Renaissance®
Life & Health Insurance Company of America

**PO Box 1596**
**Indianapolis, Indiana 46206**
**(888) 791-5995**
**www.RenaissanceDental.com**

In this Policy, "we," "our" and "us" will refer to Renaissance Life & Health Insurance Company of America. "You" or "your" will refer to the Insured named in the Summary of Dental Plan Benefits.

## AGREEMENT AND CONSIDERATION

Renaissance Life & Health Insurance Company of America ("RLHICA") will pay Benefits for Covered Services as set forth in this Policy. This Policy is issued in exchange for your payment of the premium and on the basis of the statements made on your application. It takes effect on the Effective Date as shown in the Summary of Dental Plan Benefits. It will remain in force for such further periods for which it is renewed automatically upon payment of premium. All periods will begin and end at 12:01 A.M. Standard Time, where You live.

## 10-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY

**Please read this Policy. If you are not satisfied, you may return the Policy within 10 days after you receive it. Mail or deliver it to us or to your agent. Any premium paid will be refunded. This Policy will then be void from its start.**

This Policy is signed for RLHICA as of its Effective Date.

Secretary
Renaissance Life & Health Insurance Company of America

President & CEO
Renaissance Life & Health Insurance Company of America

SAMPLE

## THIS DENTAL POLICY IS CONDITIONALLY RENEWABLE
## REFER TO RENEWABILITY AND TERMINATION PROVISIONS

## READ YOUR POLICY CAREFULLY
## This Policy is a legal contract between you and us.

NOTE: This Individual Dental Policy should be read in conjunction with the Summary of Dental Plan Benefits that is included as part of this Policy. The Summary of Dental Plan Benefits lists the specific provisions and coverages of your individual dental plan.

**This Policy is not certified as having all of the pediatric dental essential health benefits as defined in the Patient Protection and Affordable Care Act.**

**RENAISSANCE**
**INDIVIDUAL DENTAL POLICY**



SAMPLE

## Renaissance Life & Health Insurance Company of America
## Summary of Dental Plan Benefits - PPO Basic Plan

This Summary of Dental Plan Benefits is part of, and should be read in conjunction with, your Individual Dental Policy. Your Individual Dental Policy will provide you with additional information about your RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF AMERICA ("RLHICA") coverage, including information about exclusions and limitations. If a statement in this Summary conflicts with a statement in the Policy, the statement in this Summary applies to you and you should ignore the conflicting statement in the Policy.

**THIS DOCUMENT IS INTENDED TO SERVE AS AN EXAMPLE AND IS NOT AN ACTUAL POLICY. UPON COMPLETION OF YOUR ENROLLMENT YOU WILL RECEIVE AN ACTUAL COPY OF YOUR POLICY.**

| **Covered Services** | **In-Network[1]** | | **Out-of-Network** | | **Waiting Period** |
|---|---|---|---|---|---|
| | **RLHICA Pays** | **You Pay** | **RLHICA Pays** | **You Pay** | |
| **Diagnostic and Preventive Services** | | | | | |
| **Diagnostic and Preventive Services -** Used to evaluate existing conditions and/or to prevent dental abnormalities or disease (includes exams, cleanings, bitewing X-rays and fluoride treatments) | 100% | 0% | 100% | 0% | None |
| **Brush Biopsy –** Used to detect oral cancer | 100% | 0% | 100% | 0% | None |
| **Basic Services** | | | | | |
| **Emergency Palliative Treatment -** Used to temporarily relieve pain | 100% | 0% | 100% | 0% | None |
| **Radiographs/Diagnostic Imaging/Diagnostic Casts -** X-rays as required for routine care or as necessary for the diagnosis of a specific condition | 0% | 100% | 0% | 100% | Not Covered |
| **Minor Restorative Services –** Used to repair teeth damaged by disease or injury (for example, silver fillings and white fillings) | 50% | 50% | 50% | 50% | 6 months |
| **Simple Extractions** – Simple extractions including local anesthesia, suturing, if needed, and routine post-operative care | 0% | 100% | 0% | 100% | Not Covered |
| **Sealants** – Sealants for the occlusal (biting) surface of unrestored permanent molars | 0% | 100% | 0% | 100% | Not Covered |
| **Periodontal Maintenance** – Periodontal maintenance following active periodontal therapy | 0% | 100% | 0% | 100% | Not Covered |
| **Other Basic Services** – Services performed by a Dentist during after-hours visits | 0% | 100% | 0% | 100% | Not Covered |
| **Major Services** | | | | | |
| **Oral Surgery Services –** Extractions and dental surgery, including local anesthesia, suturing, if needed, and routine post-operative care | 0% | 100% | 0% | 100% | Not Covered |
| **Endodontic Services –** Used to treat teeth with diseased or damaged nerves (for example, root canals) | 0% | 100% | 0% | 100% | Not Covered |
| **Periodontic Services –** Used to treat diseases of the gums and supporting structures of the teeth | 0% | 100% | 0% | 100% | Not Covered |
| **Major Restorative Services –** Used when teeth can't be restored with another filling material (for example, crowns) | 0% | 100% | 0% | 100% | Not Covered |
| **Prosthodontic Services –** Used to replace missing natural teeth (for example, bridges, endosteal implants, partial dentures and complete dentures) | 0% | 100% | 0% | 100% | Not Covered |
| **Relines and Repairs –** Relines and repairs to fixed bridges, removable bridges, partial dentures, and complete dentures | 0% | 100% | 0% | 100% | Not Covered |
| **Other Major Services** – Occlusal guards, and limited occlusal adjustments | 0% | 100% | 0% | 100% | Not Covered |
| **Orthodontic Services**<br>**[Orthodontic Services –**Services, treatments, and procedures to correct malposed teeth (for example, braces) | 0% | 100% | 0% | 100% | Not Covered |
| **Maximum Payments & Deductibles** | | | | | |
| **Benefit Year Maximum Payment** $1,000] per person | | | | | |

SAMPLE

[1] To ensure that you have access to as many providers as possible, RLHICA contracts with various dental networks and treats Covered Services provided by those network Dentists as In-Network for the purposes of this Policy. Please note that the Allowed Amounts your provider may charge will vary based on the network in which he or she participates.

