitted, the Company reserves the right to determine benefits payable taking into account alternate procedures, services or courses of treatment, based on accepted standards of dental practice. Any amount, predetermined by the Company, shall be subject to adjustments by the Company at the time of final payment as may be necessary to correct any mathematical errors and to comply with the Policy in effect at the time the Covered Service is provided.

3. The Company shall not be liable under this Policy for any Covered Services, including those Covered Services predetermined by the Company, which are performed at a time the Covered Person's coverage is no longer in effect.

4. Prior Authorization is required for services indicated by an asterisk (*) listed in Service Categories B and C for Covered Persons through age 18. Claims for services performed which required Prior Authorization, yet did not appropriately receive Prior Authorization, will be denied.

E. **Alternate Treatment**

Frequently, several alternate methods exist to treat a dental condition. For example, a tooth can be restored with a crown or a filling. The Company will make payment based upon the Charge for the less expensive procedure if such less expensive procedure meets accepted standards of dental treatment as determined by the Company. The Company's decision does not commit the Covered Person to the less expensive procedure. However, if the Covered Person and the dentist choose the more expensive procedure, the Covered Person is responsible for the additional charges beyond those paid or allowed by the Company.

Examples:

1. If a crown is placed on a tooth when a filling would meet accepted standards of care, the amount normally reimbursed for a filling will be paid to the dentist or the Covered Person. The Covered Person is responsible for the difference in cost.
2. If precious metal (gold, etc.) is used for a partial denture rather than a non-precious metal or other suitable substitute, the amount normally paid for the non-precious metal or less expensive substitute will be reimbursed to the dentist or Covered Person. The Covered Person is responsible for the difference in cost.

F. **Dental Xtra.** Dental Xtra is a program that provides additional dental benefits for Covered Persons with one or more of the following conditions: diabetes, coronary artery disease, stroke, Sjögren's syndrome, oral cancer, head & neck cancers, pregnancy, chronic pulmonary disease (COPD), end-stage renal disease (ESRD), and metabolic syndrome (MetS). For Covered Persons with oral cancer, these benefits are available when there has been a previous diagnosis of oral cancer. For pregnancy, enrollment in the Dental Xtra program terminates on the reported expected delivery date, which is provided at time of enrollment. Covered Services are not subject to the deductible. Coinsurance does not apply for covered services, when billed by a PPO Dentist or Contracting Dentist. Covered services billed by a Non-Contracting Dentist, are subject to coinsurance as listed in the Schedule of Benefits. To receive benefits under Dental Xtra, you must qualify and be enrolled into the program. For more information about enrollment and the benefits for Dental Xtra, you may access our website at www.arkansasdentalblue.com.

Dental Xtra	Prophylaxis (Cleanings) (D1110 and D1120) or Periodontal Maintenance (D4910) Visit Every 3-Months	Periodontal Scaling or Scaling in presence of gingival inflammation (D4341, D4342, D4346) Every 24-Months	Periodic Oral Examination (D0120) 4 Every 12-Months	Fluoride Treatment (D1206 and D1208) Every 3-Months	Full Mouth Debridement to enable a comprehensive oral evaluation and diagnosis on subsequent visit (D4355) Every 24-Months
Diabetes	X	X			X
Coronary Artery Disease	X	X			X
Stroke	X	X			X
Pregnancy	X	X			X
Oral Cancer*	X		X	X	X
Sjögren's Syndrome *	X		X	X	X
Head & Neck Cancers*	X		X	X	X
Chronic Obstructive Pulmonary Disease (COPD)	X	X			X
End-Stage Renal Disease (ESRD)	X	X			X
Metabolic Syndrome (MetS)	X	X			X
*This benefit is available for members who have previously been diagnosed with oral cancer, head & neck cancers, or for members diagnosed with Sjögren's Syndrome.					

G. **Diagnostic and Preventive Services (Service Category A.)** The following American Dental Association CDT-4 Codes and their descriptions are Covered Services as listed in the Schedule of Benefits under the Diagnostic and Preventive Services Category. Services performed in this category are subject to the Deductible and are paid at the Coinsurance percentage set out in the Schedule of Benefits.

Service Category	*Proc Code*	*Description*
A	D0120	PERIODIC ORAL EXAMINATION
A	D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED
A	D0145	ORAL EVALUATION FOR A PATIENT UNDER THE AGE OF 3, PAID AS D0120
A	D0150	COMPREHENSIVE ORAL EXAMINATION
A	D0210	INTRAORAL - COMPLETE SERIES OF RADIOGRAPHIC IMAGES
A	D0220	INTRAORAL - PERIAPICAL-FIRST RADIOGRAPHIC IMAGE
A	D0230	INTRAORAL - PERIAPICAL-EACH ADDITIONAL RADIOGRAPHIC IMAGE
A	D0240	OCCLUSAL RADIOGRAPHIC IMAGE
A	D0250	EXTRA-ORAL – 2D PROJECTION RADIOGRAPHIC IMAGE CREATED USING A STATIONARY RADIATION SOURCE, AND DETECTOR
A	D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES
A	D0330	PANORAMIC RADIOGRAPHIC IMAGE
A	D0350	2D ORAL/FACIAL PHOTOGRAPHIC IMAGE OBTAINED INTRA-ORALLY OR EXTRA-ORALLY
A	D0396	3D PRINTING OF A 3D DENTAL SURFACE SCAN
A	D0470	DIAGNOSTIC CASTS
A	D1110	PROPHYLAXIS - ADULTS
A	D1120	PROPHYLAXIS - CHILD
A	D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH
A	D1208	TOPICAL APPLICATION OF FLUORIDE – EXCLUDING VARNISH
A	D1320	TOBACCO COUNSELING
A	D1351	SEALANT - PER TOOTH
A	D1353	SEALANT REPAIR – PER TOOTH
A	D1354	APPLICATION OF CARIES ARRESTING MEDICAMENT – PER TOOTH
A	D1510	SPACE MAINTAINER - FIXED UNILATERAL
A	D1516	SPACE MAINTAINER – FIXED – BILATERAL, MAXILLARY
A	D1517	SPACE MAINTAINER – FIXED – BILATERAL, MANDIBULAR
A	D1526	SPACE MAINTAINER – REMOVABLE – BILATERAL, MAXILLARY
A	D1527	SPACE MAINTAINER – REMOVABLE – BILATERAL, MNDIBULAR
A	D1551	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER – MAXILLARY
A	D1552	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER – MANDIBULAR
A	D1553	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER – PER QUADRANT
A	D1556	REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER – PER QUADRANT
A	D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER – MAXILLARY
A	D1558	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER – MANDIBULAR
A	D1575	DISTAL SHOE SPACE MAINTAINER – FIXED- UNILATERAL
A	D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN – MINOR PROCEDURES
A	D9920	BEHAVIOR MANAGEMENT

