DELTAVISION® 110 SUMMARY OF BENEFITS

BENEFIT FREQUENCY			
Eye Exam	Every 12 months	**Frames**	Every 24 months
Standard Plastic Lenses and Standard Progressive Lenses	Every 12 months	**Contact Lenses**	Every 12 months

INSURANCE BENEFITS	IN NETWORK BENEFIT	OUT OF NETWORK REIMBURSEMENT
Eye Exam	Covered in full after $10 co-pay	$30
Standard Plastic Lenses		
Single Vision	Covered in full after $25 co-pay	$25
Bifocal	Covered in full after $25 co-pay	$40
Trifocal	Covered in full after $25 co-pay	$55
Progressive Lenses		
Standard	$25 co-pay plus $65 Progressive upgrade	$40
Premium	See “Progressive Lens Price List”	$40
Lens Options		
Standard plastic scratch coating	$15 out of pocket maximum	$0
Standard polycarbonate - kids under age 19	$40 out of pocket maximum	$0
Standard polycarbonate - adults	$40 out of pocket maximum	$0
UV Treatment	$15 out of pocket maximum	$0
Tint (solid, gradient, & blue light)	$15 out of pocket maximum	$0
Standard anti-reflective coating	$45 out of pocket maximum	$0
Premium anti-reflective coating	See “Anti-Reflective Coating Price List”	$0
Photochromatic / Transitions Plastic	$75 out of pocket maximum	$0
Other add-ons and services	20% off retail price	$0
Frames	$110 Retail Allowance 20% off balance over retail allowance	$55
Contact Lenses		
Conventional	$110 retail allowance	$88
Disposable	$110 retail allowance	$88
Medically Necessary	Covered in full	$210

INSURANCE BENEFITS (continued)		
	IN NETWORK BENEFIT	OUT OF NETWORK REIMBURSEMENT
Progressive Lens Price List		
Standard Progressives	Covered in full after $90 co-pay	$40
Premium Progressives[1]		
Tier 1	Covered in full after $110 co-pay	$40
Tier 2	Covered in full after $120 co-pay	$40
Tier 3	Covered in full after $135 co-pay	$40
Tier 4	$90 co-pay + 20% off retail, minus $120 allowance	$40
Anti-Reflective Coating Price List		
Standard Anti-Reflective Coating	$45 out of pocket maximum	$0
Premium Anti-Reflective Coating[1]		
Tier 1	$57 out of pocket maximum	$0
Tier 2	$68 out of pocket maximum	$0
Tier 3	20% off retail	$0
Additional Benefits		
Retinal Imaging	$39 out of pocket maximum	$0
LASIK or PRK from US Laser Network	15% off retail price or 5% off promotional price	$0
Additional Discounts		
Additional pair of prescription eyeglasses	40% off retail price	$0
Non-prescription sunglasses	20% off retail price	$0
Remaining balance beyond plan coverage	20% off retail price	$0

1 - Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.

Where an “allowance” is shown, insured are responsible for paying any charges in excess of the allowance.

Eyeglass Lenses are paid in lieu of the Contact Lenses Benefit.

For Participating Providers, you may choose to use the insurance benefit or take advantage of a sale or coupon, but not both.

If you visit a Non-Participating Provider, you may be required to pay the Provider for services rendered and then submit your expenses for reimbursement.

A covered benefit for eligible dependent children to the end of the month in which the child reaches age 26.

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

CERTIFICATE OF COVERAGE

INTRODUCTION TO YOUR CERTIFICATE

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

If you have any questions about this Certificate, please call Delta Dental at 1-800-462-5410 or access our website at www.DeltaDentalAR.com.

We look forward to serving you!

DELTA DENTAL PLAN OF ARKANSAS, INC.

BY: Kristin Merlo

President

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

TABLE OF CONTENTS

Delta Dental Vision Certificate.....Section 1

How the Plan Works.....Section 2

Benefit Categories.....Section 3

Exclusions and Limitations.....Section 4

Claims Appeal Procedure.....Section 5

Who Gets Benefits.....Section 6

When Coverage Ends.....Section 7

Continuation of Coverage.....Section 8

General Conditions.....Section 9

Definitions.....Section 10

Attachments

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

1. DELTA DENTAL VISION CERTIFICATE

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

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

This Certificate takes effect the first day of the month after We receive Your Application, the required Premium is paid, and Your eligibility is confirmed.

