Arkansas
BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 Gaines Street
P.O. Box 2181
Little Rock, Arkansas 72203

VOLUNTARY DENTAL
GROUP POLICY

We agree to provide to the eligible Employees of the Policyholder, and their covered Dependents, the benefits set forth in the Benefit Certificate(s), attached to and incorporated as part of this Policy in accordance with the terms, provisions and limitations of this Policy.

This Policy is issued in consideration of the Policyholder's Application, a copy of which is attached, the Policyholder's covenants and the Policyholder's payment of the premium.

This Policy becomes effective at 12:01 a.m. on the effective date shown on the Application. The Policy is renewable month to month, by payment of the monthly premium. The premium for the Policy may be adjusted upon thirty (30) days' notice. The Policy is subject to termination according to its terms.

The following pages, including the Benefit Certificate(s), the Application and any riders, endorsements or amendments are part of this Policy.

It is signed at our Home Office on the effective date.

Curtis Barnett, President and Chief Executive Officer

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NON-DISCRIMINATION NOTICE

NOTICE: Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex.

We provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in various formats (large print, audio, accessible electronic formats, other formats), and language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. **If you need these services, contact our Civil Rights Coordinator.**

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
601 Gaines Street, Little Rock, AR 72201
Phone: 1-844-662-2276; TDD: 1-844-662-2275

You can file a grievance in person, by mail, or by email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201
Phone: 1-800-368-1019; TDD: 1-800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

LANGUAGE ASSISTANCE NOTICE

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-844-662-2276.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-662-2276 .

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 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

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-662-2276 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-662-2276.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-662-2276.

ملاحظة: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية مجانا. دعوة 1-844-662-2276 العدد.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-662-2276.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-662-2276.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-662-2276.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-662-2276.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-662-2276.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-662-2276 まで、お電話にてご連絡ください。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-662-2276.

ملاحظة: إذا كنت تتحدث باللغة الفارسية، والخدمات اللغوية المقدمة مجانا بالنسبة لك. يرجى الاتصال 1-844-662-2276

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-662-2276.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-662-2276 पर कॉल करें।

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-662-2276.

انتباہ: آپ اردو بولتے ہیں تو، زبان کی مدد کی خدمات بلا معاوضہ دستیاب ہیں. کال کریں 1-844-662-2276

ໂປດຊາບ: ຖ້າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-662-2276.

LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-844-662-2276

ARTICLE I. DEFINITIONS

A. Application means the Large or Small Employer Application that is executed by the Policyholder.

B. Benefit Certificate means a document containing a description of the insurance benefits provided by the Policy.

C. Company means Arkansas Blue Cross and Blue Shield.

D. Covered Person means an Employee or Dependent who is insured under this Policy.

E. Dependent means any member of the Employee's family who meets the eligibility requirements of the Plan as set out in the Benefit Certificate, who is enrolled in the Plan and for whom the Company receives a premium.

F. Employee means an individual who meets the eligibility requirements for an Employee in the Plan as set out in the Benefit Certificate, who is enrolled in the Plan.

G. Employer means a sole proprietorship, partnership or corporation which is the Policyholder.

H. Grace Period means the period of 30 consecutive days beginning with any premium due date after the first which shall be allowed for payment of premium.

I. Open Enrollment Period means the period annually, that is designated by the Employer and set forth in the Application, when Employees who are eligible for coverage may enroll in the Plan. During the Open Enrollment Period, Employees covered in the Plan may change their coverage, and that of their covered Dependents. Unless otherwise designated in this Policy, enrollments and coverage changes made during the Open Enrollment Period become effective on the anniversary date of the Policy. If for any reason, Employer fails to designate an Open Enrollment Period, or the Application fails to indicate it, the Open Enrollment Period shall be the month prior to the anniversary of the effective date of this Policy.

J. Plan means the Employee Health Benefit Plan established by the Employer. The terms of the Plan are set forth in this Policy.