H. **Special Limitations for Diagnostic and Preventive Services (Service Category A.)**

1. One (1) in a calendar year:
   Limited evaluation, problem focused, (D0140), one per patient per dentist.
2. Two (2) in a calendar year:
   a. Routine exams (D0120, D0145)
   b. Bitewings radiographic images, one occurrence of two bitewings (D0272).
   c. Routine prophylaxis (D1110, D1120)
   d. Fluoride treatment for dependent children through age 18 (D1206, D1208). (NOTE: for members enrolled in Dental Xtra (see IV.F. above) fluoride treatment is not limited to members through age 18.)
3. One (1) in a five-year period:
   Full mouth radiographic images (D0210 & D0330).
4. One (1) in a 24-month period:
   Comprehensive evaluations (D0150) limited to one per patient per dentist. Additional comprehensive evaluations during the 24-month period will be processed as periodic evaluations (D0120).
5. One (1) in a lifetime:
   Sealants (D1351) - permanent first and second molars only.

I. **Minor (Basic) Restorative Services (Service Category B.)** The following American Dental Association CDT-4 Codes are covered under the Minor (Basic) Restorative Services Category as listed in the Schedule of Benefits. Services performed in this category are subject to the Deductible and are paid at the Coinsurance percentage listed in the Schedule of Benefits.

(- Indicates that Prior Authorization is required.)*

Service Category	***Proc Code***	***Description***
B	D2140	AMALGAM - ONE SURFACE, PRIMARY OR PERMANENT
B	D2150	AMALGAM - TWO SURFACES, PRIMARY OR PERMANENT
B	D2160	AMALGAM - THREE SURFACES, PRIMARY OR PERMANENT
B	D2161	AMALGAM - FOUR OR MORE SURFACES, PRIMARY OR PERMANENT
B	D2330	RESIN - ONE SURFACE, ANTERIOR
B	D2331	RESIN - TWO SURFACES, ANTERIOR
B	D2332	RESIN - THREE SURFACES, ANTERIOR
B	D2335	RESIN - FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)
B	D2391	RESIN - BASED COMPOSITE - ONE SURFACE, POSTERIOR PAID AS D2140
B	D2392	RESIN - BASED COMPOSITE - TWO SURFACES, POSTERIOR PAID AS D2150
B	D2393	RESIN - BASED COMPOSITE - THREE SURFACES, POSTERIOR PAID AS D2160
B	D2394	RESIN - BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR PAID AS D2161
B	D2920	RE-CEMENT OR RE-BOND CROWN
B	D2930	PREFABRICATED STAINLESS CROWN - PRIMARY TOOTH
B	D2931	PREFABRICATED STAINLESS CROWN - PERMANENT TOOTH
B	D2980	CROWN REPAIR - NECESSITATED BY RESTORATIVE MATERIAL FAILURE
B	D3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION)

Service Category	*Proc Code*		*Description*
B	D3221		PULPAL DEBRIDEMENT, PRIMARY AND PERMANENT TOOTH
B	D3310		ROOT CANAL THERAPY - ANTERIOR (EXCLUDING FINAL RESTORATION)
B	D3320		ROOT CANAL THERAPY - BICUSPID (EXCLUDING FINAL RESTORATION)
B	D3330		ROOT CANAL THERAPY - MOLAR (EXCLUDING FINAL RESTORATION)
B	D3410	*	APICOECTOMY - ANTERIOR
B	D4341		PERIODONTAL SCALING AND ROOT PLANING - PER QUADRANT
B	D4342		PERIODONTAL SCALING AND ROOT PLANING – ONE TO THREE TEETH, PER QUADRANT
B	D4346		SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVER GINGIVAL INFLAMMATION – FULL MOUTH, AFTER ORAL EVALUATON
B	D4355		FULL MOUTH DEBRIDEMENT TO ENABLE A COMPRESHENSIVE ORAL EVALUATON AND DIAGNOSIS ON A SUBSEQUENT VISIT
B	D4910		PERIODONTAL MAINTENANCE PROCEDURES (FOLLOWING ACTIVE THERAPY)
B	D5511		REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR
B	D5512		REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY
B	D5611		REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR
B	D5612		REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY
B	D5621		REPAIR CAST PARTIAL FRAMEWORK, MANDIBULAR
B	D5622		REPAIR CAST PARTIAL FRAMEWORK, MAXILLARY
B	D5640		REPLACE BROKEN TEETH - PER TOOTH
B	D6930		RE-CEMENT OR RE-BOND FIXED PARITAL DENTURE
B	D6980		FIXED PARTIAL DENTURE REPAIR
B	D7111		CORONAL REMNANTS - DECIDUOUS TOOTH
B	D7140		EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT
B	D7210		SURGICAL REMOVAL OF ERUPTED TOOTH
B	D7220		REMOVAL OF IMPACTED TOOTH - SOFT TISSUE
B	D7230		REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY
B	D7240		REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY
B	D7241	*	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY WITH COMPLICATIONS
B	D7250		SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS - CUTTING PROCEDURES
B	D7280		SURGICAL ACCESS TO AN UNERUPTED TOOTH
B	D7285		INCISIONAL BIOPSY OF ORAL TISSUE - HARD (BONE, TOOTH)
B	D7286		INCISIONAL BIOPSY OF ORAL TISSUE – SOFT
B	D7321		ALVEOPLASTY NOT WITH EXTRACTIONS
B	D7510		INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE
B	D7560		MAXILLARY SINUSOTOMY FOR REMOVAL OF TOOTH FRAGMENT OR FOREIGN BODY
B	D7961		BUCCAL/LABIAL FRENECTOMY (FREMULECTOMY)