Your coverage under this Certificate begins at 12:01 a.m. standard central time zone on the effective date. Coverage will end at 12:00 midnight standard central time zone on the date set out in Section 6. Delta Dental will continue Your coverage unless and until You or Delta Dental terminates it for any of the reasons described in this Certificate. Delta Dental determines Your eligibility for Benefits under this Certificate.

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

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

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

In the case of a solicitation by direct response methods, Delta Dental will provide the disclosure form to You at the time the policy is delivered, with a notice that a full premium refund shall be received if the policy is returned to Delta Dental within the ten-day free look period for individual contracts.

2. HOW THE PLAN WORKS

2.1. Selecting a Provider

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

2.1.1. How do I select a Vision Provider?

The easiest and most accurate listing of Participating Providers is on Our website. Log into the Delta Dental Member Portal and then click on the Provider Directory link. Once at the web page, select the “Vision” icon and enter Your zip code. By entering the information requested, We will provide You with a list of Participating Providers in Your area. You can also get this information by calling EyeMed Customer Service at 888-922-4875.

2.2. Accessing Your Benefits

To utilize Your vision benefits, follow these steps:

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

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

Make an appointment with Your Provider and tell them that You have vision benefits with DeltaVision utilizing EyeMed Insight Network. If Your Provider is not familiar with DeltaVision or has any questions, have them contact EyeMed Provider Services.

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

2.3. The Claims Process

Claims must be filed by You, Your Provider, or Your authorized representative with Delta Dental within 6 months after completion of treatment for Benefits that are payable. Any Claim filed after this time period will be denied.

Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

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

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

If You visit a Non-Participating Provider, You will be required to submit an itemized invoice or receipt to Us.

2.4. Processing the Claim.

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

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

2.5. Authorized Representative

You may appoint an authorized representative to deal with EyeMed on Your behalf with respect to any Claim You file or any appeal of a denied Claim You wish to pursue (see the Claims Appeal Procedure section). You should contact EyeMed Customer Service at 888-922-4875, to request a form to designate the person You wish to appoint as Your representative.

2.6. How Payment is Determined

Network Benefits

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

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

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

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

Non-Network Benefits

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

Out-of-Country Benefits

If your Provider is an out of country provider, Delta Dental will base payment on Delta Dental's Maximum Out of Network reimbursement amount in U.S. dollars for the particular Covered Services.

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

2.7. Medically Necessary Services

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

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

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

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

2.8. Questions and Assistance

Questions regarding Your coverage should be directed to Delta Dental, toll-free, at 1-800-507-3800. You may also write to Delta Dental at P.O. Box 15969, Little Rock AR 72231. When writing to Delta Dental, please include Your name, the Subscriber's member ID number, and Your daytime telephone number.

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 You may write the Department at:

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

3. BENEFIT CATEGORIES

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

Eye Exam

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

Lenses

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

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

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

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

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

Frames

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

Contact Lenses

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

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

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

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

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

4. EXCLUSIONS and LIMITATIONS

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

1 Services or materials for which no charge is made that the Participant is legally obligated to pay, including services for which no charge would be made in the absence of vision coverage.

2 Charges by a Participant or a provider for completion of forms and/or submission of supportive documentation required by Delta Dental for a benefit determination. A charge for these services is not to be made to You by a Participating Provider.

3 Two or more pairs of glasses in lieu of bifocals, trifocals or progressives.

4 Broken, lost or stolen lenses, contact lenses or frames.

5 Medical or surgical treatment of the eye, unless such treatment is performed during a Vision Examination, subject to the applicable Vision Examination Maximum Benefit shown in the Schedule of Benefits.

6 Services or materials which are payable under any Worker's Compensation Act or similar law or any public program other than Medicaid.

7 Services or materials rendered by a provider other than an Ophthalmologist, Optometrist, or Optician acting within the scope of their license.

8 Any additional service required outside basic vision analyses for contact lenses, except fitting fees.

9 Vision examination for vision materials that may be required as a condition of employment, including but not limited to industrial or safety glasses. Coverage will be provided if the service is otherwise covered under the Covered policy.

10 Services rendered after the date a Participant ceases to be covered under the Covered Policy, except when vision materials ordered before coverage ended are delivered and the services are rendered to the Participant within 31 days from the date of such order.

11 Services rendered or materials ordered before the date coverage began under the Covered Policy.

12 Regardless of Optical Necessity, benefits are not available more frequently than that which is specified in the Schedule of Benefits.