K. Plan Administrator means the Employer.

L. Plan Year means the Plan Year stated in the Employee Health Benefit Plan Summary Plan Description, or if not stated in that document, or if that document does not exist, the twelve-month period ending on the day before the anniversary date of the effective date of this Policy.

M. Policy or Group Policy means this policy and includes the Benefit Certificate issued to Employees, amendments, the Application of the Employer and individual enrollment forms, under which the Company provides dental coverage to Covered Persons.

N. Policyholder means the Employer as shown in the Application.

ARTICLE II. COVENANTS OF THE POLICYHOLDER

As part of the consideration for this Policy, Policyholder understands, acknowledges and agrees:

A. Plan Administrator

The Policyholder is the Plan Administrator of the Employee Health Benefit Plan, the terms of which are set forth in this Policy. The Policyholder gives the Company authority and full discretion to audit Policyholder's records relating to this Policy and to determine all questions arising in connection with insurance benefits, including but not limited to eligibility, interpretation of Plan language, and findings of fact with regard to any such questions. The actions, determinations and interpretations of the Company acting on behalf of the Plan within the scope of this authority shall be conclusive and binding on the Policyholder and the Covered Person.

B. Employee and Dependent Eligibility and Effective Dates of Coverage

The Policyholder shall accurately report Employee and Dependent eligibility information to the Company. The provisions of the Plan outlining eligibility and effective dates of coverage for Employees are set out in the Benefit Certificate. **The Policyholder shall indemnify the Company for any claims the Company erroneously pays or any damages the Company incurs as a result of the Policyholder failing to provide timely, accurate information to the Company of a change in the eligibility status of an Employee or Dependent.**

C. Employee Participation

This Policy may be terminated by the Company if the percentage of eligible Employees of the Policyholder covered by the Policy becomes less than the percentage of Employee participation specified in the Application, or if the number of insured Employees falls below the minimum number of Employees specified in the Application.

D. Payment of Premium

The Policyholder shall pay the Company the premiums for covered Employees and Dependents every month, in advance. Payment of premium is due on the first day of the month or the fifteenth day of the month, depending upon the billing cycle established by the Company for the Policy. "Pay," "Paid" or "Payment," when used here in reference to premium, premium due dates or the Grace Period shall mean that the full amount of all funds due actually received by the Company at its principal offices in Little Rock, Arkansas. Placing a check into the U.S. mail or with any courier service shall not constitute payment under this Policy unless or until the check is actually received by the Company at its principal office. Nor shall any invalid or dishonored check constitute payment.

E. COBRA

If COBRA applies to the Plan, the Policyholder, as Plan Administrator, must provide its Employees and their Dependents notice of COBRA rights at the time their coverage commences under this Policy and must notify the Employee or Dependent of his right to elect continuation of coverage under COBRA within fourteen (14) days of the happening of a "qualifying event" under COBRA. **The Company shall not assume the Policyholder's obligation to provide benefits under COBRA if the Policyholder fails to provide these notices at the times specified in this Policy, nor shall the Company be responsible for providing any COBRA notices to Employees or Dependents**.

F. HIPAA PRIVACY

Restrictions on the Use or Disclosure of Protected Health Information ("PHI") Policyholder (herein referred to as Employer) hereby agrees to the following restrictions on Employer's use of, access to or disclosure of PHI of Plan participants:

1. Employer may use or disclose PHI only for Plan administrative purposes, as required by law, or as permitted under the HIPAA Privacy Rules; and

2. If Employer discloses PHI to any agents or subcontractors, Employer shall first require the agents or subcontractors to agree to the same restrictions on use and disclosure of PHI as the Employer has agreed to herein; and

3. Employer shall not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or benefit plan of Employer; and

4. Employer will promptly report to the Plan (through the Firewall Department, as designated below) any use or disclosure of PHI by Employer or within Employer's organization that is inconsistent with the uses or disclosures allowed under this ARTICLE II. F; and

