

SERFF Tracking Number: DDAR-128479370 State: Arkansas
Filing Company: Delta Dental of Arkansas State Tracking Number:
Company Tracking Number: DDAR-DCON-WINDSTREAM 12A
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Windstream 12A
Project Name/Number: /

Filing at a Glance

Company: Delta Dental of Arkansas

Product Name: Windstream 12A

TOI: H10G Group Health - Dental

Sub-TOI: H10G.000 Health - Dental

Filing Type: Form

Implementation Date Requested: 01/01/2012

State Filing Description:

SERFF Tr Num: DDAR-128479370 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num:

Co Tr Num: DDAR-DCON-
WINDSTREAM 12A

Author: Sara Farris

Date Submitted: 06/14/2012

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 06/20/2012

Disposition Status: Approved-
Closed

Implementation Date:

General Information

Project Name:

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Filing Status Changed: 06/20/2012

State Status Changed: 06/20/2012

Created By: Sara Farris

Corresponding Filing Tracking Number:

Filing Description:

Windstream made changes to its group contract.

State Narrative:

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type:

Overall Rate Impact:

Deemer Date:

Submitted By: Sara Farris

Company and Contact

Filing Contact Information

Sara Farris,

1513 Country Club

Sherwood, AR 72120

sfarris@ddpar.com

501-992-1662 [Phone]

501-992-1663 [FAX]

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Filing Company Information

Delta Dental of Arkansas CoCode: 47155 State of Domicile: Arkansas
 1513 Country Club Rd. Group Code: Company Type:
 Sherwood, AR 72120 Group Name: State ID Number:
 (501) 992-1662 ext. [Phone] FEIN Number: 71-0561140

Filing Fees

Fee Required? Yes
 Fee Amount: \$0.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Delta Dental of Arkansas	\$50.00	06/14/2012	60151467

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/20/2012	06/20/2012

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Disposition

Disposition Date: 06/20/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Windstream 12A	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/20/2012	DDAR-DCON-Windstream12A	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Windstream 12A	Initial		34.500	DDAR-DCON-Windstream 12A.pdf



Delta Dental PPO Plus Premier

Group Contract

As presented for:

**WINDSTREAM CORPORATION
4001 RODNEY PARHAM ROAD
LITTLE ROCK, AR 72212
GROUP NUMBERS 9618, 9619 AND 9620**

The issuance of this signed CONTRACT by Delta Dental Plan of Arkansas, Inc. (DDPAR) acknowledges acceptance of WINDSTREAM CORPORATION'S (GROUP) APPLICATION for coverage. The coverage set out in this CONTRACT is extended to the GROUP SPONSOR at the rates stated in and upon the terms and conditions set out in this CONTRACT including all schedules, endorsements, APPLICATIONs, and amendments.

BENEFITS will start at 12:01 a.m. Central Standard Time on the EFFECTIVE DATE. The CONTRACT is entered into and binding on the date it is signed by both parties; however, the EFFECTIVE DATE of CONTRACT BENEFITS is stated on the APPLICATION. This CONTRACT will continue for the period of time shown on the APPLICATION and after that will be extended as described in this CONTRACT, unless ended in accordance with Article 8.

This CONTRACT is effective on this the 1st day of January 1, 2012, in witness whereof, the parties have caused this CONTRACT to be signed by their authorized representatives.

DELTA DENTAL PLAN OF ARKANSAS, INC.

By: *Ed Chaste*
(Authorized Signature)

Chief Executive Officer
(Title)

Date: June 14, 2012

ARTICLE 1. DEFINITIONS

As used in this CONTRACT:

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

“ANNUAL MAXIMUM BENEFIT” is the sum that DDPAR will pay for BENEFITS for any CONTRACT YEAR.

“APPLICATION” is the form used for the GROUP SPONSOR to apply for coverage pursuant to this CONTRACT as provided by DDPAR.

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

“BENEFIT PERIOD” is the twelve (12) month period during which BENEFITS are paid as set out in the SCHEDULE OF BENEFITS. This period may vary from a twelve (12) month term at the initiation of the CONTRACT. This represents the accumulation period applicable to DEDUCTIBLEs, benefit maximums, and applicable time limits.

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

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

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

“CLAIMS ADMINISTRATOR” is Delta Dental Plan of Arkansas, Inc. (DDPAR).

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

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

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

“CODE” means the Internal Revenue CODE of 1986, as amended.

“CONTRACT” is the agreement between DDPAR and group, including the APPLICATION, all schedules, endorsements, and amendments as issued by DDPAR.

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

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

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

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

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

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

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

“DEPENDENT” is as defined in Schedule E of this CONTRACT.

“EFFECTIVE DATE” of this CONTRACT is 12:01 a.m. on the date coverage under the CONTRACT begins, as shown on the APPLICATION.

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

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

“ELIGIBLE RETIREE” is a RETIREE who meets the eligibility requirements as set forth in Schedule E of this CONTRACT.

“EMPLOYEE” is an individual employed by the GROUP SPONSOR.

“ENROLLMENT FORM” is the electronic system utilized by GROUP SPONSOR, or paper form submitted to apply for coverage for an ELIGIBLE EMPLOYEE and ELIGIBLE DEPENDENTS, if applicable under the CONTRACT between the GROUP SPONSOR and DDPAR.

“FULL TIME STUDENT” is defined as an unmarried student who is dependent on the RETIREE for support and maintenance and who meets the criteria of FULL TIME STUDENT status. Full time is twelve

(12) hours for an undergraduate student and nine (9) hours for a graduate school student per semester or students enrolled at a vocational school attending classes four (4) hours per day are considered full-time.

“GROUP HEALTH PLANS” is the group dental BENEFITS program to which this CONTRACT applies.

