IMPORTANT INFORMATION

To be eligible for an Arkansas Blue Cross dental insurance policy, you must be an Arkansas resident. Other eligibility rules may apply. Dependents who become ineligible may continue their coverage by completing a new dental plan application within 30 days of becoming ineligible for coverage under their existing policy. At that time, the policyholder will be credited for any waiting and frequency periods met and will begin a new dental benefit year; however, credit will not be given for a met deductible. This outline of coverage provides a brief description of the important features of the dental insurance policy. The outline is not the policy, and only the actual policy provisions will control. Children age 26 and above are not eligible to apply for coverage on a parent's plan. These policies are represented by the following form numbers:

Dental Pediatric Plan 64-314 (Off Marketplace), 64-315 (On Marketplace); **Dental Silver Plan** 64-316 (Off Marketplace), 64-317 (On Marketplace) **Dental Gold Plan** 64-318 (Off Marketplace), 64-319 (On Marketplace; **Dental Gold Plus Vision Plan** 64-320 (Off Marketplace), 64-321 (On Marketplace); **Dental Platinum** 64-364 (Off Marketplace), 64-365 (On Marketplace); **Dental Platinum Plus Vision** 64-366 (Off Marketplace), 64-367 (On Marketplace)

The policy itself sets forth in detail the rights and obligations of both you and the insurance company. It is, therefore, important that you read the policy carefully. This policy is guaranteed renewable as long as you reside in Arkansas. The company may change the established premium rate, but only if the rate is changed for all policies and riders of the same form number and premium classification.

WAITING PERIODS

For individuals age 19 or older, some dental plans contain waiting periods prior to certain services being covered. Once the waiting period is satisfied, those services are payable, subject to all other terms, conditions, exclusions and limitations of the policy.

PEDIATRIC BENEFIT LIMITATIONS | for Pediatric, Silver, Gold, Gold Plus Vision, Platinum and Platinum Plus Vision Plans

Routine dental exams, prophylaxis, fluoride treatments, and bitewing x-rays for dependent children under age 19 are limited to two in a calendar year; comprehensive dental evaluations are limited to one per covered person every 24 months; sealants for permanent first and second molars only and limited to one sealant per lifetime; stainless steel crowns for those under the age of 14, crown lengthening, and guided tissue regeneration are limited to one per tooth per lifetime. Removable prosthetics including complete and partial dentures are limited to one per each five-year period.

ADULT BENEFIT LIMITATIONS | for Silver, Gold, Gold Plus Vision, Platinum and Platinum Plus Vision Plans

Routine dental exams, prophylaxis are limited to two in a calendar year; bitewing x-rays (one occurrence of two, three, four or eight vertical bitewings for adults 19 and older) are limited to one in a calendar year; comprehensive dental evaluations are limited to one per covered person every 24 months; full mouth radiographs, single crowns, crown buildups including pins are limited to one per each five-year period; root canal therapy is limited to one per tooth per lifetime.

ADULT BENEFIT LIMITATIONS | for Gold, Gold Plus Vision, Platinum and Platinum Plus Vision Plans

Rebasing/relining of full or partial dentures is limited to one in a three-year period; inlays and onlays for treatment of decay, single crowns, removable prosthetics, partial denture retainers, post and cores are limited to one per each five-year period; crown lengthening, and guided tissue regeneration are limited to one per tooth per lifetime.

PEDIATRIC AND ADULT BENEFIT EXCLUSIONS | for all Plans

Orthodontic services; services, procedures or supplies not dentally necessary; services or procedures not prescribed or rendered by a dentist; services or supplies collectible under Worker's Compensation; services for conditions for which treatment is provided by federal or state government or are provided without cost; accidental injuries, injuries or diseases caused by war; cosmetic services; prescription drugs; local or block anesthesia when billed separately; experimental or investigational services; services provided by an immediate relative.