5. Employer shall allow Plan participants to inspect and copy any PHI related to the Plan participant that is in a designated record set in Employer's custody and control, as permitted or required by the HIPAA Privacy Rules, subject to certain exceptions recognized in the Rules; and

6. Employer shall amend, or allow the Plan or Company as insurer of the Plan, to amend, any portion of a Plan participant's PHI, to the extent permitted or required under the HIPAA Privacy Rules; and

7. If Employer makes some types of disclosures of PHI for purposes other than payment or health care operations, Employer will make available such information as is required under the Rules to render an accounting to the Plan participant of such disclosures. Consistent with the Rules, Employer shall not be obligated to provide information for an accounting if disclosures are for certain Plan related purposes, such as payment of benefits or health care operations, or if the Plan participant authorized the disclosures; and

8. Employer shall make its internal practices, books, and records, relating to its use and disclosure of PHI of Plan participants available to the U.S. Department of Health and Human Services upon its request; and

9. Employer shall, if feasible, return or destroy all PHI of Plan participants in Employer's custody or control that Employer has received from the Plan (through the Firewall Department, as designated below) when Employer no longer needs such PHI to administer the Plan. If it is not feasible for Employer to return or destroy PHI, Employer will limit the use or disclosure of any PHI that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible; and

10. Employer shall require that all Employees or classes of Employees included within the Firewall Department designation, as set forth below, must limit their access to and use of any PHI of Plan participants to activities required or needed for proper administration of the Plan and Plan benefits. Employer shall take appropriate steps to discipline including, where appropriate, termination of

any Employee who violates the requirements of this ARTICLE II. F.

Designation of Firewall Department.

The following classes of Employees or other workforce members under the control of Employer (sometimes referred to as the "Firewall Department" for HIPAA Privacy Rules purposes) are hereby designated in accordance with HIPAA Privacy Rules firewall provisions to be given access to PHI of Plan participants for the purposes set forth in this document:

All Employees or other workforce members under the control of Employer assigned to and working in the Human Resources Department or Division or the Employee Benefits Department or Division of Employer, or otherwise serving on a regular and routine basis to fulfill personnel or Employee benefits administration functions for Employer, including but not limited to all Employees whose job duties require communication and interaction with Company as insurer for the Plan, regarding any plan administration, claims or eligibility-related matters.

G. Agent for Employees

The Policyholder is the agent for its Employees and their Dependents in all dealings between Employees or Dependents and the Company, including:

1. payment of premiums to the Company;
2. notifying the Company of changes in Employee or Dependent status;
3. securing and forwarding to the Company applications for coverage of new Employees or new Dependents; and
4. providing Employees and Dependents all communications and notices from the Company.

H. Contract with Arkansas Blue Cross and Blue Shield

On behalf of Policyholder and its Employees, the Policyholder acknowledges its understanding that this Policy constitutes a contract solely between the Policyholder and Arkansas Blue Cross and Blue Shield, that Arkansas Blue Cross and Blue Shield is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Arkansas Blue Cross and Blue Shield to use the Blue Cross and Blue Shield Service Marks in the State of Arkansas, and that Arkansas Blue Cross and Blue Shield is not contracting as the agent of the Association. The Policyholder further acknowledges and agrees that it has not entered into this Policy based upon representations by any person other than Arkansas Blue Cross and Blue Shield and that no person, entity, or organization other than Arkansas Blue Cross and Blue Shield shall be held accountable or liable to Policyholder for any of the obligations created under this Policy.

I. Renewal Process

1. On or before the sixtieth (60^{th}) day before the anniversary date of this Policy, the Company shall deliver to the Policyholder, directly or through the agent of record for the Policyholder, a Policy renewal proposal for the next Plan Year. This Policy renewal proposal shall contain a premium quote, a summary of any Policy amendments and the Company's commitment to continue providing benefits currently covered by the Policy.