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

“MAXIMUM PLAN ALLOWANCE” is the maximum payment allowed by DDPAR for the applicable covered service(s) provided by the DENTIST(s).

“PARTICIPANT” is an ELIGIBLE EMPLOYEE, ELIGIBLE DEPENDENT, or ELIGIBLE RETIREE who is enrolled under this CONTRACT.

“PARTICIPATING DENTIST” or “NETWORK PROVIDER” is a licensed DENTIST in the plan-specific network who has contracted with and agreed to abide by the rules and regulations of DDPAR or any other organization that is a member of Delta Dental Plans Association, DeltaUSA, or its affiliates.

“PLAN ADMINISTRATOR” is the administrator of this CONTRACT, which is the GROUP SPONSOR.

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

“PRE-EXISTING CONDITION” means the state or condition of the mouth that exists prior to the patient’s EFFECTIVE DATE of coverage under this CONTRACT.

“PREMIUM” is the monthly amount to be paid, as agreed, by GROUP SPONSOR to DDPAR for coverage under this CONTRACT.

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

“QUALIFYING EVENT” means the occurrence of a specified event, as described in Schedule E that would allow an ELIGIBLE EMPLOYEE and/or ELIGIBLE DEPENDENT to enroll in coverage or drop coverage after the eligibility date and at a time other than the annual enrollment period.

“RETIREE” is an individual who has retired from employment with the GROUP SPONSOR.

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

“SUBSCRIBER” is an ELIGIBLE EMPLOYEE or ELIGIBLE RETIREE who is enrolled in this CONTRACT.

“TOTALLY DISABLED” means in the case of a DEPENDENT child, the complete inability, as a result of illness or injury, to perform the normal activities of a person of like age and sex in good health, as certified by the Social Security Administration.

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

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

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

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

ARTICLE 2. MONTHLY PREMIUMS

2.01 GROUP SPONSOR will pay all PREMIUMs to DDPAR as indicated in the SCHEDULE OF BENEFITS. All such PREMIUMs will be paid as billed.

PREMIUMs paid to DDPAR for COBRA-PARTICIPANTs will be the same as for PARTICIPANTs with the same coverage. GROUP SPONSOR may charge COBRA-PARTICIPANTs for their coverage as permitted by COBRA.

GROUP SPONSOR will pay monthly PREMIUMs for COBRA-PARTICIPANTs to DDPAR. Payment of PREMIUMs for active and COBRA-PARTICIPANTs shall be made to DDPAR in one check from the GROUP SPONSOR.

The GROUP SPONSOR will be responsible for all fees incurred by DDPAR if any check for PREMIUMs is returned by the bank.

The parties acknowledge and agree that DDPAR provides COBRA coverage as required by law but does not provide any COBRA notices or other COBRA-related administrative services and shall not be required to do so pursuant to this CONTRACT. COBRA notifications, eligibility determinations, and any other COBRA-related administrative services or functions shall be the sole responsibility of GROUP SPONSOR.

2.02 This CONTRACT will not be in effect until DDPAR receives the first month’s PREMIUM. All PREMIUMs are due at DDPAR on the first (1st) day of the month for which coverage is being extended. PREMIUMs will be deemed late if they have not been received at DDPAR by the forty sixth (46th) day of the first (1st) day of the month for which coverage is being extended. If the PREMIUM is not received by the forty sixth (46th) day, DDPAR may stop paying CLAIMS and verifying eligibility until payment is received.

2.03 Terms and conditions governing eligibility and enrollment will be found in Schedule E.

ARTICLE 3. EXCLUSIONS FOR ALL BENEFITS

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

3.02 OPTIONAL SERVICES

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

3.03 EXCLUSIONS

Unless specific coverage is elected and paid for (see your SCHEDULE OF BENEFITS), DDPAR does not pay BENEFITS for:

- a) BENEFITS or services for injuries or conditions covered under Worker's Compensation or Employer's Liability laws. BENEFITS or services available from any federal or state government agency; municipality, county, other political subdivision; or community agency; or from any foundation or similar entity.
- b) Charges for services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.
- c) Charges for services or supplies for which no charge is made that the patient is legally obligated to pay. Charges for which no charge would be made in the absence of dental coverage.
- d) Charges for TREATMENT by other than a DENTIST except that a licensed hygienist may perform services in accordance with applicable law. Services must be under the supervision and guidance of the DENTIST in accordance with generally accepted dental standards.

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

- u) All other BENEFITS and services not specifically covered in the CONTRACT and/or SCHEDULE OF BENEFITS.

ARTICLE 4. DEDUCTIBLE, ANNUAL MAXIMUM, AND COORDINATION OF BENEFITS

- 4.01** DDPAR will not pay BENEFITS until the annual DEDUCTIBLE amount has been satisfied, unless the covered procedure is not subject to the DEDUCTIBLE. The DEDUCTIBLE will apply as indicated on the SCHEDULE OF BENEFITS.
- 4.02** The DEDUCTIBLE applies to the benefit categories as shown on the SCHEDULE OF BENEFITS. Only fees a PARTICIPANT pays for services covered under the benefit schedules included in this CONTRACT will count toward satisfying the DEDUCTIBLE.
- 4.03** Unless otherwise indicated on the SCHEDULE OF BENEFITS, the DEDUCTIBLE and maximum apply to each BENEFIT PERIOD.
- 4.04 COORDINATION OF BENEFITS**

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

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

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

ARTICLE 5. CONDITIONS UNDER WHICH BENEFITS WILL BE PROVIDED

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

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

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

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

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

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

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

ARTICLE 6. CLAIMS PROCEDURES

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

6.02 FILING CLAIMS/PARTICIPATING DENTISTS. PARTICIPATING DENTISTs will complete and submit CLAIM FORMS for PARTICIPANTs at no charge. PARTICIPATING

DENTISTs may ask PARTICIPANTs to fill out the patient section of the CLAIM FORM, which includes the SUBSCRIBER's name, social security number (SSN), and address; the PARTICIPANT's name, date of birth, and relationship to SUBSCRIBER; and coordination of BENEFITS information, if applicable.