13 Allowances are one-time use benefits; no remaining balance.

14 Discounts do not apply for benefits provided by other group benefit plans.

15 Any other benefits, services, or materials not specifically covered in the Certificate, Schedule of Benefits and/or Limitations and Exclusions.

5. CLAIMS APPEAL PROCEDURE

5.1. Informal Request for Review

If You receive an explanation of benefits that indicates an Adverse Benefit Determination and You think that Delta Dental incorrectly denied all or part of Your Claim, You or Your Provider may, but are not required to, contact Delta Dental and ask Us to check the Claim to make sure it was processed correctly. You may do this by calling Delta Dental at 1-800-462-5410 or mailing Your inquiry to Delta Dental Attn: Customer Service Department at P.O. Box 15965, Little Rock, Arkansas, 72231.

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

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

5.2. Formal Claims Appeal Procedure

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

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

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

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

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

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

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

5.3. Manner and Content of Notice

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

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

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

6. WHO GETS BENEFITS

6.1. Eligible Individual

You must be (i) a resident of the State of Arkansas and (ii) a current member of Arkansas Retired Teachers Association to apply for vision coverage with Us. You will be eligible to enroll for coverage on the first day of the calendar month after You have completed an

Application, the Application has been accepted by Us, and the applicable Premium has been paid.

Subject to any requirements, restrictions, or limitations pursuant to applicable law that define when an individual is eligible to enroll for coverage, for example, an open enrollment period provided for pursuant to a health insurance marketplace exchange created pursuant to PPACA, You will be eligible to enroll for coverage on the first day of the calendar month after You have completed an Application, the Application has been accepted by Us, and the applicable Premium has been paid.

Note: If You terminate Your coverage under this Certificate, You must wait twelve months from the date of termination to be eligible to enroll with Us again.

6.2. Dependent Coverage

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

Your Eligible Dependents include:

1. Your legally married spouse (not legally separated).
2. Your child until he or she reaches the age of 26.
3. Your children who have reached the end of the Calendar Year of their nineteenth (19) birthday, but who were at that time (and continue to be) totally and permanently disabled by a physical or mental condition. Those children must also be eligible to be claimed by You or Your legal spouse as dependents under the U. S. Internal Revenue Code during the current Calendar Year. If Delta Dental asks You to do so, you must submit medical reports confirming the child's initial or continuing total disability.
4. A child of your child who is your dependent for federal income tax purposes at the time application for coverage of the child is made.

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

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

6.3. When Does Coverage Start

In order for Your coverage to take effect, You must meet the eligibility requirements described in Section 6.1 and 6.2, submit an Application for

coverage for Yourself and Your Eligible Dependents, and pay any required Premium. It is important that Your Application is received by Delta Dental in a timely manner.

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

6.4. Individual Change Form

You may obtain an Individual Change Form by calling Delta Dental at 1-844-368-6484 or by visiting Delta Dental's website at www.dentaldentalar.com. You may also contact our Customer Service center at 844-788-7627 to make changes. After You have completed the Individual Change Form, return it to Delta Dental.

Use this form to:

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

7. WHEN COVERAGE ENDS

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

7.1. When Your Coverage Ends

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

7.2. When Covered Dependent's Coverage Ends

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

7.3 Premium Due Date and Grace Period

Premium for coverage under this Certificate is due no later than the 1st day of the month for which the coverage applies. For example, if coverage is for the month of July, premium for the

month of July must be paid no later than July 1st. All Participants lose coverage when the applicable Premium is not timely received by Us.

Except as otherwise provided in this Section 7.3, a grace period of 30 days will be granted for the payment of each Premium falling due after the first Premium during which grace period the Certificate shall continue in force. However, during this period of time We will pend any and all Claims received. If Premium is not paid within 31 days after it becomes due and payable, this Certificate is terminated as of the date on which the Premium was due and payable and We will seek to recoup amounts paid to Providers during the grace period.

7.4 Reinstatement.

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

8. GENERAL PROVISIONS

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

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

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

shall be null and void. Subject to the foregoing limitation, this Certificate shall be binding on the parties and their respective successors and assigns.

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

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

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

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

8. Right to Develop Policies and Guidelines. We reserve the right to develop or adopt policies and guidelines for the administration of Benefits under this Certificate. These policies and guidelines will be interpretive only and will not be contrary to any terms of this Certificate. If you have a question about the policies or guidelines used to apply to a particular Benefit, you may contact EyeMed at 800-922-4875.