## Covered Services

| | | In-Network[1] | | Out-of-Network | | Waiting Period |
|---|---|---|---|---|---|---|
| | | RLHICA Pays | You Pay | RLHICA Pays | You Pay | |
| **TMD Lifetime Maximum Payment** | Not Covered | | | | | |
| **Ortho Lifetime Maximum Payment** | Not Covered | | | | | |
| **Deductible (per Benefit Year)** | None | | | | | |

- Benefits for Periodontal Prophylaxes (teeth cleaning by a specialist) are payable twice per Benefit Year.
- Benefits for prophylaxes and oral examinations are payable twice per Benefit Year.
- A third prophylaxis is payable per Benefit Year for individuals with a documented history of periodontal disease and a fourth prophylaxis is payable for two consecutive calendar years following periodontal surgery.
- Benefits for bite-wing X-rays are payable once per Benefit Year.
- Benefits for full mouth X-rays (which include bite-wing X-rays) are payable once in any five consecutive years.
- Crowns, onlays, dentures, bridges, and substructures are limited to once in a seven-year period.
- Benefits for Temporomandibular Disorders ("TMD") are limited to those services normally provided by a Dentist to relieve oral symptoms associated with malfunctioning of the temporomandibular joint. This does not include services that would normally be provided under medical care.
- Composite resin (white) restorations and porcelain crowns are Covered Services on posterior teeth.
- Fluoride treatments are payable twice per Benefit Year for Children up to age 14.

**Annual and Lifetime Maximum Payments for Covered Services -** The annual Maximum Payment shall be $1000 per individual per Benefit Year on Diagnostic and Preventive, Basic, and Major Services.

**Deductibles For Covered Services -** None

**Waiting Period for Covered Services –** You (and your Eligible Dependents, if covered) will be eligible for coverage for Diagnostic and Preventive, Basic, Major and Orthodontic Services in accordance with the applicable Waiting Periods set forth in the Covered Services chart above. Eligible Dependents enrolled after your date of enrollment will have their own waiting period.

**Method of Payment** – For services rendered or items provided by an In-Network Dentist, the Allowed Amount is a pre-negotiated fee that the provider has agreed to accept as payment in full. For services rendered or items provided by Out-of-Network Dentists, RLHICA determines the Allowed Amount using statistically valid claims data submitted to RLHICA and its affiliates which show the most frequently charged fees by providers in the same geographic areas for comparable services or supplies. The claims data and fees are updated periodically using the most current codes and nomenclature developed and maintained by the American Dental Association. RLHICA will base Benefits on the lesser of the Submitted Amount and the Allowed Amount. If the Submitted Amount for an Out-of-Network Dentist is more than the Allowed Amount, you are not only responsible for paying the Dentist that percentage listed in the "You Pay" column, but are also responsible for paying the Dentist the difference between the Submitted Amount and the Allowed Amount.

**Out of Country Services –** Having Renaissance coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of Dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our website or contact your benefits representative to get a copy of our Passport Dental information sheet.

**Eligibility (You and Your Eligible Dependents):**

Your Eligible Dependents including your Reciprocal Beneficiary are also eligible.

A Reciprocal Beneficiary is defined as follows and shall be treated as a "Legal Spouse" under the terms of the Policy:

- each party is the sole Receiprocal Beneficiary of the other and is not married, a party to another Reciprocal Beneficiary relationship or a partner in a civil union;
- each party is at least 18 years of age or older and competent to enter into a contract in the state in which they reside;

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- the parties are legally prohibited from marrying one another under chapter 572 of the Hawaii Insurance Laws;
- consent of either party to the Reciprocal Beneficiary relationship has not been obtained by force, duress, or fraud; and
- each of the parties sign a declaration of Reciprocal Beneficiary relationship as provided in Section 572C-5 of the Hawaii Insurance Laws.

**Once you enroll for coverage under the Policy, you must remain enrolled for a minimum of 12 months. If you terminate this coverage you may be limited in your ability to re-enroll at a later date.**

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## I. Renaissance Individual Dental Policy

We issue this Renaissance Individual Dental Policy to you, the Insured. This Policy is a summary of your dental benefits coverage. We agree to provide Benefits as described in this Policy. The Benefits provided under this Policy may change if any state or federal laws change.

**PLEASE NOTE: RLHICA recommends you obtain a Pre-Treatment Estimate before any services are rendered where the total charges will exceed $200. You and your Dentist should review your Pre-Treatment Estimate notice before your Dentist proceeds with treatment.**

## II. Definitions

### Adverse Benefit Determination

Means any denial, reduction or termination of the Benefits for which you filed a claim or a failure to provide or to make payment (in whole or in part) of the Benefits you sought, including any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which Benefits are otherwise provided was experimental or investigational, or was not medically necessary or appropriate.

### Allowed Amount

Means the maximum dollar amount upon which RLHICA will base Benefits. For services rendered or items provided by an In-Network Dentist, the Allowed Amount is a pre-negotiated fee that the provider has agreed to accept as payment in full. For services rendered or items provided by an Out-of-Network Dentist, RLHICA determines the Allowed Amount using statistically valid claims data submitted to RLHICA and its affiliates which show the most frequently charged fees by providers in the same geographic areas for comparable services or supplies. The claims data and fees are updated periodically using the most current dental procedure codes and nomenclature developed and maintained by the American Dental Association.

### Benefit Year

Means the one year period specified in the Summary of Dental Plan Benefits.

### Benefits

Means payment for Covered Services.

### Child(ren)

Means your natural children, stepchildren, adopted children, foster children or children by virtue of legal guardianship, regardless of age or dependency status, including children residing with you during the waiting period for legal adoption or guardianship.

### Coinsurance

Means the percentage of the Allowed Amount for Covered Services that you must pay for Covered Services. The Coinsurance is set forth in the Summary of Dental Plan Benefits.

### Completion Date

Means the date that treatment is complete. Treatment is complete:

- for dentures and partial dentures, on the delivery date;
- for crowns and bridgework, on the permanent cementation date;
- for root canals and periodontal treatment, on the date of the final procedure that completes treatment.

### Copayment

Means the fixed dollar amount that you must pay for Covered Services. The amount of any Copayment is set forth in the Summary of Dental Plan Benefits.

### Covered Person

Means you and/or any Eligible Dependent that is (a) named in the application or an enrollment update form, (b) approved by us, and (c) for whom the required premium payment has been received by us.

### Covered Services

Means the unique dental services for which you are covered as described in the Summary of Dental Plan Benefits and further subject to the terms and conditions of this Policy.

### Deductible

Means the amount an individual and/or a family must pay toward Covered Services during a Benefit Year before RLHICA begins paying for those services under this Policy. The Summary of Dental Plan Benefits lists the Deductible that applies to you, if any.

### Dentist

Means a person licensed to practice dentistry in the state or jurisdiction in which dental services are rendered.

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## Eligible Dependents

Means (a) your Legal Spouse; (b) your Child(ren); (c) your reciprocal beneficiary, as that term is defined in Chapter 572C of the Hawaii Revised Statutes; and (d) any other dependents who meet the criteria for eligibility set forth in the Summary of Dental Plan Benefits. If dependent coverage has been selected, it will be indicated in the Summary of Dental Plan Benefits.

## In-Network Dentist

Means a Dentist who has entered into a contract or is otherwise engaged by us to provide Covered Services for pre-negotiated fees that the Dentist has agreed to accept as payment in full. A current list of In-Network Dentists is available at www.RenaissanceDental.com.

## Insured

Means the person named in the application and enrolled by us to receive Benefits under the Policy, also referred to herein as "you" or "your".