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

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

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

- 6.04 PROCESSING THE CLAIM.** If PARTICIPANT visits a PARTICIPATING DENTIST, upon receipt of the CLAIM, it will be processed according to the GROUP SPONSOR's CONTRACT BENEFITS. For PARTICIPANTs who visit a PARTICIPATING DENTIST, notification of the benefit determination will be sent to the SUBSCRIBER in the form of an Explanation of BENEFITS, which details by service rendered what the CONTRACT allowed and the PARTICIPANT's obligation, if any.

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

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

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

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

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

a) Procedures the PARTICIPANT or PARTICIPANT's attending DENTIST Must Follow:

- 1) Write to the CLAIMS ADMINISTRATOR at the following address:

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

b) Procedures CLAIMS ADMINISTRATOR must follow for a full and fair appeal:

CLAIMS ADMINISTRATOR:

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

c) Procedures CLAIMS ADMINISTRATOR must follow to notify claimant of its decision (if
adverse):

- 1) Provide claimant with a notice that includes the following information, to wit:
 - i) The specific reason(s) for the adverse determination.
 - ii) Reference to the specific CONTRACT provision(s) on which the adverse
determination is based.
 - iii) A statement that claimant is entitled to receive, free of charge, access to and copies
of all information relevant to the CLAIM.
 - iv) A statement describing any voluntary appeal procedures, if any, and a statement of
claimant's right to bring an action under section 502 (a) of the Employee Retirement
Income Security Act.

- v) The internal rule that was relied upon in making the adverse determination.
 - vi) If adverse determination is based on a medical necessity or experimental TREATMENT, either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request.
 - vii) The following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”
- 2) Provide claimant with the aforementioned notice within seventy-two (72) hours if the CLAIM is an URGENT CARE CLAIM.
 - 3) Provide claimant with the aforementioned notice within sixty (60) days if the CLAIM is a post-service CLAIM.

ARTICLE 7. GENERAL PROVISIONS

- 7.01 ENTIRE CONTRACT - CHANGES.** This CONTRACT, including schedules, and/or the APPLICATION, and any endorsements or amendments issued by DDPAR make up the entire CONTRACT between the parties. No agent has authority to change this CONTRACT or waive any of its provisions. No change in this CONTRACT will be valid unless made by written amendment signed by both an Officer of DDPAR and GROUP. Verbal approval(s) of coverage and/or BENEFITS shall not be effective to modify this agreement in any way and are invalid and void and of no effect.
- 7.02 SEVERABILITY.** If any part of this CONTRACT or any amendment is found to be illegal, void, or not enforceable, all other portions will remain in full force and effect until cancelled as provided in Article 8.
- 7.03 CONFORMITY WITH STATE LAWS.** The laws of the State of Arkansas will govern this CONTRACT, to the extent not preempted by the Employee Retirement Income Security Act of 1974, as amended. Any part of this CONTRACT which, on its EFFECTIVE DATE, conflicts with the laws of Arkansas is hereby amended to conform to the minimum requirements of such laws.
- 7.04 LEGAL ACTIONS.** No action at law or in equity will be brought before sixty (60) days after proof of loss has been filed as required by this CONTRACT, nor prior to completion of all administrative remedies under this CONTRACT. Any action must be brought within five (5) years from the time proof of loss is required by this CONTRACT. In any case, action may only be brought after a PARTICIPANT has exercised all the review and appeal rights and completed all administrative remedies under this CONTRACT.
- 7.05 CHOICE OF JURISDICTION.** All litigation related to the terms or conditions of this CONTRACT will be in a court of valid jurisdiction in Pulaski County, Arkansas.
- 7.06 DOES NOT REPLACE WORKER’S COMPENSATION.** This CONTRACT does not affect any requirements for coverage by Worker’s Compensation Insurance.
- 7.07 CERTIFICATE OF INSURANCE.** DDPAR will furnish CERTIFICATE(s) for distribution by the GROUP SPONSOR to EMPLOYEE(s). This CERTIFICATE will set out available BENEFITS. This CERTIFICATE shall not be intended to satisfy the requirements of the summary plan description pursuant to the Employee Retirement Income Security Act of 1974, as

amended (“ERISA”), The obligation to provide a summary plan description pursuant to ERISA shall be the sole responsibility of the PLAN ADMINISTRATOR and not DDPAR.

- 7.08 CONFLICTS.** The terms of the CONTRACT, along with any amendments or endorsements issued by DDPAR, will in all cases be controlling. Should the wording of this CONTRACT, along with any amendments or endorsements issued by DDPAR conflict with the SCHEDULE OF BENEFITS, APPLICATION, or proposal, the CONTRACT, along with any amendments or endorsements issued by DDPAR will govern.
- 7.09 PROFESSIONAL RELATIONSHIP.** GROUP SPONSOR and DDPAR agree to permit and encourage the professional relationship between DENTIST and patient to be maintained without interference.
- 7.10 NOTICE.** All notices under this CONTRACT must be in writing. Notices for DDPAR will be addressed to:

Delta Dental Plan of Arkansas, Inc.
PO Box 15965
Little Rock, Arkansas 72231

Notices to the GROUP SPONSOR will be sent to the address shown on the APPLICATION. All notices will be effective forty-eight (48) hours after deposit in the United States mail with fully prepaid postage.