COVERED PERSONS 19 AND OLDER BENEFIT EXCLUSIONS | for all Plans

Re-evaluation limited, problem focused and comprehensive periodontal evaluation; oral surgery procedures for jaw deformities, resections, etc; apically positioned flap procedure; enamel microbrasion; odontoplasty; sleep apnea appliances; biologic materials to aid in soft and osseous tissues regeneration; provisional pontic and titanium pontic; provisional retainer crown; pediatric partial denture-fixed; mobilization of erupted or malpositioned tooth to aid eruption; cytology sample collection; fixed partial denture resin crowns, retainer or pontics on permanent teeth; orthodontic treatment for any reason is not covered; hospital or anesthesia fees due to the management of the patient; hospital facility fees for dental services; biopsy of oral tissue; sutures of small wounds and complicated sutures; occlusal guard.

GENERAL VISION | Coverage Limitations

All vision benefits are based on the frequency periods, copayments and discounts stated in the policy. Vision exams and materials are further limited to the allowable charge as determined by the company. Any amount over the allowable charge is the covered person's responsibility.

The following items are excluded under this plan:

- Two pairs of glasses instead of bifocals
- Replacement of lenses, frames or contacts
- Medical or surgical treatment
- Orthoptics, vision training or supplemental testing

Items not covered under the contact lens coverage:

- Insurance policies or service agreements
- Artistically painted or nonprescription lenses
- Additional office visits for contact lens pathology
- Contact lens modification, polishing or cleaning

VISION | Out-of-Network Reimbursement

If you choose an out-of-network vision provider, you pay the provider directly for all charges and then submit a claim for reimbursement. Out-of-network reimbursement includes:

Eye exam – $45;
Single vision lenses – $30;
Bifocals – $50;
Progressives – $50;
Trifocals – $65;
Lenticular – $100;
Frame – $70;
Elective contact lenses – $85;
Necessary contact lenses – $210

Our Company complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-662-2276. CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-662-2276.

Arkansas BlueCross BlueShield
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DENTAL AND VISION PLANS

PEDIATRIC
For children under the age of 19, this plan meets the Affordable Care Act (ACA) guidelines for preventive and restorative dental care.

SILVER
For children under age 19, this plan covers the same benefits as the pediatric plan, however, member cost share (copayments or coinsurance) may differ. For adults, it covers preventive services, as well as some minor and major restorative services.

GOLD
For children under age 19, this plan covers the same benefits as the pediatric plan, however, member cost share (copayments or coinsurance) may differ. For adults, it covers the preventive and minor restorative services covered by the Silver plan, and adds major restorative services. It also includes the Rollover Benefit.

GOLD PLUS VISION
This plan is available for children and adults. It includes the same dental benefits as the Gold plan in addition to vision coverage.

PLATINUM
For children under age 19, this plan covers the same benefits as the pediatric plan, however, member cost share (copayments or coinsurance) may differ. For adults, it covers the preventive, minor and major restorative services covered by the Gold plan. It also includes a higher plan year maximum and the Rollover Benefit.

PLATINUM PLUS VISION
This plan is available for children and adults. It includes the same dental benefits as the Platinum plan in addition to vision coverage.