## Legal Spouse

Means a person who is any of the following: (a) your spouse through a marriage legally recognized by the State in which the Policy was issued; (b) your partner through a civil or Reciprocal Beneficiary arrangement legally recognized by the State in which the Policy was issued; or (c) your Reciprocal Beneficiary so long as the requirements listed in the Summary of Dental Plan Benefits are met and proof that those requirements are met is provided to RLHICA at its request.

## Maximum Approved Fee

Means a system used by RLHICA to determine the approved fee for a given procedure for a Dentist. A fee meets Maximum Approved Fee requirements if it is the lowest of:

- The Submitted Fee
- The lowest fee regularly charged, offered, or received by an individual Dentist for a dental service, irrespective of Dentist's contractual agreement with another dental benefits organization.
- The maximum fee allowed for a given procedure in a given region and/or specialty, under normal circumstances.

RLHICA may also approve a fee under unusual circumstances.

In-Network Dentists are not allowed to charge patients more than the Maximum Approved Fee for the Covered Services. In all cases, RLHICA will make the final determination about what is the Maximum Approved Fee for the Covered Service.

## Maximum Payment

Means the maximum dollar amount we will pay in any Benefit Year or lifetime for Covered Services. The Maximum Payments are specified in the Summary of Dental Plan Benefits.

## Out-of Network Dentist

Means a Dentist who has not entered into a contract and is not otherwise engaged by us to provide Covered Services for pre-negotiated fees.

## Policy

Means this document, issued and delivered to you, the Insured. It includes the attached pages, the application, the Summary of Dental Plan Benefits and any attached amendments, riders, or renewals now or hereafter issued or executed.

## Pre-Treatment Estimate

Means a voluntary and optional process where we issue a written estimate of dental benefits that may be available for a proposed dental treatment under the terms of your coverage. Your Dentist submits the proposed dental treatment to us in advance of providing the treatment to you.

A Pre-Treatment Estimate is for informational purposes only and is not required in advance of obtaining dental care or as a prerequisite or condition for approval of future dental benefits payment. The benefits estimate provided on a Pre-Treatment Estimate notice is based on the information provided to us and the benefits available to Covered Persons on the date the notice is issued. It is not a guarantee of future dental benefits or payment.

Availability of dental benefits at the time a dental service is completed depends on several factors. These factors include, but are not limited to, your continued eligibility for benefits, your available annual or lifetime Maximum Payments, any coordination of benefits, the status of your Dentist, this Policy's limitations and any other provisions, together with any additional information or changes to the dental treatment. A request for a Pre-Treatment Estimate is not a claim for Benefits or a preauthorization, precertification or other reservation of future benefits.

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## RLHICA

Means Renaissance Life & Health Insurance Company of America, an Indiana domiciled insurance company licensed to underwrite health and accident insurance.

## Submitted Amount

Means the fee a Dentist bills to RLHICA for a specific service or item.

## Summary of Dental Plan Benefits

Means a description of the specific Covered Services and other provisions of your dental plan. The Summary of Dental Plan Benefits is, and should be read as, part of this Policy, and supersedes any contrary provision of this Policy.

# III. Eligibility

No person will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, age, race, color, national origin, gender identity, sex or sexual orientation.

The persons insured on the Effective Date of this Policy will be you and your Eligible Dependent(s) named in the application and approved by us. The Summary of Dental Plan Benefits will have specific information about this Policy's rules for dependent eligibility. This Policy will be classified as follows:

- Individual Plan – Insured only.
- Individual plus Legal Spouse Plan – Insured plus Legal Spouse only.
- Individual and One Child Plan – Insured and one Child.
- Individual and Two or more Children Plan – Insured and two or more Children.
- Family Plan with One Child – Insured, Legal Spouse, and one Child
- Family Plan with Two or more Children – Insured, Legal Spouse, and two or more Children.

## ADDING NEW COVERED PERSONS

New persons, meeting the definition of Eligible Dependents, may be added to the coverage provided by this Policy upon the following basis:

**Adding a Legal Spouse**: You may add your Legal Spouse by submitting a written application to us as set forth below. Coverage for your Legal Spouse will be effective upon approval by us of the application and receipt of any applicable premium.

**Adding a Newborn or Adopted Child**: A newborn or adopted Child will be covered from the time of his or her birth or the earlier of the date of placement for adoption or the date of an entry of an order granting you custody of the Child for purposes of adoption until the 31st day after his or her birth or placement or entry of an order granting custody for adoption. Such newborn or adopted Child may continue as a Covered Person after 31 days only if you make written application, as set forth below, to add him or her as a Covered Person by the 31st day after the Child's birth or placement for adoption. If this is not done, the newborn or adopted Child will cease to be a Covered Person as of the end of the 31st day.

**Adding a Child Under Guardianship**: A Child for whom you or your Legal Spouse is a court-appointed guardian will be covered from the date of the filing of the application for appointment of guardianship with a court of competent jurisdiction, subject to the terms of the Policy, until the 31st day after that date, unless the guardianship is disrupted prior to the date the court appoints you or your Legal Spouse as guardian and the Child is removed from your or your Legal Spouse's physical custody. Such Child may continue as a Covered Person only if you make a written application, as set forth below, to add him or her as a Covered Person by the 31st day after the date of the filing of the application for appointment of the guardianship.

**Adding Other Eligible Children**: Other Children may be added to the coverage provided under this Policy at any time, upon submission of a written application, as set forth below.

**Application Process and Effective Date of Coverage**: Except as specifically stated above, the Eligible Dependent is not a Covered Person until: (1) you submit an application or enrollment update form for our approval; (2) we approve the application or enrollment update form and give you written notice that the Policy is changed; and (3) we receive any additional required premium. The effective date of coverage will be on the written notice sent to you.

# IV. Benefits

## Covered Services

We agree to provide Benefits to you and your Eligible Dependents under our policies and procedures and under the terms and conditions of this Policy, including, but not limited to, the categories of Covered Services, exclusions, and limitations listed below.

**Unless otherwise specified in the Summary of Dental Plan Benefits, Covered Services may be divided into the following categories, and are subject to the exclusions and limitations listed below. Benefits are limited by any applicable Coinsurance, Copayment, or Deductible. Please see the Summary of Dental Plan Benefits for a detailed list of the Benefits, exclusions, limitations,**

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**Coinsurance, Copayments and Deductibles applicable under this Policy.**

All time limitations are measured either from the last date of service in any RLHICA plan or, to the extent records are available, from the last date of service in any dental plan.

To receive maximum Benefits, Covered Persons should receive dental services from In-Network Dentists. Your expenses will generally be higher if you receive dental services from Out-of-Network Dentists.