- 7.11 RIGHT TO RECOVERY.** Whenever BENEFITS greater than the maximum amount of allowable BENEFITS are provided, DDPAR will have the right to recover any excess. DDPAR will recover the excess from any persons, insurance companies, or other organizations involved to whom payment was made. Any PARTICIPANT covered under this CONTRACT will execute and deliver any necessary documents and do what is necessary to secure such rights to DDPAR.
- 7.12 SUBROGATION.** DDPAR acquires the PARTICIPANT’s legal rights to recovery for payment for dental services the patient required because of the action or fault of another. DDPAR has the right to recover from the PARTICIPANT any payment(s) made by or for the other party. In such cases, DDPAR has the right to recover from a third party, reasonable cost of collection and attorney’s fees thereof shall be assessed against the insurer and the insured in the proportion each benefits from the recovery.
- DDPAR has the right to make the recovery by suit, settlement, or otherwise from the person who caused the dental problem or injury. Such recovery may be from the other person, his or her insurance company, or any other source, such as third party motorist coverage.
- The PARTICIPANT must help DDPAR recover from other sources. PARTICIPANT must provide all requested information and sign necessary documents. If the PARTICIPANT fails to help DDPAR or settles any CLAIM without DDPAR’s written consent, DDPAR may recover from the PARTICIPANT. DDPAR will be entitled to any recovery received by the PARTICIPANT and reasonable and necessary attorney’s fees and court costs.
- 7.13 ENDORSEMENTS/AMENDMENTS.** This CONTRACT is subject to amendment by DDPAR and GROUP. Nothing contained in any endorsement shall affect any of the conditions, provisions, or limitations of the CONTRACT except as expressly provided in the endorsement. All conditions, provisions, and limitations of the CONTRACT shall apply to any endorsement if they are not in conflict.
- 7.14 COLLECTIONS.** Should any payment owed DDPAR by GROUP SPONSOR be due for more than thirty (30) days, DDPAR may pursue any and all collection efforts it deems necessary to

collect such payment. GROUP SPONSOR will be responsible for all costs of such collection efforts, including but not limited to collection fees, court costs, and reasonable legal fees.

- 7.15 SUBCONTRACTOR(S) AND AGENT(S).** DDPAR may subcontract certain functions or appoint an agent or agents to act on DDPAR'S behalf and fulfill expressed, limited duties under this CONTRACT. Such agent(s) have no authority to change or amend this CONTRACT.
- 7.16 DDPAR LIABILITY.** DDPAR shall have no liability for any wrongful conduct, as described in this paragraph. This includes but is not limited to tortious conduct, negligence, wrongful acts or omissions, or any other act of DENTISTS, dental assistants, dental hygienists, dental employees, hospitals, or hospital employees receiving or providing services. DDPAR shall have no liability for any services, equipment, or facilities, which, for any reason, are unsafe for or unavailable to any PARTICIPANT.
- 7.17 PUBLICATION OF THIS AGREEMENT.** No material shall be published or distributed by GROUP SPONSOR or otherwise, interpreting, relating to, or concerning this CONTRACT unless such material has been approved by DDPAR in writing in advance of such publication or distribution.
- 7.18 RIGHT TO INFORMATION.** In order for CLAIMs to be approved, DDPAR, upon its request, shall be entitled to receive from any attending or examining DENTIST or from hospitals in which a DENTIST's care is rendered certain information and records. This data will relate to the attendance to, examination of, or TREATMENT rendered to a PARTICIPANT. DDPAR, at its own expense, shall have the right but not the duty to cause any PARTICIPANT to be examined when and as often as it reasonably requires. The receipt of any PARTICIPANT of any service constitutes the consent of such PARTICIPANT to the release to DDPAR of all such information and records. The PARTICIPANT shall execute a medical release as requested by DDPAR.
- GROUP SPONSOR agrees to provide DDPAR current, complete, and correct information in regard to all SUBSCRIBERS who are entitled to coverage. This will enable DDPAR to properly affect coverage and to administer CLAIMs and provide service for all related matters.
- 7.19 MISREPRESENTATIONS.** In the absence of fraud, all statements made by applicants or the GROUP SPONSOR or by a PARTICIPANT shall be deemed **representations** and not **warranties**.
- 7.20 NOTICE TO EMPLOYEES.** Pursuant to the Gramm-Leach-Bliley Act (GLB) and Regulation 74 enacted by the Arkansas Insurance Department, DDPAR shall provide notice to its customers about its privacy policies and practices. Notice will be made upon an individual's enrollment in the plan and annually thereafter for the duration of the term of coverage. GROUP SPONSOR agrees to distribute copies of this notice to their EMPLOYEES who receive dental insurance through DDPAR.
- 7.21 FRAUD NOTICE.** Any person who knowingly presents a false or fraudulent CLAIM for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- 7.22 DELTAUSA.** The parties acknowledge that DDPAR is subject to certain Rules and Regulations (and that same may be amended from time to time) by a national organization, to wit, DeltaUSA. The parties will act in good faith to comply with any such Rules and Regulations (and amendments, if any).
- 7.23 COUNTERPARTS.** This CONTRACT and any amendments thereto may be executed in one or more counterparts, and if in more than one counterpart, each, when taken together, shall constitute one and the same instrument. Signatures on this CONTRACT which are exchanged by facsimile

or other electronic means are true and valid signatures for all purposes hereunder and shall bind the GROUP and DDPAR to the same extent as original signatures.