Service Category	*Proc Code*	*Description*
B	D7962	LINGUAL FRENECTOMY (FRENULECTOMY)
B	D9222	DEEP SEDATION/GENERAL ANESTHESIA – FIRST 15 MINUTES
B	D9223	DEEP SEDATION/GENERAL ANESTHESIA – EACH SUBSEQUENT 15 MINUTE INCREMENT
B	D9230	INHALATION OF NITROUS OXIDE
B	D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - FIRST 15 MINUTES
B	D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH SUBSEQUENT 15 MINUTE INCREMENT
B	D9248	NON-INTRAVENOUS CONSCIOUS SEDATION
B	D9310	CONSULTATION - FOR SPECIALIST ENROLLED IN MEDICAID PROGRAM
B	D9910	APPLICATION OF DESENSITIZING MEDICAMENT

J. **Special Limitations for Minor (Basic) Restorative Services (Service Category B.).**

1. One (1) in a twelve-month period:
   One restoration per surface on all teeth.
2. One (1) per tooth per lifetime:
   a. Stainless-steel crowns (D2930, D2931) - under age 14.
   b. Root canal therapy (D3310, D3320, D3330), no allowance for additional canals.
3. Two (2) per calendar year, (D9310) – consultation-diagnostic service provided by dentist or physician other than requesting dentist or physician.
4. One (1) in a 24-month period:
   a. Periodontal scaling and root planing (D4341, D4342 & D4346).
   b. Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit (D4355).

K. **Major Restorative Services (Service Category C.)** The following American Dental Association CDT-4 Codes are covered under the Major Restorative Services Category as listed in the Schedule of Benefits. Services performed in this category are subject to Deductible and are paid at the Coinsurance percentage set out in the Schedule of Benefits.

(- Indicates that Prior Authorization is required.)*

Service Category	*Proc Code*		*Description*
C	D2710	*	CROWN - RESIN-BASED COMPOSITE (INDIRECT)
C	D2750	*	CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL - APPLIES ONLY FOR ANTERIOR INCISORS AND CUSPIDS
C	D2751	*	CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL - APPLIES ONLY FOR ANTERIOR INCISORS AND CUSPIDS
C	D2752	*	CROWN - PORCELAIN FUSED TO NOBLE METAL- APPLIES ONLY FOR ANTERIOR INCISORS AND CUSPIDS
C	D2753	*	CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS
C	D4210	*	GINGIVECTOMY/GINGIVOPLASTY - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT
C	D4211	*	GINGIVECTOMY/GINGIVOPLASTY- ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT

Service Category	*Proc Code*		*Description*
C	D4212	*	GINGIVECTOMY/GINGIVOPLASTY- TO ALLOW ACCESS FOR RESTORATIVE PROCEDURE - PER TOOTH
C	D4240	*	GINGIVAL FLAP, INCLUDING ROOT PLANING - PER QUADRANT
C	D4241	*	GINGIVAL FLAP, INCLUDING ROOT PLANING - ONE TO THREE TEETH, PER QUADRANT
C	D4249	*	CLINICAL CROWN LENGTHENING - HARD TISSUE
C	D4260	*	OSSEOUS SURGERY (INCLUDING ELEVATION OF FULL THICKNESS FLAP & CLOSURE - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT)
C	D4261	*	OSSEOUS SURGERY (INCLUDING ELEVATION OF FULL THICKNESS FLAP & CLOSURE- ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT)
C	D4263	*	BONE REPLACEMENT GRAFT - SINGLE SITE
C	D4264	*	BONE REPLACEMENT GRAFT - EACH ADDITIONAL SITE IN QUADRANT
C	D4266	*	GUIDED TISSUE REGENERATION - RESORBABLE BARRIER PER SITE PER TOOTH
C	D4267	*	GUIDED TISSUE REGENERATION - NONRESORBABLE BARRIER PER SITE PER TOOTH
C	D4270	*	PEDICLE SOFT TISSUE GRAFT PROCEDURE
C	D4273	*	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE-(INCLUDING DONOR AND RECIPIENT SURGICAL SITES) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT
C	D4275	*	NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT (INCLUDING RECIPIENT SITE AND DONOR MATERIAL) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT
C	D4276	*	COMBINED CONNECTIVE TISSUE AND DOUBLE PEDICLE GRAFT
C	D4277	*	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT AND DONOR SURGICAL SITES) - FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT
C	D4283	*	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURGICAL SITES) – EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE
C	D4285	*	NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT SURGICAL SITE AND DONOR MATERIAL) – EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE
C	D5110	*	COMPLETE DENTURE – UPPER
C	D5120	*	COMPLETE DENTURE – LOWER
C	D5211	*	MAXILLARY PARTIAL DENTURE - RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH)
C	D5212	*	MANDIBULAR PARTIAL DENTURE - RESIN BASE (INCLUDING RETENTIVE/CLASING MATERIALS, RESTS, AND TEETH)
C	D5221	*	IMMEDIATE MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

Service Category	*Proc Code*		*Description*
C	D5222	*	IMMEDIATE MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)
C	D5223	*	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)
C	D5224	*	IMMEDIATE MANDIBULAR PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)
C	D5650		ADD TOOTH TO EXISTING PARTIAL DENTURE

L. **Special Limitations for Major Restorative Services (Service Category C.)**

1. One (1) per tooth per lifetime:
   a. Crown lengthening (D4249), only covered when bone is removed.
   b. Guided tissue regeneration (D4266) is allowed once per site (two adjacent teeth).
2. One (1) in a five-year period:
   a. Single crowns, only if treatment is for decay purposes or a broken tooth. This does not include fracture-line repair in teeth. Crowns are not covered for patients under age 14 unless rationale is provided and approved by a Dental Advisor.
   b. Removable prosthetics, including complete and partial dentures.