2. Upon receipt of the Policy renewal proposal, the Policyholder may request changes to be incorporated in the renewed Policy.
3. Within five (5) business days after receiving the Policyholder's request for changes to the Policy, the Company shall provide the Policyholder a revised Policy renewal proposal, incorporating the Policyholder's changes accepted by the Company.
4. On or before the anniversary date of the Policy, the Company will issue a renewed Policy that includes Policyholder requested changes accepted by the Company.
5. By paying the first monthly premium, the Policyholder agrees to the provisions of the renewed Policy. This premium payment will activate the coverage provided by the renewed Policy and keep the Policy in force for two months.
6. In order to keep the renewed Policy in force beyond the second Policy month, in addition to paying the monthly premiums, the Policyholder must submit to the Company executed attestations required by the Company and if requested by the Company, an Arkansas State Wage and Hour report showing the employees covered by the Policy. The Policyholder's failure to submit these documents will result in the termination of the Policy at the end of the second Policy month.

ARTICLE III. CLAIMS

A. Claim Processing and Claim Appeal Procedures.

The Company shall process claims and conduct appeals in accordance with the claim processing and appeal procedures set out in the Benefit Certificate.

B. Facility of Payment

1. The Company may, at its option, pay all or any benefits to the dentist, institution or the person giving dental services or supplies to the Covered Person.

2. Any payment made according to the above paragraph shall discharge the Company to the extent of any such payment. The Company shall not be bound to see to the use of the money so paid.

C. Legal Actions

The Covered Person may not initiate legal action with respect to a claim until the Covered Person has exhausted his or her rights of appeal under the Plan. No legal action shall be brought after the expiration of three (3) years from the time that a claim is required to be submitted.

D. Assignment

No assignment of benefits under this Policy shall be valid until approved and accepted by the Company. The Company reserves the right to make payment of benefits, in its sole discretion, directly to the provider of service or to the Covered Person.

ARTICLE IV. GENERAL PROVISIONS

A. Entire Contract

The entire contract of insurance is made up of this Policy, the Benefit Certificate issued to Employees, amendments to the Policy, amendments to the Benefit Certificate and the Application of the Policyholder. The individual applications also become a part of this contract. Benefit Summary Cards issued to Covered Persons are for convenient summary only and do not constitute part of this contract of insurance. In the absence of fraud, all statements made by the Policyholder or by persons insured are representations and not warranties. No such statement shall be used in any contest under this Policy unless it is contained in a written instrument and a copy of such instrument is or has been furnished to such person.

B. Time Limit on Certain Defenses

Except for failure to comply with the participation and contribution requirements or nonpayment of premium, this Policy shall not be contested after it has been in force for two years. Statements a Covered Person makes about his insurability shall not be used to void insurance or deny a claim unless:

1. the statements are contained in a written document signed by the Covered Person; and
2. the loss on which claim is based occurs within two (2) years following the date of the signed written document.

C. Changes to Policy

1. The Company reserves the right to amend this Policy, in which case the amendment shall be deemed an amendment to the Policyholder's Employee health benefit plan. The procedure for amendment to this Policy and the Plan shall be that the Company shall give 30 days' written notice to the Policyholder, prior to the next renewal date of the Policy. The change shall go into effect on the date fixed in the notice.
2. No agent or employee of the Company may change or modify any benefit, term, condition, limitation or exclusion of this Policy. Any change or amendment must be in writing and signed by an officer of the Company.

D. Changes of Premium Rates

The premiums charged for insurance under this Policy may be changed with 30 days' written notice:

1. on any premium due date; or
2. if the Policy's terms have been changed.

E. Misstatement of Age

If the age of a Covered Person has been misstated and such misstatement requires a correction in the premium rate, premiums shall be adjusted to the premium rate for the correct age, and the difference in past premium paid shall be paid to or refunded by the Company.

F. Right of Rescission

Fraud or intentional misrepresentation of material fact(s) may be used by the Company as the basis for rescission of coverage of the Policyholder, any Employee or any Dependent.