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

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

11. Notice of Claim. We must receive Your Claim for Benefits within no more than 6 months from the date You receive the service. Failure to meet this requirement will result in payment denial.

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

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

14. Proofs of Loss. Written proof of loss must be furnished to Delta Dental at its said office in case of claim for loss for which Your Policy provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which Delta Dental is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

15.

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

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

18. Choice of Jurisdiction. All litigation, including any action requesting a jury trial, related to the terms or conditions of this Certificate will be in a court of valid jurisdiction.

19. Legal Actions. No action at law or in equity will be brought before 60 days after proof of loss has been filed as required by this Certificate. Any action must be brought within 3 years from the time proof of loss is required by this Certificate.

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

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

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

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

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

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

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

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

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

9. Definitions

9.1. “Adverse Benefits Determination” means any denial, reduction or termination of Benefits by Delta Dental for which a Claim has been filed.
9.2. “Application” means the Delta Dental Individual and Family Application You submit to Delta Dental in order to enroll in a policy.
9.3. “Benefit” means the sums that Delta Dental will pay for limited-scope vision services under Your policy as set out in this document, subject to the conditions, limitations, and restrictions set forth herein.
9.4. “Certificate of Coverage (Certificate)” is this document evidencing that certain insurance coverage/protection is provided to Participants.
9.5. “Claim” means a request for Benefits under this Certificate by the Participant, a Provider, or an authorized representative of the Participant which is submitted in accordance with Delta Dental’s standard procedures for filing a Claim. A Claim includes a request for payment for a service, supply, prescription drug, equipment or treatment. A Claim does not include any Benefit inquiries where such inquiries do not follow the requirements established in the Claim procedures.
9.6. “Contract Year” is the twelve (12) month period beginning on the first day of the calendar month in which Your Premium has been paid and each subsequent twelve (12) months while this Certificate is in effect.
9.7. “Covered Dependent” means an Eligible Dependent who is enrolled for Benefits under this Certificate and for whom Delta Dental has received Premium.
9.8. “Covered Services” is the unique vision services selected for coverage as described in the Schedule of Benefits and subject to the terms of this Certificate.
9.9. “Eligible Dependent” is an individual who meets the eligibility requirements as set forth in Section 6.2.
9.10. “Policy” is the vision Benefits to which the Certificate applies.
9.11. “Non-Participating Provider” is any Provider other than a Participating Provider.
9.12. “Participant” is an Eligible individual or an Eligible Dependent who is enrolled for Benefits under this Certificate and for whom Delta Dental has received Premium.
9.13. “Participating Provider” is a Provider who has contracted with or for the benefit of Delta Dental.
9.14. “Premium” is the monthly amount to be paid by You to Delta Dental for coverage under the Certificate.
9.15. “Provider” means an Ophthalmologist, Optometrist or Optician who is operating within the scope of his or her license or a dispensing optician.
9.16. “Schedule of Benefits” is the document that lists the Benefits that will be provided a Participant. Such Schedule of Benefits shall be the one in effect and for which vision Premiums are remitted at the time vision care is provided.
9.17. “Subscriber” means the individual to whom this Certificate is issu

GRAMM-LEACH-BLILEY PRIVACY NOTICE

What Does Delta Dental Do With Your Personal Information?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Delta Dental Plan of Arkansas, Inc.

Amendment to Individual Contract

Individual Plan ARTA01

The following changes are made to Delta Dental Plan of Arkansas, Inc.'s vision benefits:

Material Copays: The current plan has a material copay that is applied to frames and/or eyeglass lenses.

The new plan will have a copay that is applied to eyeglass lenses. There is no copay on frames or contact lenses.

Frames or Contact Lenses: Under the current plan, the contact lens allowance could be utilized in lieu of an eyeglass frame and eyeglass lenses.

Under the new plan, the contact lens allowance can be utilized in lieu of eyeglass lenses. Meaning, a member can use their contact lens benefit, and still have the allowance for the eyeglass frame. Contact lenses and eyeglass lenses cannot be utilized in the same benefit year, but members can take advantage of discount options to pay for the eyeglass lenses out of pocket.

Optional Lens Options: Under the current plan, some optional services, such as lens options, were covered to the providers' retail amount or a discounted fee.

The new plan will have set out of pocket maximum amounts on optional services, clearly identifying out of pocket expenses.

All other provisions of the contract remain in full force and effect. This Amendment shall become effective on 12:01 a.m. CST, January 1, 2023.

Delta Dental Plan of Arkansas, Inc.



Chief Executive Officer