ARTICLE V. SPECIFIC BENEFIT LIMITATIONS

The following services will be subject to the limitations set forth below:

A. Integral Services

These services are considered part of another service. No additional allowance will be paid if billed as a separate service.

1. Supragingival scaling is Integral to a prophylaxis.
2. Prophylaxis on the same day as a periodontal maintenance visit (D4910) or periodontal treatment, including surgery.
3. Prophylaxis on the same day as scaling and root planing (D4341, D4342, & D4346), regardless of the number of quadrants or teeth reported.
4. Periapical radiographic images taken on the same day as a panorex (D0330).
5. Periapical radiographic images and/or bitewings taken on the same day as a full series (D0210).
6. Intraoral I&D (D7510) with root canal therapy.
7. Diagnostic radiographic images taken the same day as the initial root canal therapy is covered. Any other radiographic images 30 days before or after root canal therapy are Integral.
8. Pulpotomies, in conjunction with root canal therapy by the same dentist within 45 days prior to root canal therapy completion date, are Integral to root canal therapy.
9. Pulpotomy on the same date as deciduous root canal therapy.
10. Payment is made for the most extensive periodontal surgical procedure that includes any lesser procedures on the same date. If procedures are fragmented, the lesser procedures will be denied as Integral.
11. Scaling and root planing on the same date as surgical periodontal procedures.
12. Periodontal maintenance when reported with scaling and root planing on the same date regardless of the number of quadrants or teeth reported.
13. Periodontal maintenance on the same day and same dentist as surgical periodontal procedures.
14. Complete or partial denture adjustments within six-months of insertion.
15. Frenulectomy (D7961 and D7962) when provided the same date, same dentist, same area of the mouth is Integral to soft tissue grafts.

16. Small cysts are denied as being Integral to extractions and surgical procedures in the same area of the mouth by the same dentist.
17. Crown lengthening on the same day by same dentist and same area as osseous surgery. The osseous surgery will be denied as being Integral to the crown lengthening.
18. Palliative emergency treatment is denied as being Integral to definitive treatment when provided on the same day.
19. Isolation of tooth with rubber dam.
20. Local and block anesthesia.
21. Gingival irrigation – per quadrant (D4921) is integral to any perio service.
22. Immunization counseling (D1301).

B. The following services are specifically limited with the following conditions:

1. Sealants (D1351) are covered on permanent first and second molars; and are limited to one sealant per lifetime. Sealant repairs (D1353) are integral within twelve-months of placement by the same dentist.
2. If the allowance for the combination of multiple periapicals, bitewings or full series of radiographic images exceeds the allowance for a full series they will be combined to a full series.
3. Intraoral incision and drain without root canal therapy is processed as a palliative treatment. On an inquiry basis, the I&D is allowed if it was the only treatment required.
4. Four quadrants of osseous surgery reported on the same date will require a Dental Advisor review.
5. Periodontal scaling without root planing will process as a routine prophylaxis or periodontal maintenance treatment.
6. Payment for periodontal maintenance does not include an evaluation.

   If an evaluation is reported it will be processed as a separate procedure. We will decrease the allowance for (D4910) by the current allowance for existing code (D0120).
7. Separate restorations may be allowed on same surface for anterior teeth. Separate lines represent separate restorations. Procedures related to a restoration are not paid as separate, including repairs/replacements for twelve-months.
8. Multiple posterior restorations are paid as one multi-surface restoration when provided on the same day by the same dentist regardless of being reported as separate restorations.
9. Apicoectomies, in absence of root canal therapy, are denied unless the canals are calcified. Apicoectomy is not allowed within 30 days of root canal therapy.
10. Pulpotomies are covered only on deciduous teeth.
11. Periodontal maintenance (D4910) is covered if:
    a. prior approved
    b. the patient has periodontal coverage
    c. it follows active periodontal treatment
    d. a routine prophylaxis has not been allowed on the same day
    e. the number of periodontal maintenance procedures does not exceed two per year.
12. Diagnostic radiographic images are not covered if there is no documentation in the patient's records indicating why the radiographic images were ordered and/or what was diagnosed by the dentist upon reviewing the prescribed radiographic images.
13. Nitrous oxide/analgesia (D9230) is covered when used with a surgical procedure or a procedure other than examination, prophylaxis, fluoride, sealants, and X-rays.

ARTICLE VI. SERVICES NOT INCLUDED

(American Dental Association CDT-4 procedure code numbers listed below are merely examples of code numbers not covered. Other code numbers may apply to services not covered. You may contact the Company to receive a full list of CDT-4 procedure codes at no cost.)

Except as specifically provided in this Policy, no coverage will be provided for:

A. a service, procedure or supply which is not Dentally Necessary, or which is not listed in the Schedule of Benefits;

B. a service, procedure, or supply which is not prescribed or rendered by or under the general supervision of a dentist;

C. any treatment, service, or supply received for any illness or accidental injury arising out of, or in the course of employment or occupation for wage, profit or gain;

Nor will the Company pay benefits for injury or illness for which the Covered Person receives any benefits from motor vehicle no-fault law, regardless of any limitations in scope or coverage amount which may apply to his benefits claim under such laws.