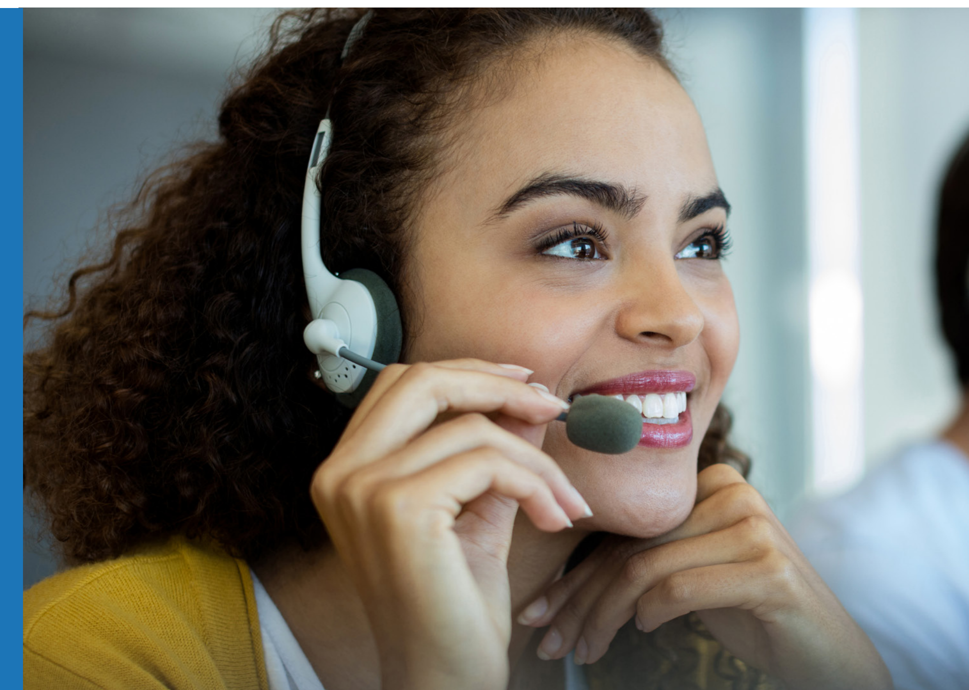
Most Popular Lens Enhancements

For Dental Gold Plus Vision and Platinum Plus Vision Plans

Most lens enhancements are covered after a copay, saving members an average of 20 – 25%

Lens Enhancement	Single Vision[1]	Multifocal[1]
Solid Tints and Dyes (Pink I and II)	$0	$0
Solid Tints and Dyes (except Pink I and II)	$15	$15
Plastic Gradient Dye	$17	$17
UV Protection	$16	$16
Polycarbonate Lenses (for adults) Polycarbonate lenses are covered-in-full for dependent children.	$31	$35
Anti-reflective Coating	$41	$41
Photochromic Lenses	$70	$82
Standard Progressive	N/A	$55
Premium Progressive	N/A	$95 – $105
Custom Progressive	N/A	$150 – $175

[1]Prices shown reflect the standard plastic price for each respective category. Premium lens enhancement prices may vary. Prices are valid only through VSP network doctors and are subject to change without notice.



QUESTIONS?
CONTACT YOUR AGENT!

SOLID TINTS AND DYES
Solid color tints and dyes are not only fashionable, they also reduce the amount of light coming through the lenses.

PLASTIC GRADIENT DYES
Gradient dyes are usually dark at the top and gradually lighten toward the bottom of the lenses.

UV PROTECTION
The combination of UV protection that's built into lenses and applied as a coating can block 98% – 100% of transmitted and reflected UVA and UVB rays.

POLYCARBONATE LENSES
Polycarbonate lenses are one of the thinnest, lightest, and most impact-resistant materials available. Plus, they provide UV protection and scratch resistance.

ANTI-REFLECTIVE COATING
Anti-reflective coating can reduce eyestrain caused from glare, reflections, and the "halos" you see around lights at night. Plus, it helps protect your lenses from scratches and smudges, and can repel dust and water.

PHOTOCHROMIC LENSES
Photochromic lenses automatically darken when exposed to sunlight and lighten when out of sunlight.

PROGRESSIVE LENSES
Unlike traditional bifocal and trifocal lenses that have lines, progressive lenses are line-free. Also, the power gradually changes with distance.

VISION BENEFITS

Gold Plus Vision + Platinum Plus Vision Plans

PLAN COVERAGE THROUGH A VSP NETWORK DOCTOR	
Benefit	**Description (Frequency: Every 12 months)**
Annual Eye Exam	• Eye exam covered-in-full, after $10 copay

Lenses	• Glass or plastic, single vision, lined bifocal, lined trifocal or lenticular prescription lenses are covered-in-full, after $25 copay
	  • Oversize lenses, scratch-resistant coating covered-in-full
	  • Polycarbonate lenses are covered-in-full for children (ages 18 and under)
	• Most popular lens enhancements are also covered, subject to an additional copay[1,2]
	• 20% savings on additional glasses or sunglasses, within 12 months of vision exam[2,3]