G. Grace Period

Any premium for this insurance which is not paid on or before the date it becomes due is in default. After the first premium payment, the Policyholder shall be allowed a [30] days Grace Period. During the Grace Period, there is no interest charge. Although the insurance shall remain in force during the Grace Period, the Company shall have the right to delay the processing of claims for services received by Covered Persons during the Grace Period, pending the payment of the premium due.

H. Termination of This Policy

1. The Policyholder may terminate this Policy on any premium due date by giving the Company written notice of termination in advance of the premium due date. Any premiums paid beyond the requested termination date shall be refunded.

2. The Company may terminate this Policy on any premium due date if:

   a. the premium due is not paid within the Grace Period;

   b. the percentage of eligible Employees of Policyholder covered by the Policy becomes less than the percentage of Employee participation specified in the Application, or if the number of insured Employees falls below the minimum number of insured Employees specified in the Application;

   c. the Employer fails to contribute the agreed upon share of the premiums specified in the Application; or

   d. the Employer performs an act or practice that constitutes fraud or makes an intentional misrepresentation of a material fact under the terms of the coverage.

3. The Company may terminate this Policy upon giving the Employer 90 days' notice, in the event the Company discontinues issuing this Policy form in the State of Arkansas. In such event the Company shall offer the Employer the option to purchase any other group health insurance coverage currently being offered by the Company in Arkansas.

4. This Policy shall terminate as of the date on which the premium was due and payable, if the premium due is not paid within the Grace Period.

5. When the Policy terminates, the Policyholder is liable to the Company for payment of all premiums which are due but unpaid at the time of termination or for reimbursement to the Company for all claims paid for services incurred during the Grace Period, including but not limited to any and all claims, damages, fines, penalties, losses, expenses, judgments, awards, settlements, punitive damages, attorneys' fees or costs of any kind which are incurred by the Company as a result of any claim or lawsuit a Covered Person makes for services received during the Grace Period, whichever is the greater amount.

6. It is the duty of the Policyholder, and not the Company, to notify all affected Covered Persons that the Policy and their coverage is terminated. The Company shall not be responsible under any circumstances to provide notices to any Employee or other Covered Person of the status of premium payments, coverage or the lack of coverage under this Policy or the Plan. However, if the Policyholder has not paid the premium during the Grace Period, the Company shall notify all Employees that the Policy has terminated for non-payment of premium.

7. If this Policy terminates for any of the reasons set out in ARTICLE IV, Subsection H.2 or H.4, the Policyholder shall not be eligible to reapply for another Policy with the Company for a period of six months from the date this Policy terminated.

8. If this Policy terminates due to nonpayment of premium, the Policyholder may be eligible for reinstatement in the sole discretion of the Company, provided certain conditions are met. The following items are required to be submitted for reinstatement to be considered.

   a. Payment via cashier's check for all premiums due;

   b. Payment via cashier's check of a non-refundable reinstatement application fee in the amount of $350 (or such other amount as may be deemed by Arkansas Blue Cross to cover reinstatement processing); and

   c. Completion and return of a signed group application for reinstatement.

   A reinstatement request, together with the above requirements must be submitted within fifteen (15) days of the date on the "confirmation of termination" letter. The reinstatement request will then be forwarded to a designated underwriter for review. Following review (which the Company will attempt to complete on most applications within 3-5 business days), the Policyholder will be notified of the decision regarding the reinstatement request.

I. Refund of Premiums

If the Company terminates the coverage of a Covered Person, premium payments received on account of the terminated Covered Person applicable to periods after the effective date of termination shall be refunded to the Employer, unless the Covered Person had made a contribution to the premium and there was no basis for rescission. Such refund shall be made within 30 days, and the Company shall have no further liability under this Group Policy.

If the Employer terminates coverage of a Covered Person, the Company shall refund premium payments applicable to periods after the effective date of termination, provided that the Employer can demonstrate that the Covered Person made no contribution to such premium payments. The Employer must request the Company refund premiums paid for such Covered Person's coverage within 60 days from the effective date of termination of such coverage. Failure of the Employer to make a refund request within 60 days of the effective date of termination of the Covered Person's coverage shall result in the Employer waiving refund of any premiums paid for such coverage. If claims have been paid past the termination date, the payment amount of the claims will be deducted from premium refunds.