In the event that the Company pays any claim by the Covered Person for insurance benefits under this Policy, and subsequently learn that the Covered Person had filed a claim for workers' compensation benefits as to such claim, or that the Covered Person had settled a workers' compensation claim with any workers' compensation carrier, or has otherwise received any amount toward payment of such a claim under the Arkansas Workers' Compensation Law, state or federal workers' compensation, Employer's liability or occupational disease law, or motor vehicle no-fault law, the Covered Person agrees to reimburse the Company to the full extent of the Company's payments on such claim;

D. conditions to which dental treatment is provided without cost to any Covered Person by any political subdivision or governmental authority (This does not include plans of insurance or other benefit plans provided by the federal or state governments to government Employees and Employee's dependents);

E. disease contracted or injuries sustained while serving in the military forces of any nation;

F. any condition to which services, treatment, or supplies of any kind are furnished or paid for under Title XVIII (Medicare) or the Social Security Act, as amended;

G. services, procedures or supplies with respect to congenital mouth malformations or skeletal imbalances, including, but not limited to:

1. Treatment related to cleft palate therapy;
2. Treatment related to disharmony of facial bone; or
3. Treatment related to or required as a result of orthognathic surgery; or
4. Orthodontic treatment required in orthognathic surgical cases;

H. Cosmetic Treatment, services or supplies that are cosmetic in nature or performed on an elective basis, e.g., teeth bleaching, crowns or veneers on sound teeth, etc;

I. prescription drugs;

J. local or block anesthesia, when billed separately;

K. general anesthesia (D9222, D9239) for a non-covered service, as well as simple extractions, or routine chair-side procedures;

L. any experimental or investigational services or supplies or for any condition or complication arising from or related to the use of such experimental or investigational services or supplies. The Company shall have full discretion to determine whether a dental treatment is experimental or investigational. Any dental treatment may be deemed experimental or investigational, in the Company's discretion, if:

1. reliable evidence (as defined below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the dental treatment or procedure is that further studies or clinical trials are necessary to determine its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.
2. reliable evidence (as defined below) shows that a majority opinion among experts, as stated in the published authoritative literature, regarding the dental treatment or procedure neither supports nor denies its use for a particular condition or disease.
3. reliable evidence (as defined below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the dental treatment or procedure should not be used as a first line therapy for a particular condition or disease.

"Reliable Evidence" shall mean only the following sources:

(a) the patient's dental records or other information from the treating Dentist(s) or from a consultant(s) regarding the patient's dental history, treatment or condition;

(b) the written protocol(s) under which the treatment or procedure is provided to the patient;

(c) any consent document the patient has executed or will be asked to execute, in order to receive the treatment or procedure;

(d) published reports and articles in the authoritative dental and scientific literature, signed by or published in the name of a recognized dental expert, regarding the treatment or procedure at issue as applied to the injury, illness or condition at issue; or

(e) the written protocol(s) used by another facility studying substantially the same dental treatment or procedure;

M. the cost to replace lost, stolen, or damaged prosthetic appliances;

N. services incurred prior to the Covered Person's effective date or after the termination date of coverage with the Company;

O. any dental or medical services performed by a physician for services covered or otherwise provided to the Covered Person by a medical-surgical plan;

P. services which the Covered Person incurs at no cost;

Q. plaque control programs, oral hygiene or dietary instructions;

R. charges for broken appointments;

S. any dental services or supplies required as the result of any accidental injury;

T. any dental services or supplies resulting from an injury caused by another party;

U. dental procedures requiring appliances or restorations that are necessary for full mouth rehabilitation, the restoration of occlusion, or to alter vertical dimensions of occlusion (except when involving full or partial dentures);

V. services by an immediate relative. "Immediate relative" means your spouse, parents, children, brother, sister, or legal guardian of the person who received the services;

W. procedures requiring the presence of a tooth will be denied if history indicates the tooth has been extracted (e.g., a crown is being reported and the tooth is listed as extracted in history);

X. if a course of treatment is performed by more than one (1) dentist, the Company will pay only the charges that would have been made by a single dentist for those services;

Y. charges for the completion of any insurance forms;

Z. synthetic grafts placed in extraction sites;

AA. periodontal provisional splinting, intracoronal or extracoronal;

AB. any services to restore tooth structure lost in order to rebuild or maintain occlusal surfaces due to mal-aligned or maloccluded teeth, lost from wear, or for stabilizing the teeth;

AC. replacement of fillings due to mercury sensitivity;

AD. pulpectomy on a permanent tooth;

AE. extraoral I&D (D7520);

AF. procedure for isolation of tooth with rubber dam (D3910);

AG. precious metal for partial dentures;

AH. Treatment and reduction of dislocation and management of TMJ/TMD (Temporomandibular Joint / Temporomandibular Joint Dysfunction) (D7810 – D7899) including diagnostic radiographic images, occlusal appliances, and/or splints;

AI. pulpotomy on a permanent tooth will deny as not covered unless there is an indication of an emergency in which case it is paid as a palliative treatment;

AJ. root recovery (D7250) not completely covered by bone, if provided by the same dentist who extracted the tooth;

AK. procedures performed prior to coverage or placed after termination of coverage are not covered;

AL. palliative emergency treatment (D9110) when definitive treatment is provided by the same dentist on the same day;

AM. a panoramic radiographic image or panorex (D0330). Children under the age of six require prior authorization;

AN. hospital or anesthesia fees due to the management of the patient;

AO. hospital facility fees for dental services;

AP. sutures of small wounds and complicated sutures (D7910, D7911, D7912);

AQ. occlusal guard (D9940);

AR. house calls (D9410) and hospital calls (D9420) for dental services;

AS. any procedure deemed by the Dental Advisor to be of questionable efficacy;

AT. pediatric partial denture-fixed (D6985);

AU. any service not listed under ARTICLE III. Covered Services.

