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 5th of each month (Example: February premium will be drafted February 5th).

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. Applications can be submitted through mail or online at www.mysmilecoverage.com/SOAR. This application must be received by Delta Dental of Arkansas by the 25th of the month prior to the effective date (example: received by January 25th to be effective February 1st). Applications received after the 25th of the month will be made effective on the 1st of the following month (example: received on January 26th, 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 understand that if I applied for the dental plan outlined in this brochure I will not have benefits for major restorative services during the first six months after the issue date for a disease or physical condition which I now have or have had in the past, unless I supply Delta Dental of Arkansas with certification of creditable coverage.

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: _____ Agency Name: H&H Employee Benefit Specialists

Agency NPN: 01652069 Phone Number: (888) 224-5233

You can now enroll online!
Visit www.mysmilecoverage.com/SOAR to register today!
It's fast and easy!

WHY DELTA DENTAL?

Dental insurance is our specialty

Dental insurance is not a sideline of our business—it is the heart. We are the state's largest and most experienced dental insurance company, and our expertise is why nearly 2 million members across the country trust their smiles to Delta Dental of Arkansas.

Largest network of dentists

Delta Dental has the largest network of dentists in Arkansas and across the nation,[2] which means you will find affordable care wherever you are.

Customer service excellence

Delta Dental is committed to providing superior customer service. We are here to answer any questions you may have about benefits, claim status, eligibility and more. If you have a question, let us know!

Easy to use

We make it easy for you to access the information you need at any time. Through our website, you can:

- ✓ Locate a dentist
- ✓ Check claims status and history
- ✓ Review plan coverage
- ✓ Print ID cards, and more!

1 J Am Dent Assoc, Vol 134, No suppl_1, 41S-48S. 2003 American Dental Association and Dental Management of The Medically Compromised Patient, 8th Edition, 2013, Mosby Elsevier, St. Louis, MO.

2 Delta Dental Plans Association, web.

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 a State of Arkansas Retiree Program 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 (844) 304-7627.

DELTA DENTAL®

Delta Dental of Arkansas
32354 Collection Center Drive
Chicago, IL 60693-0323

DELTA DENTAL®

Delta Dental Individual and Family

for the State of Arkansas Retiree Program

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 than 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 nondental diseases—including heart disease and diabetes—before they become larger problems.[1]

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
- ✓ Stainless steel crowns for dependent children up to age 16

MAJOR RESTORATIVE SERVICES

- ✓ Crowns
- ✓ Endodontics (root canals)
- ✓ Oral surgery
- ✓ Dentures, bridges, partials
- ✓ Periodontics treatment (gum disease)

Dental Plans

	Delta Dental Dentist	Nonparticipating Dentist
Individual/Family Deductible	$50/$150	
Individual Benefit-year Maximum	$1,500	
What the plan pays for after you have satisfied the deductible		
Preventive & Diagnostic	100%	80%
Basic Restorative Services	80%	60%
Major Restorative Services	60%	50%
Waiting Periods*		
Preventive & Diagnostic	None	
Basic Restorative Services	None	
Major Restorative Services	6 months	

Dental Monthly Premiums	
Individual Only	$38.98
Individual & Spouse	$77.70
Individual & Child(ren)	$75.86
Individual & Family	$125.72

Out-of-network Benefits

Services conducted through an out-of-network dentist will be reduced as indicated above by Delta Dental of Arkansas after applying the applicable deductibles, copayments 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 six 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.

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.

*Deductible does not apply.

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.

Vision Plans

In-network Vision Covered Benefits		
Vision Exam	Every 12 months	Covered in full after $10 copay
Frame	Every 24 months	Covered in full after $15 copay for any frame with a wholesale value up to $50 (retail prices will vary but will be approximately up to $150). Frames from participating Walmart locations are covered up to a $68 retail value.
Lenses	Every 12 months	Standard single vision, bifocal, trifocal and lenticular covered in full after $15 copay
Contact Lenses (in lieu of lenses and frames)		
Contact Lens—Elective	Every 12 months	$150 which can be used toward the evaluation, fitting and follow-up care
Contact Lens—Medically Necessary	Every 12 months	Covered in full with prior authorization
Laser Vision Correction	Once per lifetime	$150 per covered member

Dental + Vision Monthly Premiums	
Individual Only	$48.23
Individual & Spouse	$96.21
Individual & Child(ren)	$92.95
Individual & Family	$153.39

Note: Rates include both dental and vision benefits. For more information about out-of-network benefits, please call (844) 304-7627.

DELTA DENTAL

Delta Dental Individual and Family Application
Plan Number SOARR01

Rates effective 10/1/2019–12/31/2020

Requested Effective Date		
Month	Day	Year
	1st	

Please mail to:
Delta Dental of Arkansas
32354 Collection Center Drive
Chicago, IL 60693-0323

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 + Vision

Type of Coverage (Choose one)

☐ Individual Only ☐ Individual & Spouse ☐ Individual & Child(ren) ☐ Individual & Family

Dependents

	First Name	Last Name	Date of Birth	Sex
Spouse				
Child				
Child				
Child				

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: _____

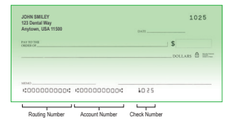
Payment Method—Bank Draft or Credit Card Only (Do not send a live check)

Bank Draft (EFT): ☐ Monthly ☐ Annually

Bank Account Type: ☐ Checking ☐ Savings

Routing Number: _____

Account Number: _____



PLEASE SEND A VOIDED 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 5th of each month.

*Bank also applies to savings and loan

SOARR09-2019