## Diagnostic and Preventative Services

Services and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease. These services include oral evaluations (examinations), prophylaxes (cleanings), bitewing X-rays and fluoride treatments. These services are subject to the following exclusions and limitations:

1. Topical fluoride treatments are payable twice in any Benefit Year for Covered Persons under age 14;
2. Oral examination submitted as a consultation or evaluation are payable twice in any Benefit Year, whether provided under one or more RLHICA Plans. An evaluation is not a Covered Service when done in conjunction with a consultation;
3. Prophylaxes, including periodontal maintenance procedures, are payable twice in any Benefit Year;
4. Bitewing X-rays are payable once in any Benefit Year;
5. Space maintenance services are payable once per lifetime, per area on posterior teeth, for Covered Persons under age 14;
6. We will not make payment for preventive control programs, including home care items, oral hygiene instructions, nutritional counseling, and tobacco counseling and all charges for the same will be your responsibility;
7. We will not make payment for tests and laboratory examinations (including, but not limited to cytology, bacteriology or pathology) and caries susceptibility tests and all charges for the same will be your responsibility, unless otherwise indicated in the Summary of Dental Plan Benefits or in this Policy.

## Brush Biopsy

Oral brush biopsy procedure and laboratory analysis used to detect oral cancer, an important tool that identifies and analyzes precancerous and cancerous cells.

## Basic Services

### Emergency Palliative Treatment

Emergency treatment to temporarily relieve pain is not a Covered Service when done in conjunction with any services except X-rays, tests or examinations.

### Radiographs (X-rays) / Diagnostic Imaging / Diagnostic Casts

X-rays as required for routine care or as necessary for the diagnosis of a specific condition, subject to the following exclusions and limitations:

1. Full mouth X-rays (which include bitewing X-rays) or a panoramic X-ray (with or without bitewing X-rays) are payable once in any 5 year period;
2. A serial listing of X-rays is paid as full mouth X-rays if the total fee equals or exceeds the fee for full mouth X-rays;
3. Any supplemental films with full mouth X-rays are part of the complete procedure;
4. Cephalometric films, oral/facial photographic images or diagnostic casts are not payable except in conjunction with Orthodontic Services and all charges for the same will be your responsibility;
5. Posterior-anterior or lateral skull and facial bone survey, sialography, temporomandibular joint films (including arthrograms) or tomographic films are not payable and all charges for the same will be your responsibility.

### Minor Restorative Services

Minor restorative services to rebuild and repair natural tooth structure when damaged by disease or injury. These services include amalgam (silver) and composite resin (white) restoration (fillings), subject to the following exclusions and limitations:

1. Amalgam and composite resin restorations are payable once per tooth surface within a 24 month period regardless of the number or combination of restorations placed on a surface;
2. We will not make payment for dentistry for aesthetic reasons and all charges for the same will be your responsibility.
3. Retention pins are payable once in a two-year period. Only one substructure per tooth is a Covered Service.

### Simple Extractions

Simple extractions including local anesthesia, suturing, if needed, and routine post-operative care.

### Sealants

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Sealants are payable only for the occlusal (biting) surface of first permanent molars for Covered Persons under age 9 and second permanent molars for Covered Persons under age 14. The surface must be free from decay and restorations. Sealants are a Benefit payable once in any 3 year period.

### Periodontal Maintenance Following Therapy

Periodontal maintenance following active periodontal therapy procedures to treat diseases of the gums and supportive structures of the teeth along with benefits for prophylaxes, including periodontal maintenance procedures are payable twice in any Benefit Year.

### Other Basic Services

After hours visits, not to exceed once per Benefit Year.

## MAJOR SERVICES

### Oral Surgery Services

Surgical extractions and dental surgery, including local anesthesia, suturing, if needed, and routine postoperative care are subject to the following exclusions and limitations:

1. We will not make payment for the following services and items and all charges for the same will be your responsibility unless otherwise specified in the Summary of Dental Plan Benefits: appliances, restorations, X-rays or other services for the diagnosis or treatment of temporomandibular disorders ("TMD") including myofunctional therapy;
2. We will not make payment for the following services and items and all charges for the same will be your responsibility: charges related to hospitalization or general anesthesia and/or intravenous sedation for restorative dentistry or surgical procedure unless a specified need is shown.

### Endodontic Services

The treatment of teeth with diseased or damaged nerves (for example, root canals) is subject to the following exclusions and limitations:

1. Endodontic therapy, endodontic retreatment, and apicoectomy/periradicular services are payable once per tooth in any 24 month period;
2. Root canal fillings on primary teeth are limited to primary teeth without succedaneous (replacement) teeth;
3. We will not make payment for pulp caps and all charges for the same will be your responsibility.
4. Pulpotomy is a Covered Service only for Covered Persons under the age of 21.

### Maxillofacial Prosthetics

RLHICA will not make payment for maxillofacial prosthetics and all charges for the same will be your responsibility.

### Periodontic Services

The treatment of diseases of the gums and supporting structures of the teeth is subject to the following exclusions and limitations:

1. Full mouth debridement will be payable once in Covered Person's lifetime;
2. Scaling and root planing are payable once per area in any 24 month period;
3. Periodontal surgery is payable once per area in any 3 year period;

### Major Restorative Services

Major restorative services, such as crowns, are payable only for extensive loss of tooth structure due to caries (decay) or fracture. These services are subject to the following further exclusions and limitations:

1. Indirect restorations including porcelain/ceramic substrate, porcelain/resin processed to metal and cast metal restorations (including crowns and onlays) and associated procedures such as cores and post and core substructures on the same tooth are payable once in any 7 year period;
2. Substructures and indirect restorations, including porcelain/ceramic substrate, porcelain/resin processed to metal, and cast restorations are not payable for Covered Persons under age 12 and all charges for the same will be your responsibility. Cores are payable only when necessary to retain a crown or a tooth with extensive breakdown due to decay or fracture;
3. Optional treatment: if a Covered Person selects a more expensive service than is customarily provided, we may make an allowance based on the fee for the customarily provided service. You are responsible for the difference in cost;
4. Inlays, regardless of the material used: we will pay only the applicable amount that it would have paid for a resin-based composite restoration. You will be responsible for any additional charges;
5. We will not make payment for the following services and items and all charges for the same will be your responsibility: charges related to hospitalization or general anesthesia and/or intravenous sedation for restorative dentistry or surgical procedure unless a specified need is shown;

SAMPLE

6. We will not make payment for dentistry for aesthetic reasons and all charges for the same will be your responsibility;
7. Veneers are not a Covered Service and all charges for the same will be your responsibility.