ARTICLE VII. SUBROGATION

If a Covered Person is injured by a third party, the Company is subrogated to all rights the Covered Person may have against any party liable for payment of medical treatment (including any and all insurance carriers) to the extent of payment for the services or benefits provided, to the extent allowed by law. The Covered Person must cooperate fully with the Company in its efforts to collect from the third party, and if the Covered Person fails to do so, the Company shall be entitled to withhold coverage of or offset future claim payments for benefits, services, payments, or credits due under this Policy. The Company may assert its subrogation rights independently of the Covered Person. In addition to the above-referenced subrogation rights, the Company also has reimbursement rights should the Covered Person, or the legal representative, estate or heirs of the Covered Person recover damages by settlement, verdict or otherwise, for an accident, injury or illness. If a recovery is made, the Covered Person shall promptly reimburse the Plan any monetary recovery made by the Covered Person and includes, but is not limited to, uninsured and underinsured motorist coverage, any no-fault insurance, medical payments coverage, direct recoveries from liable parties, or any other source.

ARTICLE VIII. COORDINATION AGAINST OTHER DENTAL COVERAGE

A. **Definitions:**

1. **Allowable Expense** is a necessary, reasonable, and customary item of expense for dental care; when the item of expense is covered at least in part by one or more plans covering the insured for whom claim is made.

   When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

2. **Claim Determination Period** is a calendar year. However, it does not include any part of a year during which a Covered Person has no coverage under this Policy.

3. **Other Dental Plan** is any form of coverage which is separate from this Policy with which coordination is allowed. Other Dental Plans shall be any of the following which provides dental benefits or services:

   a. Group insurance or group-type coverage, whether insured or uninsured, including prepayment groups. It does not include school accident type coverage (grammar, high school, and college student coverage's, including athletic injury, either on a twenty-four (24) hour basis or on a "to and from school basis").

   b. Individually underwritten dental plan with a coordination of benefits provision.

   c. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

   Each contract or other arrangement for coverage under a., b. or c. is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

4. **Primary Plan** is the plan which determines its benefits first and without considering the other plan's benefits. A plan that does not include a COB provision may not take the benefits of another plan into account when it determines its benefits. In other words, a plan that does not have a COB provision is always the Primary Plan.

5. **Secondary Plan** is the plan which determines its benefits after those of the other plan (Primary Plan). Benefits may be reduced because of the other plan's (Primary Plan) benefits.

   When there are more than two plans covering the person, This Plan may be a Primary Plan as to

one or more other plans and may be a Secondary Plan as to a different plan or plans.

6. **This Plan** is this Individual Policy.

B. **Applicability**

If Policyholder is covered by any other dental benefits plan and receive services covered by both This Plan and the other plan, benefits will be coordinated. This means that one plan will be primary, while the other plan will be secondary. Each plan will provide only that portion of its benefit that is required to cover expenses. Coordination of Benefits prevents duplicate payments and overpayments.

The Company will determine the Allowable Expense in accordance with ADA guidelines on coordination of benefits.

C. **Order of Benefit Determination Rules**

1. General

When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless;

a. The other plan has rules coordinating its benefits with those of This Plan; and

b. Both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other plan.

2. Rules

This Plan determines its order of benefits using the first of the following rules which applies:

a. Non-Dependent/Dependent - The benefits of the plan which covers the Covered Person as an employee, member or subscriber are determined before those of the plan which covers the Covered Person as a dependent; except that: if the Covered Person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is

(i) Secondary to the plan covering the Covered Person as a dependent and

(ii) Primary to the plan covering the Covered Person as other than a dependent then the benefits of the plan covering the Covered Person as a dependent are determined before those of the plan covering that Covered Person as other than a dependent.

b. Dependent Child/Parents Not Separated or Divorced - Except as stated in Paragraph c. below, when This Plan and another plan cover the same child as a dependent of different persons, called parents:

(i) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

(ii) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

(iii) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born.

However, if the other plan does not have the rule described in (i) immediately above, but instead has a rule based on gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

c. Dependent Child/Separated or Divorced - If two or more plans cover a Covered Person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(i) First, the plan of the parent with custody of the child;

(ii) Then, the plan of the spouse of the parent with custody;

(iii) Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan.

This paragraph does not apply with respect to any Claim Determination Period or calendar year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. Joint Custody - If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph b.

e. Continuation Coverage - If a Covered Person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:

(i) First, the benefits of a plan covering the Covered Person as an employee, member or subscriber (or as that Covered Person's dependent);

(ii) Second, the benefits under the continuation coverage.

If the other plan does not have the rules described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

f. Longer/Shorter Length of Coverage - If none of the above rules determine the order of benefits, the benefits of the plan which covered a member or subscriber longer are determined before those of the Plan which covered that Covered Person for the shorter term.

D. **Effect on the Benefits of This Plan:**

1. When This Section Applies

This section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of This Plan may be reduced under this section.

2. Reduction in this Plan's Benefits

The benefits of This Plan will be reduced when the sum of:

a. The benefits that would be payable for the allowable expense under This Plan in the absence of this COB provision; and

b. The benefits that would be payable for the allowable expense under the other plans, in the absence of provisions with a purpose like that of this COB provision; whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

ARTICLE IX. OTHER PROVISIONS

A. Entire Policy.

This Policy, any amendments thereto, and this Application, Change Request Form and the Schedule of Benefits constitute the entire agreement between the parties. No part of this Policy shall be changed or waived in any way except by written amendment signed by the President of the Company. No Agent has the authority to change any of its terms.

You hereby expressly acknowledge your understanding that this Policy constitutes a contract solely between you and Arkansas Blue Cross and Blue Shield, that Arkansas Blue Cross and Blue Shield is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Arkansas Blue Cross and Blue Shield to the use the Blue Cross and Blue Shield Service Marks in the State of Arkansas, and that Arkansas Blue Cross and Blue Shield is not contracting as the agent of the Association. You further acknowledge and agree that you have not entered into this Contract based upon representations by any person other than Arkansas Blue Cross and Blue Shield and that no person, entity, or organization other than Arkansas Blue Cross and Blue Shield shall be held accountable or liable to you for any of the obligations created under this Policy.