J. Claim Recoveries.

There may be circumstances in which the Company recovers amounts paid as claims expense from a provider of services, from a Covered Person or from a third party. Such circumstances include rebates paid to the Company by pharmaceutical manufacturers based upon amounts of claims paid by the Company for certain specified pharmaceuticals, amounts recovered by the Company from health care providers or pharmaceutical manufacturers through certain legal actions instituted by the Company relating to the claims expense of more than one Covered Person, recoveries by the Company of overpayments made to health care providers or to

Covered Persons, and recoveries from other parties with whom the Company contracts or otherwise relies upon for payment or pricing of claims. The following rules govern the Company's actions with respect to such recoveries:

1. In the event that such a recovery relates to a claim paid more than two years before the recovery, no adjustment will be made to any Deductible or Coinsurance paid by a Covered Person and the Company shall be entitled to retain such recoveries for its own use.

   If the recovery relates to a claim paid within two years and is not otherwise addressed in this subsection, Deductibles and Coinsurance amounts for a Covered Person will be adjusted if affected by the recovery.

2. Only recoveries made within two years of the date of the error by the Company or overpayments to health care providers or to Covered Persons by the Company will be applied for the purpose of group rating or divisible surplus calculation, if applicable. The cost actually paid by the Company to procure such recoveries will be treated as an administrative expense in considering group rating or divisible surplus, if applicable.

3. In the event the Company receives from pharmaceutical manufacturers rebates based upon amounts of claims paid for certain specified pharmaceuticals, the Company shall be entitled to retain such rebates for its own use, and no adjustments will be made to claims paid or to Deductibles or Coinsurance amounts paid by a Covered Person.

4. If a Covered Person is no longer covered by the Company at the time of any such recovery, regardless of the amount or of the time of such recovery, the Company shall be entitled to retain such recovery for its own use.

5. If such recovery amounts can not be attributed on an individual basis, because of having been paid as a lump sum settlement for less than the total amount of claims expense of the Company or otherwise, no adjustments will be made to any Deductible or Coinsurance amounts paid by the Covered Person and the Company shall be entitled to retain such recovery for its own use.

K. Records and Reports

The Policyholder shall keep records and furnish information to the Company upon request regarding:

1. Covered Persons and their insured Dependents;

2. changes in the amounts of insurance; and

3. termination of insurance.

L. Benefit Certificates

The Company shall provide the Policyholder with Benefit Certificates or booklets like the one which is incorporated into and made a part of this Policy. It is the obligation of the Policyholder to distribute these Benefit Certificates to each Covered Person.

M. ERISA Notices and Plan Documents

The Policyholder, and not the Company, shall be responsible, as Plan Administrator, for providing all ERISA notices and summary plan descriptions to Covered Persons.

N. Sex and Number

When used in this Policy, the masculine includes the feminine, the singular the plural, and the plural the singular.

O. Conformity With Statutes

If any provision does not comply with any law of the State of Arkansas, this Policy is deemed amended to meet the minimum requirements of the law, unless such law is pre-empted by federal law or found to be void by a court of competent jurisdiction, in which case any amendment to the Policy required by the pre-empted or voided law shall be deemed rescinded.

ARTICLE V. POLICY PROVISIONS RELATIVE TO MEMBERSHIP, MEETINGS AND VOTING

A. Membership

By virtue of ownership of this Policy, the Policyholder is a member of Arkansas Blue Cross and Blue Shield. This Policy is a non-participating policy. This means that the Policyholder does not receive distribution of any premium, revenues, savings or assets of the Company.