- 7.24 FORCE MAJEURE.** No party shall be liable for any default or delay in the performance of its obligations under this CONTRACT if and to the extent such default or delay is from causes outside the reasonable control of a party. Such causes may include fire, flood, earthquake, natural disasters or acts of God, terrorist acts, riots, civil disorders, freight embargoes, government action, or the like, provided the non-performing party is without fault in causing such default or delay, and such default or delay could not have been prevented by reasonable precautions and could not reasonably be circumvented by the non-performing party through the use of alternate sources, workarounds plans or other means (including disaster recovery services, if any). However, the non-performing party shall not be excused from its obligations to protect the other party's confidential information or to provide disaster recovery and business continuity services, as may be required under this CONTRACT. In such event the non-performing party shall be excused from further performance or observance of the obligations so affected for as long as such circumstances prevail and such party continues to use commercially reasonable efforts to recommence performance or observance without delay. Any party so delayed in its performance shall immediately notify the party to whom performance is due by telephone (to be confirmed in writing within twenty-four (24) hours of the inception of such delay) and describe at a reasonable level of detail the circumstances causing such delay. Should any event delay the performance by a party for thirty (30) days or more, the other party may terminate this CONTRACT upon written notice to the delayed party.

ARTICLE 8. RENEWAL, CANCELLATION, AND TERMINATION

- 8.01** Prior to the end of the CONTRACT TERM, DDPAR must give the GROUP SPONSOR at least one hundred twenty (120) days' notice of any change of PREMIUM or BENEFITS. Such notice will renew the CONTRACT for a one (1) year term unless GROUP SPONSOR provides written notice of cancellation.
- 8.02** This CONTRACT may be canceled only as follows:
- a) By GROUP SPONSOR with ninety (90) days' written notice prior to the end of a CONTRACT TERM.
 - b) By DDPAR with ninety (90) days' written notice prior to the end of a CONTRACT TERM.
 - c) By DDPAR if GROUP SPONSOR:
 - 1) does not furnish DDPAR a listing of all EMPLOYEES as required under Schedule E, or
 - 2) does not permit DDPAR to inspect GROUP SPONSOR's records as called for under Schedule E, or
 - 3) does not pay all PREMIUMs as required by Article 2, or
 - 4) misrepresents any information required in the CONTRACT, or
 - 5) does not meet the underwriting guidelines established for the program as described in the APPLICATION.
- 8.03** DDPAR must give GROUP SPONSOR fifteen (15) days' written notice to cancel the CONTRACT because GROUP SPONSOR did not pay PREMIUM(s). Cancellation by DDPAR for any other reason requires ninety (90) days' written notice.

If the CONTRACT is canceled, the GROUP SPONSOR will owe DDPAR all unpaid PREMIUM(s) that were due prior to cancellation. Should GROUP SPONSOR fail to pay DDPAR PREMIUM(s) through the cancellation date within fifteen (15) days of cancellation, DDPAR may collect the greater of any unpaid PREMIUM or the reimbursement for any CLAIM PAYMENT(s) made plus interest on the unpaid PREMIUM or CLAIM PAYMENT(s) at a rate equal to twelve (12) percent annually or one (1) percent per month.

8.04 TERMINATIONS

- a) **GROUP:**
- 1) This CONTRACT will terminate at the end of the term of the CONTRACT unless renewed and applicable PREMIUM(s) are paid to and received by DDPAR.
 - 2) This CONTRACT will terminate if the GROUP SPONSOR does not meet the group eligibility requirements applicable to this CONTRACT and as described in the APPLICATION, as determined by DDPAR, in its sole discretion.
 - 3) This CONTRACT may be terminated by either party upon material breach of any of the terms of the CONTRACT if not corrected upon fifteen (15) days' written notice.
 - 4) As provided in the Force Majeure provision in Article 7.
 - 5) If the CONTRACT is terminated, GROUP SPONSOR will owe DDPAR all unpaid PREMIUM(S) that were due prior to termination.
- b) **PARTICIPANT:**
- Coverage will end as specified in the APPLICATION or as amended by the group administrator for a/an SUBSCRIBER(s) and/or his/her DEPENDENT coverage, if applicable, (unless they elect continuation of coverage through COBRA, and if COBRA is applicable, or through another applicable state continuation coverage) upon the earliest of any of the following events:
- 1) at the termination of this CONTRACT,
 - 2) at the termination, for any reason, of the SUBSCRIBER's employment with this group,
 - 3) at any time when the SUBSCRIBER loses his or her eligibility for coverage under the CONTRACT , or
 - 4) when PREMIUMs or any other payments required under this CONTRACT are not made.

In addition, coverage will end on the last day of the month in which a DEPENDENT child or FULL TIME STUDENT reaches the limiting age specified in the APPLICATION.

Retro-active terminations will only be allowed for the current physical month plus up to one additional month if applicable as long as no claims have been benefited.

ARTICLE 9. ATTACHMENTS

These attached documents are considered part of this CONTRACT:

- Schedule A – Diagnostic and Preventive BENEFITS and their Limitations and Exclusions
- Schedule B – Basic Restorative BENEFITS and their Limitations and Exclusions
- Schedule C – Major Restorative BENEFITS and their Limitations and Exclusions
- Child Orthodontic BENEFITS Rider
- Adult Orthodontic BENEFITS Rider
- Schedule E – Eligibility and Enrollment
- APPLICATION

- SCHEDULE OF BENEFITS

**DELTA DENTAL PLAN OF ARKANSAS
SCHEDULE E
ELIGIBILITY AND ENROLLMENT**

E1.01 ELIGIBLE EMPLOYEES. All active, full-time EMPLOYEE(s) of the GROUP SPONSOR working a minimum number of hours as defined in the Application will be eligible to enroll for coverage under this CONTRACT. All EMPLOYEE(s) will be eligible to enroll for coverage following the completion of any required probationary period as specified in the APPLICATION or as amended by the GROUP SPONSOR.

RETIREES of the GROUP SPONSOR and as designated by the GROUP SPONSOR will be eligible to enroll for coverage under this CONTRACT. All RETIREES will be eligible to enroll for coverage within 31 days of their retirement date.