B. Time Limit on Certain Defenses.

1. Except for fraudulent misstatements made by you in the application for this Policy, no misstatement shall be used to void any of its terms after three (3) years.
2. Incontestable. Except for a disease or physical condition excluded from coverage by name or description no claim for loss occurring after twelve (12) months from the effective date of this Policy shall be denied.

C. Notice and Proof of Claim.
1. You must submit written proof of any services, supplies or treatment and the Charges to the Company within one hundred eighty (180) days after such services, supplies or treatment were received.
2. The Company, upon receipt of such notice, will furnish to you such forms as are usually furnished by it for filing proof of loss. If such forms are not so furnished within fifteen (15) days after the Company receives such notice, you shall be deemed to have complied with the requirements as to proof of loss upon submitting, within the time fixed for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.
3. Subject to all applicable statutory provisions and rules and regulations of the Arkansas Insurance Department, all benefits payable under this Policy will be payable immediately upon receipt of written proof of loss.

D. Legal Actions. No Court suit shall be brought to recover on this Policy before sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No legal action shall be brought after the expiration of three (3) years from the time written proof of loss is required to be furnished.

E. This Policy shall be in effect until terminated by its terms.

F. Unless you change residence from Arkansas (See ARTICLE III., D.4.) this Policy and any amendments or riders to it are guaranteed renewable. This means that the Policy shall remain in force, so long as the Policyholder complies with its terms and so long as the premiums are paid in a timely manner. Your premium rate may change upon renewal if your age increases, if you relocate into a different rating area or the Company changes the established premium rate for all policies and riders of the same form number and premium classification as this Policy.

G. Before any benefits can be paid, you agree, as a condition of coverage under this Policy, and authorize and direct any provider of dental services or supplies to furnish Arkansas Blue Cross and Blue Shield, its agents, or any of its subsidiaries, upon request, all records, or copies thereof, relating to such services or supplies. Further, as a condition of your coverage, you authorize the release of such records to any third-party review person or entity, for purposes of dental review or second opinion surgery. Finally, as a condition of coverage, you agree to fully and truthfully respond to inquiries from the Company about your claim or condition, including, but not limited to, your other insurance coverage, third party liability, or workers' compensation benefits and to request that any dentist or other provider so respond to all such inquiries. You understand and agree that your failure to respond to inquiries from the Company, or failure to cooperate fully to obtain information requested by the Company from your dentist or other provider shall be, by itself, grounds for denial of benefits under this Policy.

H. Assignment. No assignment of benefits under this Policy shall be valid until approved and accepted by the Company. The Company reserves the right to make payment of benefits, with a valid assignment, directly to the provider of service.

I. How To Appeal A Claim
1. If a claim for benefits is denied either in whole or in part, you will receive a notice explaining the reason or reasons for the denial. You may request a review of a denial of benefits for any claim or portion of a claim by sending a written request to the Appeals Coordinator of Arkansas Blue Cross and Blue Shield, 601 S. Gaines Street, Little Rock, Arkansas 72203. Your request must be made within sixty (60) days after you have been notified of the denial of benefits.
2. In preparing your request for review, you or your duly authorized representative will have the right to examine documents pertinent to your claim. However, medical information can be released to you only upon the written authorization of your physician. You or your representative may submit, with your request for review, any additional information relevant to your claim and may also submit issues and comments in writing. A complete review will then be made of all information relating to your claim. You will receive a final decision in writing within sixty (60) days after the receipt of

your review request, except where special circumstances require extensive review. A final decision will be sent to you after no longer than one hundred twenty (120) days.

3. The Company acting on behalf of the Plan shall have authority and full discretion to determine all questions arising in connection with your insurance benefits, including but not limited to eligibility, interpretation of Plan language, and findings of fact with regard to any such questions. The actions, determinations and interpretations of the Company acting on behalf of the Plan with respect to all such matters, and with respect to any other matters within the scope of its authority, shall be conclusive and binding on you and the Plan to the extent allowed by law.

J. Despite our best efforts, we may make a claim payment which is not for a benefit provided under this Policy, or we may make payment to you when payment should have gone directly to the Provider of treatment or services instead. In the event of an erroneous or mistaken payment, you agree to refund the full amount of such payment to us promptly upon our request. The Company will have the right to offset future payments made to you or your provider if prompt refund of such payment is not received.

K. Insurance Department. Arkansas Blue Cross and Blue Shield is an insurance company regulated by the Arkansas Insurance Department. You 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: 1 Commerce Way, Suite 102, Little Rock, Arkansas 72202. You may also file an online complaint by visiting the Arkansas Insurance Department website at www.insurance.arkansas.gov.

ARTICLE X. POLICY PROVISIONS RELATIVE TO MEMBERSHIP, MEETINGS AND VOTING

A. Membership

By virtue of ownership of this Policy, the Policyholder is a Member of Arkansas Blue Cross and Blue Shield. This Policy is a non-participating policy. This means that the Policyholder does not receive distribution of any premium, revenues, savings, or assets of the Company.

B. Annual Meeting

An annual meeting of the Members shall be held each and every calendar year in the State of Arkansas for the purpose of electing directors, receiving and considering reports as to the business and affairs of the Company and transacting such other business as may properly come before the meeting. The meeting shall be held between January 1 and April 1 of each year at such place, date and time as shall be fixed by the Board of Directors or the Chief Executive Officer. The Board of Directors may, from time to time, provide that the place, date, and time of the annual meeting shall be set forth in the Policy of Members as set out in Section D. below.