B. Annual Meeting

An annual meeting of the members shall be held each and every calendar year in the State of Arkansas for the purpose of electing directors, receiving and considering reports as to the business and affairs of the Company and transacting such other business as may properly come before the meeting. The meeting shall be held between January 1 and April 1 of each year at such place, date and time as shall be fixed by the Board of Directors or the Chief Executive Officer. The Board of Directors may, from time to time, provide that the place, date and time of the annual meeting shall be set forth in the Policy of members as set out in ARTICLE V, Section D. below:

> "THE ANNUAL MEETING OF THE MEMBERS SHALL BE HELD EACH YEAR AT THE HOME OFFICE, LOCATED AT 601 GAINES STREET, LITTLE ROCK, ARKANSAS, ON THE THIRD MONDAY IN MARCH AT 1:00 P.M. (PROVIDED, IF SUCH DAY SHALL BE A LEGAL HOLIDAY, THEN AT THE SAME TIME AND PLACE ON THE NEXT SUCCEEDING DATE WHICH IS NOT A LEGAL HOLIDAY)."

C. Special Meetings

A special meeting of members for any purpose may be called by the Board of Directors or Chief Executive Officer, and shall be called by the Chief Executive Officer of the Secretary at the request of members holding one-third (1/3) of the voting power entitled to vote thereat. Such request shall state the purpose or purposes of the meeting, and no other business outside the scope of the state purpose or purposes shall be transacted. Unless ordered by the Board of Directors, the time and place of each special meeting of members shall be determined by the Chief Executive Officer.

D. Notice of Meetings

So long as each insurance Policy issued by the Company sets forth the place, date and hour of the annual meeting of members, no notice of any annual meeting shall be required to be given to any member, regardless of the number or nature of proposals to be considered and voted upon at the annual meeting. If notice of the annual

meeting is not set forth in each insurance Policy, written or printed notice of the annual meeting and every special meeting of the members, stating the place, date, time and the purpose or purposes of such meeting shall be given to the members entitled to vote at such meeting not less than ten (10), nor more than sixty (60), days before the date of the meeting. All such notices shall be given, either personally or by the mail, by or at the direction of the Chief Executive Officer or Secretary unless ordered by the Board of Directors. Notices which shall be mailed shall be deemed to be "given" when deposited in the United States Mail addressed to the member at the member's address as it appears on the records of the Company, with postage prepaid [first class mail, if the notice is mailed thirty (30) days or less before the date of the meeting], and any notice transmitted other than by mail shall be deemed to have been "given" when delivered to the member.

E. Quorum

Except as otherwise provided by applicable law, a majority of the members of the Company (present in person or by proxy) shall be necessary to constitute a quorum for the transaction of business at any annual or special meeting of the members of the Company.

F. Voting Rights

Each member shall be entitled to one vote for each policy held by him upon each matter coming to a vote at meetings of members provided, a group policyholder shall be entitled to a number of votes equal to the number of certificate holders insured under this Group Policy. Such vote may be exercised in person or by written proxy.

G. Vote Required

A majority of the voting power represented at any meeting of members shall be necessary and sufficient to approve any given matter. There shall be no cumulative voting.

H. Proxy

At all meetings of members, a member may vote by proxy executed in writing by the member or by the member's duly authorized attorney in fact. Such proxy shall be filed with the Secretary before commencement of the meeting or at such late time as shall be expressly permitted by the Corporate officer presiding at such meeting. Each Application for an insurance Policy issued by the Company shall contain a provision pursuant to which the Policyholder thereof grants a revocable proxy to the Board of Directors with respect to all matters to be considered and voted upon by members at any meeting occurring while such insurance Policy is in force.

ARKANSAS CONSUMERS INFORMATION NOTICE

For additional information regarding your Arkansas Blue Cross and Blue Shield benefits, please feel free to contact us at:

Arkansas Blue Cross and Blue Shield
Customer Service
Post Office Box 2181
Little Rock, Arkansas 72203
Telephone (501) 378-2010 or Toll Free (800) 421-1112

If we at Arkansas Blue Cross and Blue Shield fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201
Telephone (501) 371-2640 or toll free (800) 852-5494
insurance.consumers@arkansas.gov.