### Prosthodontic Services

Services and appliances that replace missing natural teeth (such as fixed bridges, endosteal implants, partial dentures, and complete dentures) are subject to the following exclusions and limitations:

1. One complete upper and one complete lower denture is payable once in any 7 year period for any individual;
2. A partial denture, fixed bridge, or removable bridge and any associated services are payable once in any 7 year period;
3. Fixed bridges, endosteal implants and removable partial dentures are not payable for Covered Persons under age 16 and all charges for the same will be your responsibility;
4. Optional treatment: if a Covered Person selects a more expensive service than is customarily provided, we may make an allowance based on the fee for the customarily provided service. You are responsible for the difference in cost;
5. Services for tissue conditioning are payable twice per denture unit in any 3 year period.
6. Endosteal implants are allowed once per tooth, per lifetime. We will not make payment if the implant is placed within 7 years following prosthodontic or major restorative services involving that tooth and all charges for the same will be your responsibility;
7. We will not make payment for specialized implant surgical techniques, bone replacement grafts, removal of an implant, implant maintenance procedures, or implant repairs and all charges for the same will be your responsibility unless otherwise specified in the Summary of Dental Plan Benefits;
8. We will not make payment for the following services and items and all charges for the same will be your responsibility: lost, missing or stolen appliances of any type; temporary, provisional, or interim prosthodontic appliances; precision or semi-precision attachments, copings or myofunctional therapy.
9. We will not make payment for (a) procedures to replace a missing tooth or teeth that were lost prior to the date that a Covered Person was covered under this Policy; or (b) the replacement of teeth beyond the normal complement of teeth; or (c) services associated with overdentures; or (d) posterior bridges in conjunction with partial dentures in the same arch, and all charges for the same will be your responsibility.

### Relines and Repairs

Relines and repairs to fixed bridges, partial dentures, and complete dentures. A reline or a complete replacement of denture base material is limited to once in any 3 year period per appliance.

### Other Major Services

1. An occlusal guard is payable once in a Covered Person's lifetime;
2. Limited occlusal adjustments are limited to 1 in a 5 year period;
3. We will not make payment for the following services and items and all charges for the same will be your responsibility: repair, relines, or adjustments of occlusal guards.

## Orthodontics

### Orthodontic Services

No person will be eligible for Orthodontic Services under this Policy unless Orthodontic Services are provided for in the Summary of Dental Plan Benefits. Services, treatment, and procedures to correct malposed teeth (for example, braces), are subject to the following exclusions and limitations:

1. Our payment for Orthodontic Services will be limited to the lifetime Maximum Payment specified in the Summary of Dental Plan Benefits;
2. Orthodontic Services are payable until the end of the calendar year in which the Covered Person attains the age of 19, unless otherwise specified in the Summary of Dental Plan Benefits;
3. Our payment for orthodontic retention services (removal of appliances, construction and placement of retainer) is included in its payment of overall Orthodontic Services. If a Dentist bills these services separately, payment will be denied.
4. If the treatment plan is terminated before completion of the case for any reason, our obligation will cease with payment up to the date of termination;
5. The Dentist may terminate treatment, with written notification to us and to the patient, for lack of patient interest and cooperation. In those cases, our obligation for payment ends on the last day of the month in which the patient was last treated;
6. We will not make payment for the following services and items and all charges for the same will be your responsibility: lost, missing, or stolen appliances of any type or replacement or repair of an orthodontic appliance.

SAMPLE

### Payment for Covered Services

This Policy provides Benefits based on whether a Covered Person receives dental services from an In-Network Dentist or an Out-of-Network Dentist.

If a Covered Person receives Covered Services from an Out-of-Network Dentist, Benefits may be less than the amount that would have otherwise been payable with an In-Network Dentist. However, if a Covered Person requires emergency treatment and receives Covered Services from an Out-of-Network Dentist, Covered Services for the emergency care rendered during the course of the emergency will be treated as if they had been provided by an In-Network Dentist. Also, if a Covered Person receives Covered Services that are not of the type provided by any In-Network Dentist, these Covered Services will be treated as if they had been provided by an In-Network Dentist.

The Benefits for both In-Network and Out-of-Network Dentists are shown in the Summary of Dental Plan Benefits.

**Payment of Dental Bills When Seeing an In-Network Dentist**

If a Covered Person receives Covered Services from an In-Network Dentist, the fee for services has already been agreed to between the Dentist and RLHICA. In-Network Dentists accept these pre-negotiated fees as payment in full for the dental care provided. You will be responsible for paying the Dentist that percentage of the Allowed Amount listed in the "You Pay" column of the Summary of Dental Plan Benefits for In-Network Dentists for the categories of services rendered.

You are also responsible for any charges for Deductibles, amounts above annual or lifetime Maximum Payments, optional treatment or specific exclusions or limitations of this Policy.

**Payment of Dental Bills When Seeing an Out-of-Network Dentist**

If a Covered Person receives Covered Services from an Out-of-Network Dentist, payment will be based upon the percentage of the Allowed Amount that is set forth in the Summary of Dental Plan Benefits. You will be responsible for paying the Dentist that percentage of the Allowed Amount listed in the "You Pay" column of the Summary of Dental Plan Benefits for Out-of-Network Dentists for the categories of services rendered. In addition, if the Submitted Amount for an Out-of-Network Dentist is more than the Allowed Amount, you are also responsible for paying the Dentist the difference between the Submitted Amount and the Allowed Amount.

You are also responsible for any charges for Deductibles, amounts above annual or lifetime Maximum Payments, optional treatment or specific exclusions or limitations of this Policy.

## V. Exclusions and Limitations

### Exclusions

In addition to the exclusions listed above in the Benefits Section, we will not make payment for the following services, items or supplies and all charges for the same will be your responsibility, unless otherwise specified in the Summary of Dental Plan Benefits:

1. Services for injuries or conditions paid pursuant to Workers' Compensation or Employer's Liability laws. Services that are received from any government agency, political subdivision, community agency, foundation, or similar entity. NOTE: This provision does not apply to any programs provided under Title XIX of the Social Security Act, that is, Medicaid;
2. Services or appliances started prior to the effective date of a Covered Person's coverage under this Policy, excluding orthodontic treatment in progress (if a Covered Service);
3. Charges for failure to keep a scheduled visit with the Dentist;
4. Charges for completion of forms or submission of claims;
5. Services, items or supplies for which no valid dental need can be demonstrated, as determined by us;
6. Services, items or supplies that are specialized techniques, as determined by us;
7. Services, items or supplies that are investigational in nature, including services, items or supplies required to treat complications from investigational procedures, as determined by us;
8. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist or other licensed provider under the scope of his or her license as permitted by applicable state law;
9. Services, items or supplies excluded by our policies and procedures;
10. Services, items or supplies, as determined by us, which are not provided in accordance with accepted standards of dental practice;
11. Services, items or supplies for which no charge is made, for which the patient is not legally obligated to pay or for which no charge would be made in the absence of our coverage;
12. Services, items or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared;

SAMPLE

13. Services, items or supplies that are generally covered under a hospital, surgical/medical, or prescription drug program;
14. Services, items or supplies that are not within the categories of Covered Services as shown in the Summary of Dental Plan Benefits;
15. Prescription drugs, non-prescription drugs, premedications, fluoride rinses and self-applied fluorides, localized delivery of antimicrobial or chemotherapeutic agents, relative analgesia, non-intravenous conscious sedation, therapeutic drug injections, hospital visits, desensitizing medicaments and techniques, behavior management, athletic mouthguards, house/extended care facility visits, mounted occlusal analysis, complete occlusal adjustment, enamel microabrasions, odontoplasty, or bleaching;
16. Correction of congenital or developmental malformations, cosmetic surgery or dentistry for aesthetic reasons as determined by us;
17. Any appliance, restoration or surgical procedure used to: (a) change vertical dimension; (b) restore or maintain occlusion; (c) replace tooth structure lost as a result of abrasion, attrition, abfraction or erosion; and (d) splint or stabilize teeth for periodontal reasons;
18. Local anesthesia;
19. Gingivectomy as an aid to the placement of a restoration.