EMPLOYEES classified by the GROUP SPONSOR as temporary, seasonal, or leased, will not be eligible to enroll for coverage under this CONTRACT.

E1.02 INITIAL PLAN ENROLLMENT-ACTIVE EMPLOYEES. ELIGIBLE EMPLOYEE(s) and their ELIGIBLE DEPENDENT(s) must enroll for coverage during the ELIGIBLE EMPLOYEE's first 60 days of employment, or within thirty-one (31) days of a QUALIFYING EVENT or as otherwise described below, or during an annual enrollment, or as allowed by the group.

QUALIFYING EVENTS that allow an ELIGIBLE EMPLOYEE to enroll in coverage, drop coverage, or add/drop ELIGIBLE DEPENDENTS include any of the following:

- a) an individual becomes an ELIGIBLE DEPENDENT of the ELIGIBLE EMPLOYEE through marriage, birth, adoption, placement for adoption, establishment of legal wardship or guardianship; or
- b) an ELIGIBLE EMPLOYEE experiences a divorce, legal separation, or annulment; or
- c) a DEPENDENT of the ELIGIBLE EMPLOYEE dies; or
- d) an ELIGIBLE EMPLOYEE or DEPENDENT commences or terminates employment or gains or loses coverage under another health plan or dental insurance; or
- e) an EMPLOYEE changes employment status and becomes an ELIGIBLE EMPLOYEE; for instance, moving from under 20 regular hours a week to 20+ regular hours a week, or moving from a non-eligible union to an eligible union or non-bargaining employment status; or
- f) an ELIGIBLE EMPLOYEE returns from an unpaid leave of absence, or
- g) an ELIGIBLE EMPLOYEE has been rehired within 31 days of termination, or a RETIREE is rehired; or
- h) an ELIGIBLE EMPLOYEE may make a change in coverage to correspond with a spouse's, domestic partner's, or family member's coverage change under another employer's health or dental plan due to marriage, divorce, death, birth/adoption/legal guardianship, loss of eligibility status or if the other plan's plan year is different than Windstream's plan year; or
- i) an ELIGIBLE EMPLOYEE or ELIGIBLE DEPENDENT becomes eligible for a premium assistance subsidy under Medicaid or a State Children's Health Insurance Program ("CHIP"); or
- j) an ELIGIBLE EMPLOYEE's or ELIGIBLE DEPENDENT's coverage under Medicaid or a State Children's Health Insurance Program ("CHIP") is terminated due to loss of eligibility. ELIGIBLE EMPLOYEE must request coverage within sixty (60) days after receipt of a determination letter from Medicaid or CHIP).

ELIGIBLE EMPLOYEES and ELIGIBLE DEPENDENTS must enroll for coverage within thirty one (31) days from the QUALIFYING EVENT. Notwithstanding the foregoing, if the QUALIFYING EVENT results from the birth or adoption of a child, and the child is under the age

of three (3), the child may be enrolled, as applicable, at any time until the first of the calendar month following the child's third birthday.

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

E1.03 INITIAL PLAN ENROLLMENT-RETIREEES. RETIREE(s) and their ELIGIBLE DEPENDENT(s) must enroll for coverage within thirty one (31) days from the RETIREE's date of retirement. RETIREE(s) and ELIGIBLE DEPENDENTs who do not do so, and who do not enroll within thirty-one (31) days of a QUALIFYING EVENT or as described below, will not be able to enroll at a future date.

A QUALIFYING EVENT for enrollment occurs when an individual becomes an ELIGIBLE DEPENDENT of the RETIREE through marriage, birth, adoption, placement for adoption, or establishment of legal wardship or guardianship.

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

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

If a DEPENDENT of a RETIREE loses coverage due to the occurrence of their birthday as specified in the APPLICATION, and said DEPENDENT enrolls in an eligible college or university on a full-time basis, that FULL-TIME STUDENT can be enrolled under a QUALIFYING EVENT.

E1.04 ANNUAL ENROLLMENT PERIOD-Active Employees. ELIGIBLE EMPLOYEEs and ELIGIBLE DEPENDENTs who do not enroll for coverage on a timely basis upon initial eligibility or upon a QUALIFYING EVENT will be permitted to enroll for coverage under the CONTRACT during annual enrollment or as allowed by the group. The PLAN ADMINISTRATOR will establish an annual enrollment period prior to the beginning of each CONTRACT YEAR.

E1.05 ANNUAL ENROLLMENT PERIOD-RETIREEES. RETIREEs and ELIGIBLE DEPENDENTs who do not enroll for coverage on a timely basis upon initial eligibility or upon a QUALIFYING EVENT will not be permitted to enroll at a future date. RETIREEs who have enrolled in a timely manner may cancel their enrollment during any annual enrollment period. Once RETIREEs cancel their coverage, they may not reenroll at a future date.

E1.06 ELIGIBLE DEPENDENTS. ELIGIBLE DEPENDENTs include SUBSCRIBER's legally married spouse (not legally separated), same sex domestic partner as defined by the GROUP and each child who is the age specified in the APPLICATION or younger. Such DEPENDENT must be a resident of the United States. Under certain circumstances, the SUBSCRIBER may be required to provide PLAN ADMINISTRATOR or DDPAR with proof of the SUBSCRIBER/DEPENDENT relationship.

The term "child" means a) a natural born child, b) a stepchild, c) an adopted child or a child lawfully placed with you for adoption, d) a child for whom the ELIGIBLE EMPLOYEE is the

legal guardian, e) a child for whom the ELIGIBLE EMPLOYEE is legally required to provide medical coverage, or f) same-sex domestic partner's children, if those children are listed on the ELIGIBLE EMPLOYEE's federal tax return as a DEPENDENT. An ELIGIBLE EMPLOYEE'S grandchild is eligible only if the ELIGIBLE EMPLOYEE's child (who is the parent of the grandchild and is an ELIGIBLE DEPENDENT) is enrolled in the plan and the grandchild lives in the same residence and is dependent on the ELIGIBLE EMPLOYEE for support (grandchild or the parent of the grandchild must be listed on the ELIGIBLE EMPLOYEE's federal tax return as a DEPENDENT.)

