Delta Dental
Individual and Family
for the Arkansas Retired Teachers Association

DENTAL AND VISION PLANS AT A PRICE THAT WILL MAKE YOU SMILE.

WHY DENTAL INSURANCE?

To improve your health
People with dental insurance typically visit the dentist more often that those without, resulting in better dental and overall health. Besides keeping your smile healthy, your dentist can also help identify more than 120 signs and symptoms of non-dental diseases—including heart disease and diabetes—before they become larger problems.

To save you money in the long run
Prevention costs less than treatment. Most dental plans, such as Delta Dental Individual and Family, encourage prevention by covering the cost of exams, cleanings, X-rays and more in order to help prevent dental disease rather than to perform expensive, and sometimes painful, restoration work later.

WHAT’S COVERED?

PREVENTIVE & DIAGNOSTIC
✓ Two routine exams per benefit period
✓ X-rays
✓ Two cleanings per benefit period
✓ Two fluoride applications for dependent children up to age 19
✓ Sealants for dependent children up to age 16

BASIC RESTORATIVE SERVICES
✓ Minor emergency treatment
✓ Fillings
✓ Simple extractions
✓ Space maintainers for dependent children up to age 14

MAJOR RESTORATIVE SERVICES
✓ Crowns
✓ Endodontics (root canals)
✓ Oral surgery
✓ Stainless steel crowns for dependent children up to age 16
✓ Dentures, bridges, partials
✓ Periodontics treatment (gum disease)
Dental Plans

In-network Dental

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Deductible</td>
<td>$50</td>
</tr>
<tr>
<td>Benefit-year Maximum</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

What the plan pays for after you have satisfied the deductible

<table>
<thead>
<tr>
<th>Field</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive &amp; Diagnostic</td>
<td>100%</td>
</tr>
<tr>
<td>Basic Restorative Services</td>
<td>80%</td>
</tr>
<tr>
<td>Major Restorative Services</td>
<td>50%</td>
</tr>
</tbody>
</table>

Waiting Periods*

<table>
<thead>
<tr>
<th>Field</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive &amp; Diagnostic</td>
<td>None</td>
</tr>
<tr>
<td>Basic Restorative Services</td>
<td>6 months</td>
</tr>
<tr>
<td>Major Restorative Services</td>
<td>12 months</td>
</tr>
</tbody>
</table>

Monthly Premiums

<table>
<thead>
<tr>
<th>Plan</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$29.91</td>
</tr>
<tr>
<td>Individual &amp; Spouse</td>
<td>$63.63</td>
</tr>
<tr>
<td>Individual &amp; Child(ren)</td>
<td>$59.80</td>
</tr>
<tr>
<td>Family</td>
<td>$91.94</td>
</tr>
</tbody>
</table>

Out-of-network Benefits

The benefit allowance for services of an out of network dentist will be reduced by 10 percent for eligible services as determined by Delta Dental of Arkansas after applying the applicable deductibles, co-payments and maximums. This means your out-of-pocket expense will be more if you choose an out-of-network dentist.

*Waiting periods will be waived if:

1. Your application is received within 31 days of the termination of your prior carrier.
2. You have had at least 6 months of continuous coverage in Basic Restorative Services.
3. You have had at least 12 months of continuous coverage in Major Restorative Services.

To waive waiting periods, please submit a copy of your Certificate of Creditable Coverage verifying your previous dental coverage and a copy of your covered benefits.

Carry Over Benefit

Delta Dental allows you to “carry over” unused portions of your benefits to help increase your annual benefit maximum limit. The maximum amount you can add to your benefit each year is $250 with a lifetime total of $1,000. To qualify for an increase in your annual limit, you must submit at least one claim for covered services during your benefit year and paid claims must be less than $499.

The dental plans offered in this brochure do not include pediatric dental services as required under the Affordable Care Act (ACA). To learn more about Delta Dental’s ACA compliant dental plans and assistance to help you determine if you need an ACA compliant pediatric dental plan, please call our marketing representatives at (800) 971-4108 or visit www.mysmilecoverage.com/AR.

Vision Plans

<table>
<thead>
<tr>
<th>Plan</th>
<th>Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Exam</td>
<td>Covered in full after $10 co-pay</td>
</tr>
<tr>
<td>Frame</td>
<td>Covered in full after $25 co-pay for any frame with a wholesale value up to $35 (retail prices will vary but will be approximately $75–$100). Frames from participating Walmart locations are covered up to a $52 retail value.</td>
</tr>
<tr>
<td>Lenses</td>
<td>Standard single vision, bifocal, trifocal and lenticular covered in full after $25 co-pay.</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>$110 which can be used toward the evaluation, fitting and follow-up care.</td>
</tr>
<tr>
<td>Contact Lens—Medically necessary</td>
<td>Covered in full with prior authorization</td>
</tr>
<tr>
<td>Laser Vision Correction</td>
<td>5%–25% off</td>
</tr>
</tbody>
</table>

Dental + Vision Monthly Premiums

<table>
<thead>
<tr>
<th>Plan</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$37.00</td>
</tr>
<tr>
<td>Individual &amp; Spouse</td>
<td>$75.20</td>
</tr>
<tr>
<td>Individual &amp; Child(ren)</td>
<td>$72.35</td>
</tr>
<tr>
<td>Family</td>
<td>$110.73</td>
</tr>
</tbody>
</table>

TAKE CARE OF YOUR SMILE AND YOUR VISION!

Delta Dental also offers vision insurance when you select an individual or family dental plan.

Vision and eye health problems are the second most prevalent and chronic health care problems in the United States—affecting more than 120 million people. Like dental insurance, vision plans promote routine care which keeps your eyes healthy and can help detect diseases such as diabetes.