## Limitations

In addition to the limitations listed above in the Benefits Section, the following limitations apply under this Policy, unless otherwise specified in the Summary of Dental Plan Benefits:

1. Our obligation for payment of Benefits ends on the last day of the month in which coverage is terminated under this Policy;
2. When services in progress are interrupted and completed later by another Dentist, we will review the claim to determine the amount of payment, if any, to each Dentist;
3. Care terminated due to the death of a Covered Person will be paid to the limit of our liability for the services completed or in progress;
4. The Maximum Payment will be limited to the amount specified in the Summary of Dental Plan Benefits;
5. If a Deductible amount is specified in the Summary of Dental Plan Benefits, we will not be obligated to pay, in whole or in part, for any services, items or supplies to which the Deductible applies, until the Deductible amount is met.

# VI. Accessing Your Benefits

To access your Benefits, follow these steps:

1. Please read this Policy including the Summary of Dental Plan Benefits carefully to become familiar with the Benefits, payment methods and terms of this Policy.
2. Make an appointment with your Dentist and tell him or her that you have coverage with RLHICA. If you or your dental office need a claim form, if your Dentist is not familiar with this Policy or if you or your Dentist have any questions regarding this Policy, you may contact us by writing Attention: Customer Services Department, P.O. Box 1596, Indianapolis, Indiana 46206 or by calling the toll-free number, 1-888-791-5995.
3. Note: We recommend you obtain a Pre-Treatment Estimate before any services are rendered where the total charges will exceed $200. A Pre-Treatment Estimate is not required to receive payment, but it allows you to know what services may be covered before your Dentist provides them. You and your Dentist should review your Pre-Treatment Estimate notice before your Dentist proceeds with treatment. Once treatment is complete, you or your dental office will submit a claim to us for payment.

### Notice of Claim

Written notice of claim shall be given to us within twenty days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf to us at (insert the location of the office as the insurer may designate for the purpose) or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

### Claim Forms

Upon request, we will furnish to you, a Covered Person, or your dental office, such forms as are usually furnished by us for filing proofs of loss. If such forms are not furnished within 15 days after such request, you will be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time frame fixed in this Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. Claim forms are also available at our website, www.RenaissanceDental.com.

The claim form must be completed and should include the following information:

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a. Your full name, address and date of birth;
b. Your Social Security number;
c. The name and date of birth of the person receiving dental care; and
d. The Policy number.

Claims, adjustment requests, and completed information requests should be mailed to:

RLHICA
PO Box 17250
Indianapolis, IN 46217

**Proof of Loss**

Written proof of loss must be given within one year from the time Covered Services are provided., If it was not reasonably possible to give written proof in the time required, RLHICA shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than fifteen (15) months from the time specified unless the claimant was legally incapacitated.

**Time of Payment of Claims**

After receiving all required claim information, and in accordance with prompt payment of claims laws, we will pay all Benefits immediately upon receipt of the claim. If applicable, failure to pay within 30 days may entitle you to interest at the state prescribed rate per annum from the 30th day. Interest amounts less than one dollar ($1.00) will not be paid.

If you receive notice of an Adverse Benefit Determination, we will notify you or your authorized representative of the Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. We may extend this period by up to 15 days if we determine that the extension is necessary due to matters out of our control.

If we determine that an extension is necessary, we will notify you within 30 days of the circumstances requiring the extension and the date by which we expect to render a decision. If such an extension is necessary because you did not submit all the information necessary to decide the claim, the notice of extension will specifically describe the additional information required to complete processing of the claim. You will have at least 45 days to provide the requested information. If you deliver the information within the time specified, the 15-day extension period will begin after you provide the information.

Except as otherwise set forth in this Policy, all Benefits are payable to you. Benefits unpaid at your death will be paid to your Legal Spouse. If you have no Legal Spouse, the Benefits will be paid to your estate.

Checks for Benefits are sent to either (1) you and it is your responsibility to make full payment to the Dentist; or (2) directly to the Dentist if the Covered Person has assigned Benefit payments to the Dentist who rendered Covered Services under this Policy.

**Unpaid Premium**

Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

**Physical Examination**

We shall have the right and opportunity to examine any Covered Person while a claim is pending or while a dispute over the claim is pending. These examinations are made at our expense and as often as we may reasonably require during the pendency of a claim hereunder where it is not prohibited by law.

**Assignment**

Benefits to a Covered Person are for the personal benefit of you or the Covered Person and cannot be transferred or assigned. With your authorization, and our approval, Benefits for dental services may be assigned to the provider providing treatment. We reserve the right to refuse to approve an assignment to a provider providing treatment and make payment directly to you. Benefits paid pursuant to such assignment shall discharge our obligation with respect to the amount of the Benefits so paid.

**Late Claims Submission**

Except as otherwise provided in this Policy, we will not honor and no payment will be made for services, items or supplies if a claim for those services, items or supplies has not been received by us within one year from the date that the services, items or supplies were provided.

**Right of Recovery**

If we pay a claim for which another person or company is liable, we have the right to recover our payment from the other person or company. The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

## VII. Disputed Claims Procedure

If you receive notice of an Adverse Benefit Determination, and if you think that we incorrectly denied all or part of your claim, you or your Dentist should contact our Customer Services Department and ask them to check the claim to make sure it was processed correctly. You may do this by

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calling the toll-free number, 1-888-791-5995 and speaking to a telephone advisor. You may also mail your inquiry to the Customer Services Department at P.O. Box 1596, Indianapolis, IN 46206.

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 should not be considered a formal request for review of a denied claim. We provide this opportunity for you to describe problems and submit explanatory information that might indicate your claim was improperly denied and allow us to correct any errors quickly and without delay.

Whether or not you have asked us informally to recheck our initial determination, you can submit your claim to a formal review through the Disputed Claims Appeal Procedure described below.

If you receive notice of an Adverse Benefit Determination, you, or your authorized representative, should seek a review as soon as possible, but you must file your request for review within 180 days of the date on which you receive your notice of the Adverse Benefit Determination which you are asking us to review.