For Louisiana state residents, grandchildren up to age 26 are eligible if the ELIGIBLE EMPLOYEE has legal custody of the grandchild and the grandchild resides with the ELIGIBLE EMPLOYEE. The grandchild may be eligible regardless of student or marital status. Grandchildren age 26 or over who are incapable of self-support because of a disability and were covered under the Windstream plans prior to reaching the limiting age of 26 may be able to continue coverage subject to annual recertification.

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

A RETIREE's DEPENDENT child who is a FULL TIME STUDENT will continue to be an ELIGIBLE DEPENDENT until the day such DEPENDENT child attains the limiting age as defined in the APPLICATION. School vacation periods during any CALENDAR YEAR which interrupt but do not terminate what otherwise would have been a continuous course of study in that CALENDAR YEAR shall be considered part of school attendance on a FULL TIME STUDENT basis.

If an unmarried, DEPENDENT child of a RETIREE, upon reaching age nineteen (19), is TOTALLY DISABLED and resides with the SUBSCRIBER, such DEPENDENT will continue to be an ELIGIBLE DEPENDENT under the CONTRACT until such time as the DEPENDENT is no longer TOTALLY DISABLED or coverage under the CONTRACT terminates for any reason. If a DEPENDENT child of an ELIGIBLE EMPLOYEE, upon reaching age twenty six (26), is TOTALLY DISABLED and resides with the SUBSCRIBER, such DEPENDENT will continue to be an ELIGIBLE DEPENDENT under the CONTRACT until such time as the DEPENDENT is no longer TOTALLY DISABLED or coverage under the CONTRACT terminates for any reason.

The EMPLOYEE will be required to provide DDPAR or PLAN ADMINISTRATOR with written evidence of a DEPENDENT child's disability status.

E1.07 EFFECTIVE DATE OF COVERAGE. Coverage for an ELIGIBLE EMPLOYEE, RETIREE, or ELIGIBLE DEPENDENT who timely enrolls will be effective on whichever of the following occurs first:

- a) IBEW 1671 ELIGIBLE EMPLOYEE and ELIGIBLE DEPENDENT will be effective on 1st of the month following 60 days of employment, provided ELIGIBLE EMPLOYEE and ELIGIBLE DEPENDENT enrolls within sixty (60) days of employment.

Non-Bargaining ELIGIBLE EMPLOYEE and ELIGIBLE DEPENDENT and union ELIGIBLE EMPLOYEE and ELIGIBLE DEPENDENT in CWA 3174, 3371, 3372, 7470, 74701, 6171, 617101, 4488, 4321, 4485, 13000, 10300, 10800, 10500, 10900, 3683, 3684, 3716, 3511, and IBEW 0463, 1189, 1929, 2089, 2374, 150701, 150710, will be effective on the 1st of the month following 90 days of employment, provided the ELIGIBLE EMPLOYEE and ELIGIBLE DEPENDENT enrolls within sixty (60) days of employment.

CWA 7172 and IBEW 204 ELIGIBLE EMPLOYEES and ELIGIBLE DEPENDENTS will be effective on the 91st date of employment, provided the ELIGIBLE EMPLOYEES and ELIGIBLE DEPENDENTS enroll within sixty (60) days of employment.

- b) The 1st of the month following the date of retirement for RETIREES and ELIGIBLE DEPENDENTS, provided RETIREE and ELIGIBLE DEPENDENTS enroll within thirty one (31) days of retirement date (date of employment termination).
 - c) On the event date of a QUALIFYING EVENT, provided ELIGIBLE EMPLOYEES and ELIGIBLE DEPENDENTS enroll within thirty one (31) days from the QUALIFYING EVENT unless otherwise specified in E1.02(j), or unless the QUALIFYING EVENT is a divorce, legal separation, or annulment as specified in E1.02(b). If the ELIGIBLE EMPLOYEE experiences a QUALIFYING EVENT of divorce, legal separation, or annulment, then the newly enrolled coverage becomes effective on the 1st day of the month following the QUALIFYING EVENT.
 - d) On the event date of a QUALIFYING EVENT, provided RETIREE and ELIGIBLE DEPENDENTS enroll within thirty one (31) days from the QUALIFYING EVENT unless otherwise specified in E1.02(j).
 - e) As of the first day of the plan year following the annual enrollment period, if the ELIGIBLE EMPLOYEES, RETIREES, and ELIGIBLE DEPENDENTS enrolls for coverage during the annual enrollment period.
- E1.08** The APPLICATION for coverage is subject to DDPAR's approval.
- E1.09** For coverage to be in effect, DDPAR must have received the enrollment information and the payment of that month's PREMIUM. The monthly PREMIUM for a PARTICIPANT must have been paid for coverage to be in effect for that month.
- E1.10** GROUP SPONSOR will be responsible for enrolling all PARTICIPANTS. Enrollment information must be furnished to DDPAR in a timely manner. Enrollment must be reported using one of DDPAR's standard formats. If special programming is needed to accommodate GROUP SPONSOR's electronic eligibility format, the cost may be billed to the group.
- E1.11** By the EFFECTIVE DATE of the CONTRACT, the GROUP SPONSOR will furnish eligibility information for all PARTICIPANT(s). This information shall include the EMPLOYEE's names, addresses, social security numbers, dates of birth, dates of hire, DEPENDENT coverage information, and location code (if required by group). GROUP SPONSOR may submit this information via electronic media or by completing dental ENROLLMENT FORMS provided by DDPAR. GROUP SPONSOR will report all ELIGIBLE EMPLOYEE(s) hired after the EFFECTIVE DATE and any COBRA-PARTICIPANT(s), as applicable.
- E1.12** DDPAR will provide to GROUP SPONSOR each month a listing of EMPLOYEE(s) and DEPENDENT(s) as reported to DDPAR. GROUP SPONSOR will confirm continued eligibility of EMPLOYEE(s) and DEPENDENT(s) and return the listing to DDPAR by the first day of the month. GROUP SPONSOR will also report terminations as they occur, but in no case later than the first day of the month. DDPAR will not pay BENEFITS for an EMPLOYEE or his or her DEPENDENT(s) if the EMPLOYEE is not on the listing.
- E1.13** The PARTICIPANT will be allowed to continue BENEFITS during a PARTICIPANT's unpaid leave of absence as determined by the policy of the GROUP SPONSOR. If it is the policy of the GROUP SPONSOR not to continue BENEFITS for an unpaid leave of absence, the PARTICIPANT will not have coverage during this leave. PARTICIPANTS may continue coverage under COBRA, if applicable, or an applicable state continuation of coverage provision when the EMPLOYEE is on strike or layoff.