Choose the dental plan that best fits your needs, and add vision to receive coverage for eye exams and glasses or contacts. With Delta Dental, you can keep your smile and vision healthy at a price you can afford.
FREQUENTLY ASKED QUESTIONS

Q: Who is eligible for coverage under a Delta Dental Individual and Family plan?
A: You must be an Arkansas resident and an ARTA member to be eligible for coverage. Acceptance is guaranteed regardless of age, dental history or pre-existing conditions.

Q: What are the age limitations for dependent children?
A: Dependent children can continue coverage until the end of the month in which they turn 26.

Q: What services are NOT covered under this plan?
A: For a complete list of services not covered, please visit our website to view the Schedule of Benefits. General services that are not covered include:

- Tooth implants
- Tooth whitening
- Athletic mouth guards
- Braces and retainers
- Treatment for TMJ (temporomandibular joint disturbances)
- Services to correct cosmetic dentistry
- Dental care started prior to the date the patient became covered under this plan

For more information, call your agents.

Matt Hughes (479) 967-1339
Mary Alice Hughes (501) 988-2726
Delta Dental Individual and Family Application
Plan number INARTA001

Requested Effective Date
Month Day Year
1st

Rates effective 1/1/14–12/31/14

Please mail to:
Delta Dental of Arkansas
PO Box 646, Jacksonville, AR 72078

Applicant Information
Applicant Name: __________________________ Date of Birth: __________ Sex: _______
Mailing Address: __________________________________________ City: __________ State: _______ ZIP: __________
Social Security Number: __________________________ Phone Number: __________________________
Email: __________________________________________

Receive claims and other important, time sensitive information using this email!

Plan Selection (Choose one)
☑ Dental  ☐ Dental Plus Vision

Type of Coverage (Choose one)
☐ Individual  ☑ Individual & Spouse  ☑ Individual & Child(ren)  ☑ Individual, Spouse & Child(ren)

Dependents
<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Date of Birth</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Previous Coverage
Will this replace existing dental coverage? ☑ Yes  ☐ No
If you are purchasing this coverage to replace an existing Delta Dental of Arkansas plan, please provide the anticipated termination date of your current plan: __________. If the coverage will replace a plan with another carrier, please submit a copy of the Certificate of Creditable Coverage and a list of covered benefits. A Certificate of Creditable Coverage and covered benefits can be obtained from your previous insurance carrier or your employer group health administrator.

Household Residential Information
Do all proposed insureds reside in Arkansas? ☑ Yes  ☐ No
If no, please provide reason: __________________________________________

Payment Method—Bank Draft or Credit Card Only (Do not send a live check)
Bank Draft (EFT): ☑ Monthly  ☐ Annually
Bank Account Type: ☑ Checking  ☐ Savings
Routing Number: __________________________
Account Number: __________________________

PLEASE SEND A VOIED CHECK WITH APPLICATION.

I authorize Delta Dental of Arkansas (DDAR) and the BANK* indicated above to debit my DDAR premium from my checking or savings account indicated above. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such time and such manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) days written notice of the BANK’s termination of this agreement.

I understand that by revoking the Pre-Authorized Bank Draft Program after I have agreed to it, I will also be terminating my DDAR coverage, unless DDAR has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorized Bank Draft Program date.

Signature of Bank Account Holder: __________________________ Date: __________

Monthly bank drafts are processed on the 1st of each month. If the 1st of the month falls on a weekend or holiday, then bank drafts will be processed the following business day.

*BANK also applies to Savings and Loan

DDARTA-2014-WEB
Credit Card Information

Credit Card:  ■ Monthly  ■ Annually
Credit Card Type:  ■ Visa  ■ MasterCard  ■ Discover
Credit Card Number: __________________________________________________________
Expiration Date (MM/YYYY): ____________________________  CVV Number (3 digit security code on back of card): _______________________
Credit Card Holder’s Name: _______________________________________________________
Signature of Credit Card Holder: ____________________________________________________________________________________ Date: _________________

Monthly credit card drafts are processed on the 26th of the prior month (Example: February premium will be drafted January 26th).

Correspondence

NOTICE—All correspondence regarding this plan will be sent electronically to the email address listed on the front of this application unless applicant requests to be contacted via mail.

■ Check box to opt out of electronic correspondence

Policy Effective Date

The Delta Dental policy effective date is always the 1st of the month. This application must be received by Delta Dental of Arkansas by the 15th of the month prior to the effective date (example: received by January 15th to be effective February 1st). Applications received after the 15th of the month will be made effective on the 1st of the following month (example: received on January 16th, will be effective March 1st).

Authorization

I authorize dentists, dental office personnel and other health care professionals and entities to disclose to Delta Dental of Arkansas, its agents and employees (including, without limitation, its claims and customer service personnel) all information necessary to determine (1) eligibility for coverage and (2) covered benefits. This authorization is made for each individual to be enrolled or affected by this change. The authorization is valid for the term of coverage for the purpose of collecting information in connection with claims for benefits. The applicant or the applicant’s authorized representative is entitled to receive a copy of the authorization form.

Applicant Signature: __________________________________________________________________________ Date: _________________
Signature of Parent/Legal Guardian: __________________________________________________________________________ Date: _________________
(if policy is for a minor only)

City in which application was signed: ____________________________________________________________, Arkansas

Certification

I certify that the information supplied by me on this form is accurate to the best of my knowledge. 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 fine and confinement in prison. Statements made in this application are representations not warranties.

Applicant Signature: __________________________________________________________________________ Date: _________________

To Be Completed By Sales Representative ONLY If Applicable

Agent Name: Matt Hughes  Agency Name: ____________________________
Producer#: HUG001  Phone Number: (479) 967-1339