Frames	• Frames are covered-in-full[4] up to $125 allowance[2] • 20% off any amount exceeding allowance[2] • Frames are covered-in-full[4] up to $70 allowance at Walmart[2]
Contact Lenses	• Elective contact lens materials (instead of glasses) are covered-in-full up to $100 allowance • 15% savings on contact lens exam services; copay not to exceed $60[2] • Find additional savings on contact lenses by clicking on "special offers" at **vsp.com**
VALUE ADDED BENEFIT	
VSP Laser VisionCare℠ Program	• VSP-contracted laser centers provide discounts for laser surgery, including Photo Refractive Keratectomy (PRK), Custom PRK, Lasik, Custom Lasik and Intralase[5] • VSP has negotiated special pricing with participating centers, which can add up to hundreds of dollars in savings for VSP members. Contact the centers near you to learn more about their pricing.[6] • Find a VSP-contracted Laser VisionCare provider at **vsp.com**

DENTAL GOLD PLUS VISION MONTHLY RATES (per person)

Individual (age 0-20)	$36.62	Individual (age 21 and up)	$41.18

DENTAL PLATINUM PLUS VISION MONTHLY RATES (per person)**

Individual (age 0-20)	$38.32	Individual (age 21 and up)	$48.62

In addition to all of the dental benefits, with Dental Gold Plus Vision and Dental Platinum Plus Vision, you have:

- Coverage for eye examinations and eyeglasses or contact lenses
- The ability to maximize your benefits by using an eye doctor or eye-care center in the network*
- The freedom to choose any eye doctor*

*It will cost more to visit an out-of-network eye doctor. To see which eye doctors are in the network, visit **vsp.com**.

**Platinum Plus Vision includes the SunCare benefit.

SunCare benefit: If a vision examination does not result in a need for corrective vision materials, you may use your vision materials benefits (frame and lens) to purchase non-prescription sunglasses from a participating provider's frame board. Non-prescription sunglasses purchased under this benefit exhaust your frame and lens benefits for the frequency period. This means if you use this benefit to purchase non-prescription sunglasses, you are not eligible for additional vision materials benefits until the completion of the next frequency period.

[1]Most popular lens enhancements include progressives, anti-reflective, photochromics, polycarbonate, plastic dyes, and UV protection. All other lens enhancements also available at 20% savings. [2]Based on applicable laws; benefits may vary by location. [3]Discounts valid through any VSP network doctor within 12 months of the last covered eye exam. [4]Less any applicable copay. [5]Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. [6]The VSP Laser VisionCare Program® is a discount plan only. Discounts only apply to services received from a VSP participating laser center. No monetary benefits are payable to members under this program.

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Rollover Benefit

Included in Dental Gold and Platinum Plans

The annual maximum rollover benefit allows individual adults to "roll over" up to $350 for Gold and $500 for Platinum of unused benefits to the next year.

With the annual maximum rollover benefit feature, you may roll over $350 for Gold and $500 for Platinum to the next calendar year, as long as:

- You submit at least one claim during the year; **and**
- Your total claims do not exceed $500 for Gold and $700 for Platinum for that calendar year.

The rollover is available to each adult member on your Gold or Platinum policy and it can accumulate from one calendar year to the next, up to a maximum of $1,000 for Gold and $1,250 for Platinum. This means you can potentially have an annual maximum of $2,000 for Gold and $2,750 for Platinum, per adult member, which can provide even more protection for those unexpected dental bills.

Dental Xtra

Dental Xtra is a program for Arkansas Blue Cross dental insurance members who are pregnant, have diabetes, coronary artery disease, suffered a stroke, been diagnosed with oral cancer or Sjögren's syndrome. It provides qualifying members with additional dental benefits, which are paid 100% when using a participating dentist, won't count toward the maximum dollar amount your dental plan will cover for the calendar year and requires no co-payment, coinsurance or deductible.