**To request a formal review of your claim, send your request in writing to:**

**Dental Director**
**Renaissance Dental - RLHICA**
**PO Box 1596**
**Indianapolis, IN 46206**

Please include your name and address, the Insured's Social Security number, the reason why you believe your claim was wrongly denied, and any other information you believe supports your claim. You also have the right to review this Policy and any documents related to it. If you would like a record of your request and proof that it was received by us, you should mail it certified mail, return receipt requested.

The Dental Director, or any other person(s) reviewing your claim, will not be the same as, nor will they be subordinate to, the person(s), who initially decided your claim. The reviewer will grant no deference to the prior decision about your claim, but rather will assess the information, including any additional information that you have provided, as if he/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 a dental or medical judgment (including determinations with respect to whether a particular treatment, or other item is experimental, investigational or not medically necessary or appropriate), the reviewer will, as necessary, consult a dental health care professional with appropriate training and experience. The dental health care professional will not be the same individual, or that person's subordinate, consulted during the initial determination.

The reviewer will make his/her determination on review within 60 days of his/her receipt of your request. If your claim is denied on review (in whole or in part), you will be notified in writing. The notice of an Adverse Benefit Determination during the Disputed Claims Appeal Procedure will meet the requirements described below under the heading "Manner and Content of Notice."

### Manner and Content of Notice

Your notice of an Adverse Benefit Determination will inform you of the specific reasons(s) for the denial, the pertinent Policy provisions(s) on which the denial is based, the applicable review procedures for dental claims, including applicable time limits, and that you are entitled to access, free of charge, upon request, all documents, records and other information relevant to your claim, free of charge. The 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 Disputed 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.

If you (a) need the assistance of a governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer, you may also contact the Health Insurance Branch of the Hawaii Insurance Division, P.O. Box 3614, Honolulu, HI 96811.

## VIII. Coordination of Benefits

### COORDINATION OF THE POLICY BENEFITS WITH OTHER BENEFITS

**A. APPLICABILITY**

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1. This Coordination of Benefits ("COB") provision applies to This Plan when a Covered Person has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

2. If this COB provision applies, the order of benefit determination rules should be looked at first. These rules determine whether the Benefits of This Plan are determined before or after those of another Plan. The Benefits of This Plan:

   a. Shall not be reduced when, under the order of benefit determination rules, This Plan determines its Benefits before another Plan; but

   b. May be reduced when, under the order of benefits determination rules, another Plan determines its benefits first. The above reduction is described in Paragraph D. "Effect on the Benefits of This Plan."

3. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

**B. DEFINITIONS**

1. **"Allowable Expense"** means a health or dental care expense, including deductibles, coinsurance and copayments, covered under this Policy when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

   When a Plan provides payment for services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

2. **"Claim Determination Period"** means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

3. **"Closed Panel Plan"** means a Plan that provides health or dental care benefits to covered persons primarily in the form of services through a panel or providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in the cases of emergency or referral by a panel member.

4. **"Plan"** is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

   a. Group and nongroup insurance contracts, health maintenance organization ("HMO") contracts, Closed Panel Plans or other forms of group or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage;

   b. Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

   Each contract or other arrangement for coverage under (a) or (b) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

5. **"Primary Plan/Secondary Plan:"** The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

   When This Plan is a Primary Plan, its Benefits are determined before those of the other Plan and without considering the other Plan's benefits.

   When This Plan is a Secondary Plan, its Benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

   When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

6. **"This Plan"** means the dental coverage provided for Covered Person pursuant to this Policy.

**C. ORDER OF BENEFIT DETERMINATION RULES**

1. General. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its Benefits determined after those of the other Plan, unless:

   a. The other Plan has rules coordinating its benefits with those of This Plan; and

   b. Both those rules and This Plan's rules, in subparagraph (C)(2) below, require that This Plan's Benefits be determined before those of the other Plan.

2. Rules. This Plan determines its order of Benefits using the first of the following rules which applies:

   a. Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, member, or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that: if the person is also a Medicare beneficiary,

SAMPLE

and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(i) Secondary to the Plan covering the person as a dependent and;

(ii) Primary to the Plan covering the person as other than a dependent (*e.g.*, a retired employee), then the order of benefit determination is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Plan is primary.

b. Dependent Child/Parents not Separated or Divorced. Except as stated in subparagraph (C)(2)(c) below, when This Plan and another Plan cover the same Child as a dependent of different persons, called "parents:"

(i) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

(ii) If both parents have the same birthday, the benefits of the Plan which covered the parents longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in subparagraph (C)(2)(b)(i) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

c. Dependent Child/Parents Separated or Divorced. If two or more Plans cover a person as a dependent Child of divorced or separated parents, benefits for the Child are determined in this order:

(i) First, the Plan of the parent with custody of the Child;

(ii) Then, the Plan of the spouse of the parent with custody of the Child;

(iii) Then, the Plan of the parent not having custody of the Child; and

(iv) Then, the Plan of the spouse of the parent not having custody of the Child.

If the other Plan does not have this subparagraph (C)(2)(c) and if, as a result, the Plans do not agree on the order of benefits, this subparagraph (C)(2)(c) shall be ignored.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the Child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This subparagraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the Child, the Plans covering the Child shall be subject to the order of benefit determination contained in subparagraph (C)(2)(b) above.

d. Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this subparagraph (C)(2)(d) is ignored.

e. Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal law (*i.e.*, COBRA) or state law also is covered under another Plan, the benefits of the Plan covering the person as employee, member, or subscriber (or that person's dependent) shall be determined before the benefits under the continuation coverage. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this subparagraph (C)(2)(e) shall be ignored.

f. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered a person longer are determined before those of the Plan which covered that person for the shorter term.

**D. EFFECT ON THE BENEFITS OF THIS PLAN**

1. When This Paragraph Applies. This Paragraph D. applies when, in accordance with Paragraph C. "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other Plans. In that event the Benefits of This Plan may be reduced under this Paragraph D. Such other Plan or Plans are referred to as "the other Plans" in subparagraph (D)(2) immediately below.

2. Reduction in This Plan's Benefits. The Benefits of This Plan will be reduced when the sum of:

a. The Benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

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b. The Benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the Benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the Benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

### E. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. We have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person subject in all events, to all provisions of applicable law. We need not tell, or get the consent of, any person to do this. Each person claiming Benefits under This Plan must give us any facts we need to pay the claim.

### F. FACILITY OF PAYMENT

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, we may pay that amount to the organization which made that payment.

That amount will then be treated as though it were a Benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

### G. RIGHT OF RECOVERY

If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services

## IX. Premiums

### A. PREMIUM PAYMENT

Each premium installment is to be paid on or before its due date. A due date is the last date of the period for which the preceding premium was paid. Premium is to be paid annually. We will also accept monthly premium payment if paid by credit card or direct debit from your checking account.