> "THE ANNUAL MEETING OF THE MEMBERS SHALL BE HELD EACH YEAR AT THE HOME OFFICE, LOCATED AT 601 GAINES STREET, LITTLE ROCK, ARKANSAS, ON THE THIRD MONDAY IN MARCH AT 1:00 P.M. (PROVIDED, IF SUCH DAY SHALL BE A LEGAL HOLIDAY, THEN AT THE SAME TIME AND PLACE ON THE NEXT SUCCEEDING DATE WHICH IS NOT A LEGAL HOLIDAY)."

C. Special Meetings

A special meeting of Members for any purpose may be called by the Board of Directors or Chief Executive Officer and shall be called by the Chief Executive Officer or the Secretary at the request of Members holding one-third (1/3) of the voting power entitled to vote thereat. Such request shall state the purpose or purposes of the meeting, and no other business outside the scope of the stated purpose or purposes shall be transacted. Unless ordered by the Board of Directors, the time and place of each special meeting of Members shall be determined by the Chief Executive Officer.

D. Notice of Meetings

So long as each insurance Policy issued by the Company sets forth the place, date, and hour of the annual meeting of Members, no notice of any annual meeting shall be required to be given to any Member, regardless of the number or nature of proposals to be considered and voted upon at the annual meeting. If notice of the annual meeting is not set forth in each insurance Policy, written or printed notice of the annual meeting and every special meeting of the Members, stating the place, date, time and the purpose or purposes of such meeting shall be given to the Members entitled to vote at such meeting not less than ten (10), nor more than sixty (60), days before the date of the meeting. All such notices shall be given, either personally or by the mail, by or at the direction of the Chief Executive Officer or Secretary unless ordered by the Board of Directors. Notices which shall be mailed shall be deemed to be "given" when deposited in the United States Mail addressed to the Member at the Member's address as it appears on

the records of the Company, with postage prepaid [first class mail, if the notice is mailed thirty (30) days or less before the date of the meeting], and any notice transmitted other than by mail shall be deemed to have been "given" when delivered to the Member.

E. Quorum

Except as otherwise provided by applicable law, a majority of the Members of the Company (present in person or by proxy) shall be necessary to constitute a quorum for the transaction of business at any annual or special meeting of the Members of the Company.

F. Voting Rights

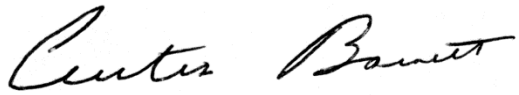
Each Member shall be entitled to one vote for each policy held by him upon each matter coming to a vote at meetings of Members provided, a group policyholder shall be entitled to a number of votes equal to the number of certificate holders insured under this Group Policy. Such vote may be exercised in person or by written proxy.

G. Vote Required

A majority of the voting power represented at any meeting of Members shall be necessary and sufficient to approve any given matter. There shall be no cumulative voting.

H. Proxy

By accepting this Policy, the Policyholder appoints the Board of Directors ("Board") of the Company to act on the Policyholder's behalf at all meetings of Members of the Company. This appointment shall include such persons as the Board may designate by resolution to act on its behalf. This proxy gives the Board, or its designee, full power to vote for the Policyholder on all matters that may be voted upon at any meeting. This proxy, unless revoked, shall remain in effect during the term of this Policy. The Policyholder may revoke this proxy in writing by advising the Company of such revocation at least five (5) days prior to any meeting. The Policyholder may also revoke its proxy by attending and voting in person at any Members' meeting.



Curtis Barnett, President and Chief Executive Officer

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. Gaines Street
Little Rock, Arkansas 72201

ARKANSAS CONSUMERS INFORMATION NOTICE

For additional information regarding your Arkansas Blue Cross and Blue Shield benefits, please feel free to contact us at:

Arkansas Blue Cross and Blue Shield
Customer Service
Post Office Box 2181
Little Rock, Arkansas 72203
Telephone (501) 378-2010 or Toll Free (800) 421-1112

If we at Arkansas Blue Cross and Blue Shield fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1 Commerce Way, Suite 102
Little Rock, Arkansas 72202
Telephone (501) 371-2640 or toll free (800) 852-5494
insurance.consumers@arkansas.gov.

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy and contract owners who live in this state and, in some cases, to keep coverage in force. Please note that the valuable extra protection provided by the member insurers through the Guaranty Association is limited. This protection is not a substitute for a consumers' careful consideration in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") provides coverage of claims under some types of policies or contracts if the insurer or health maintenance organization becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned on residence in the State of Arkansas. Other conditions may also preclude coverage.

The Guaranty Association will respond to any questions you may have which are not answered by this document. Your insurer or health maintenance organization and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy or health maintenance organization coverage.

You should not rely on availability of coverage under the Guaranty Association when selecting an insurer or health maintenance organization.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, Arkansas 72201

Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, Arkansas 72202

The state law that provides for this safety net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"), which is codified at Ark. Code Ann. §§ 23-96-101, et seq. Below is a brief summary of the Act's coverage, exclusions and limits. This summary does not cover all provisions of the Act, nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state; or
- Their policy or contract was issued by a hospital or medical service organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends, voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employer plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals);
- Unallocated annuity contracts issued to or in connection with benefit plans protected under the Federal Pension Benefit Corporation ("FPBC"), regardless whether the FPBC is yet liable or not;
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution;
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by state or federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, claims for policy misrepresentations, and extra-contractual or penalty claims; or
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustee(s).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 in life insurance death benefits without regard to the number of policies and contracts there were with the same company, even if they provided different types of coverages. The Guaranty Association will pay a maximum of $500,000 in health benefits, provided that coverage for disability insurance benefits and long-term care insurance benefits shall not exceed $300,000. The Guaranty Association will pay $300,000 in present value of annuity benefits, including net cash surrender and net cash withdrawal values. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits. These are limitations under which the Guaranty Association is obligated to operate prior to considering either its subrogation and assignment rights or the extent to which those benefits could be provided from assets of the impaired or insolvent insurer.