Enroll At No Additional Cost:

1. Visit **arkansasdentalblue.com**
2. Click "Enroll online" on the left-hand side
3. Fill out the "Enroll in Dental Xtra" online form
4. Wait for your enrollment form to be evaluated
5. Receive a welcome letter about one month after enrollment

Dental Xtra	Prophylaxis (cleanings) or periodontal maintenance* visit every 3 months	Periodontal Scaling*, or scaling in the presence of gingival inflammation every 24 months	Pre-diagnostic oral cancer screening** every 6 months	Fluoride Treatment** Every 3 Months
Diabetes	✓	✓		
Coronary Artery Disease	✓	✓		
Stroke	✓	✓		
Pregnancy	✓	✓		
Oral Cancer	✓		✓	✓
Sjögren's syndrome	✓		✓	✓

*Periodontal maintenance and scaling available with plans that offer periodontal benefits.

**This benefit is available for members who have previously been diagnosed with oral cancer or for members diagnosed with Sjögren's syndrome.

Dental Plans

	PEDIATRIC	SILVER	SILVER	GOLD		PLATINUM	
	Child Only	**Child(ren)**	**Adult**	**Child(ren)**	**Adult**	**Child(ren)**	**Adult**
Plan Year Maximum	Unlimited	Unlimited	$1,000	Unlimited	$1,000	Unlimited	$1,500
Annual Limit on Cost Sharing	$350	$350 for One Child; $700 for Two or More Children	Unlimited	$350 for One Child; $700 for Two or More Children	Unlimited	$350 for one child; $700 for Two or More Children	Unlimited
Rollover Benefit	None	None	None	None	Yes	None	Yes
Dental Xtra Benefit *(see next page)*	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Calendar-Year Benefits	**Member Pays**			**Member Pays**			
Deductible	$20	$50	$50	$35		$20	$20
Diagnostic and Preventive Coverage Exams, Prophylaxis (Teeth Cleaning), X-rays (Pediatric Plan Also Covers Fluoride Treatment and Sealants)	0% coinsurance after deductible	10% coinsurance after deductible	10% coinsurance after deductible	0% coinsurance after deductible		0% coinsurance after deductible	$0
Minor Restorative Coverage Fillings, Endodontics (Root Canals), Oral Surgery, Extractions, Periodontics (Treatment for Gum Disease) (Pediatric Plan Also Covers Anesthesia)	20% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance after deductible	20% coinsurance after deductible		20% coinsurance after deductible	20% coinsurance after deductible
Major Restorative Coverage All Ages — Crowns, Partials and Dentures, Surgical Periodontics 19 and over — Bridges, Inlays and Onlays, Implants Orthodontics not covered	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible**	50% coinsurance after deductible		50% coinsurance after deductible	50% coinsurance after deductible
Implants	Not Covered	Not Covered	Not Covered	Not Covered	Covered	Not Covered	Covered
Orthodontics	Not Covered	Not Covered	Not Covered	Not Covered		Not Covered	Not Covered
Waiting Periods*	None	None	6 Months Minor Restorative	None	6 Months Minor and 6 Months Major Restorative	None	6 Months Minor and 6 Months Major Restorative
Monthly Rates (per person)							
Rates Per Person (Children Ages 0-20; Adult Ages 21 and up)	$31.73	$23.94	$22.57	$30.22	$34.78	$31.73	$42.03

Note: Information in grid represents in-network benefits.

* The six-month waiting period for minor restorative services (Silver, Gold or Platinum) and the six-month waiting period for major restorative services (Gold or Platinum) will be waived if you meet the following criteria:

1. Your application is received within **30** days of the termination date of your previous coverage; and
2. No later than **60** days from the effective date of your new policy with Arkansas Blue Cross and Blue Shield, you provide us with:
   - A copy of your previous dental policy Certificate of Coverage, which reflects the policy's effective and termination dates; and
   - A copy of your previous policy's benefit schedule, which reflects at least six months of coverage for minor and/or major restorative services.

Note: In order to waive the major restorative waiting period, previous coverage must include comprehensive major restorative services such as crowns and bridges.

** Re-cementations, repairs and adjustments only.