- E1.14** If it is the policy or legal responsibility of the GROUP SPONSOR to continue coverage during a leave of absence, the GROUP SPONSOR will be responsible for the timely payment of all PREMIUMs due to DDPAR for the EMPLOYEE on leave of absence. The GROUP SPONSOR must continue to consider the person a permanent EMPLOYEE, and all other GROUP BENEFITS, including dental, must be continued.
- E1.15** An EMPLOYEE loses coverage when employment BENEFITS are terminated by the GROUP SPONSOR at the end of month employment is terminated, when applicable PREMIUM(s) are not paid/received, when EMPLOYEE loses eligibility, or at the end of the CONTRACT. DEPENDENT(s) will lose coverage along with the EMPLOYEE or earlier if DEPENDENT loses his or her DEPENDENT status. EMPLOYEE(s) will lose coverage as specified in the APPLICATION.
- E1.16** Possession of an identification card does not guarantee a PARTICIPANT is eligible for BENEFITS. Eligibility is based on information reported to DDPAR by the GROUP. Eligibility may be confirmed by calling DDPAR's Customer Service Representatives, but the card **is not a guarantee of payment.**
- E1.17** DDPAR will not continue to pay BENEFITS for any PARTICIPANT(s) when they lose eligibility upon notification from the GROUP SPONSOR. As provided by COBRA, USERRA, or any applicable state continuation of coverage provision, if applicable, coverage may continue for up to eighteen (18) months where the EMPLOYEE's coverage ends as a result of a reduction in work hours or termination of employment in accordance with and pursuant to such provisions. Coverage may not continue if the termination is the result of gross misconduct.

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

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

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

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

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

An ELIGIBLE EMPLOYEE who is absent from employment in order to serve in the uniformed services, as well as his or her ELIGIBLE DEPENDENTs, may elect to continue health coverage

during the period of uniformed service, if applicable. The maximum length of the continuation coverage required under USERRA is the lesser of:

- a) twenty four (24) months (beginning on the day that the uniformed service leave commences), or
- b) a period beginning on the day the uniformed service leave commences and ending on the day the EMPLOYEE fails to return to or reapply for employment within the time allowed by USERRA.

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

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

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

- E1.18** As PLAN ADMINISTRATOR, it will be the GROUP SPONSOR's responsibility to tell EMPLOYEEs and DEPENDENTs of their rights under this CONTRACT.
- E1.19** GROUP SPONSOR will let DDPAR inspect GROUP SPONSOR's records to verify that the listing of EMPLOYEEs is correct and to confirm compliance with Article 2. DDPAR will give GROUP SPONSOR reasonable, written notice before the date of inspection.
- E1.20 TAKE OVER PROVISIONS.** Within sixty (60) days from the date of the end of a prior plan, subject to the terms of this CONTRACT, DDPAR will cover all ELIGIBLE EMPLOYEEs and DEPENDENTs:
 - a) If each EMPLOYEE or DEPENDENT was validly covered under the previous plan at the date of the end of the plan.
 - b) If each EMPLOYEE or DEPENDENT is a member of the class of individuals eligible for coverage under the prior carrier's plan, regardless of any of the plan's limitations or exclusions related to "actively at work" or hospital confinement.
 - c) Only if the group accident and health BENEFITS were provided to a group consisting of more than fifteen (15) members.

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

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

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

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



SERFF Tracking Number: DDAR-128479370

State: Arkansas

Filing Company: Delta Dental of Arkansas

State Tracking Number:

Company Tracking Number: DDAR-DCON-WINDSTREAM 12A

TOI: H10G Group Health - Dental

Sub-TOI: H10G.000 Health - Dental

Product Name: Windstream 12A

Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	06/20/2012
Comments:		
Attachment:		
Compliance Certification 6-14-12.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application	Approved-Closed	06/20/2012
Bypass Reason: n/a		
Comments:		

COMPLIANCE CERTIFICATION

I, the undersigned, do hereby certify and attest that to the best of my knowledge and belief:

1. The Flesch reading score of Form DDAR-DCON-Windstream 12A is 34.5, which is below that required by Arkansas law; and
2. The nature of dental insurance requires the use of dental terminology such as "temporomandibular", which will inflate the Flesch reading score; and
3. Form Form DDAR-DCON-Windstream 12A should be approved with a Flesch reading score of 34.5.

Signed this 14th day of June, 2012.

A handwritten signature in cursive script, appearing to read "Sara Farris".

Sara Farris, Director of Compliance