We may periodically change the premium associated with this Policy. Premium payments will be based on the premiums in effect on the due date. Your Policy plan, your age, the number of family members covered, and place of residence on the premium due date are factors which may be used in determining premium rates. We will make no change in your premium solely because of claims made under this Policy. At least 30 days' notice of any premium change as permitted by this clause will be mailed to you at your last address as shown in our records.

### B. GRACE PERIOD

This Policy has a 31-day grace period (the "Grace Period"). This means that if a premium installment, other than the initial premium installment, is not paid by the date it is due, it may be paid during the following 31days. The Grace Period will not apply if, at least 30 days before the premium due date, we have delivered or mailed to your last known address written notice of our intent not to renew this Policy. Your Policy will remain in force during this Grace Period.

### C. REINSTATEMENT

If you do not pay the premium by the end of the Grace Period, your Policy will lapse. This Policy may be reinstated, but we may require an application. You must pay the premium to us.

If an application is not required, your Policy will be reinstated when the premium is accepted by us or our agent. If an application is required, and a conditional receipt is issued, your Policy will be reinstated when the application is approved by us. If the application is disapproved, we will notify you in writing and your Policy will not be reinstated. If the application is received by us, but is neither disapproved in writing nor approved, your Policy will be reinstated 45 days after the date of the conditional receipt.

Premium accepted for reinstatement may be applied to a period for which premium had not been paid. The period for which back premium may be required will not begin more than 60 days before the date of reinstatement.

The reinstated Policy will cover claims for Covered Services provided after the date of reinstatement.

A change may be made in your Policy in connection with the reinstatement. These changes will be sent to you for you to attach to your Policy. In all other respects, you and we will have the same rights as before your Policy lapsed.

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### D. MISSTATEMENT OF AGE

If the age for any Covered Person has been misstated, the benefits may be adjusted, based on the relationship of the premium paid to the premium that should have been paid based on the correct age.

## X. Renewability and Termination of Coverage

### A. CONDITIONALLY RENEWABLE – PREMIUM MAY CHANGE

You may keep this Policy in force by timely payment of the premiums. However, we may refuse renewal due to:

1. non-payment of premium, subject to the Grace Period provision;
2. fraud or material misrepresentation by you or any other Covered Person with your knowledge, in applying for this coverage or filing a claim for Benefits;
3. your engaging in intentional and abusive noncompliance with material provisions of the Policy;
4. you no longer reside or live in our service area;
5. RLHICA ceasing to renew all policies issued that are associated with this Policy to residents of the state where you live.
6. your death.

At least 30 days' notice of any non-renewal action permitted by this clause will be mailed to you at your last address as shown in our records. This notice will identify the date upon which coverage under the Policy will cease. If we fail to provide 30 days' notice of our intent to non-renew coverage, your coverage will remain in effect until 30 days after notice is given or until the effective date of replacement coverage, whichever occurs first. However, no Benefits will be paid for expenses incurred during any period of time for which premium has not been paid.

### B. TERMINATION

All coverage will cease on termination of the Policy. This Policy will terminate on:

1. nonpayment of premiums when due, subject to the Grace Period provision;
2. the date we receive a written request from you to terminate the Policy, or any later date stated in your request;
3. the date we decline to renew the Policy as provided by the above renewal clause; or
4. the date of your death, if this Policy is an Individual Plan.

We will refund any premium paid and not earned due to Policy termination. The refund will be pro rata, based on the number of full days that remain in the premium period.

If this Policy is other than an Individual Plan, it may be continued after your death: (a) by your Legal Spouse, if he or she is a Covered Person; otherwise, (b) by the youngest Child who is a Covered Person. The Policy will be changed to a plan appropriate, as determined by us, to the Covered Persons who continue to be covered under it. Your Legal Spouse, or youngest Child, will replace you as the Insured. A proper adjustment will be made in the premium required for the Policy to be continued. We will also refund any premium paid and not earned due to your death. The refund will be pro rata, based on the number of full days that remain in the premium period.

**Termination of Legal Spouse's Coverage**: Your Legal Spouse will cease to be a Covered Person at the end of the premium period in which he or she no longer meets the definition of Legal Spouse.

**Termination of a Child's Coverage**: A Child will cease to be a Covered Person at the end of the premium period in which we receive a written request from you to remove the Child from coverage under this Policy.

**Benefits After Coverage Terminates**: Termination of coverage will be without prejudice to any claim for expenses incurred prior to the date coverage terminates. Benefits for dental services incurred after a Covered Person ceases to be insured are provided for certain procedures. No Benefits are provided, however, if the Policy is terminated because of: (a) a request by you; (b) fraud or material misrepresentation on your part; or (c) your failure to pay premiums. Certain procedures begun before the coverage terminates may be covered if the services were completed within a 60-day period measured from the date of termination. In those cases, we evaluate those services in progress to determine what portion may be paid by us. The balance of the total fee is your responsibility.

## XI. General Conditions

### Entire Contract; Changes

This Policy is the entire contract between you and us. No change in this Policy will be effective until approved in writing by an officer of RLHICA. This approval must be noted on or attached to this Policy. No agent or broker has the authority to change this Policy or to waive any of its provisions.

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Note: This Policy is subject to change if, in the future, federal and state privacy laws and regulations require us to comply with such laws and regulations. Should any such change to this Policy be necessary by law, you will receive written notice from us informing you of the reasons for any change to your Policy and the process by which you will receive an amended Policy or the amended section of this Policy.

## Subrogation

If we pay a claim for which another person or company is liable, we have the right to recover our payment from the other person or company.

## Obtaining and Releasing Information

While you are covered under this Policy, you agree to provide us with any information we need to process your claims and administer your Benefits. This includes allowing us to have access to your dental records.

## Time Limit on Certain Defenses

A material misstatement by you in any application for this Policy may be used to void this Policy or to deny a claim. This action may be taken in the first three years of your coverage. This provision shall be read in conjunction with state insurance laws and is not applicable in all jurisdictions. After the three-year period, this action may be taken only for a fraudulent misstatement. No claim for loss incurred commencing after three years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded on the date of loss from coverage by name or specific description had existed prior to the effective date of coverage of this Policy.

## Dentist-Patient Relationship

Covered Persons may choose their Dentist. Each Dentist maintains the dentist-patient relationship with the patient and is solely responsible to the patient for dental advice and treatment and any resulting liability.

## Conformity With State Laws

If this Policy is in violation of the laws of the State in which this Policy was issued, this Policy shall be held valid, but shall be construed as provided in such laws. Any part of the Policy in conflict with the laws of the state where you live on the Policy's Effective Date is changed to conform to the minimum requirements of that state's laws.

## Legal Actions

No legal action may be brought to recover on this Policy within 60 days after written proof of loss has been given as required by this Policy, unless prohibited by applicable state law. No such action may be brought after the expiration of (3) three years from the time written proof of loss is required to be given. This provision does not preclude you from seeking a decision from a jury trial once all administrative appeals have been exhausted.

## Notice

Any notice that we give to you under this Policy will be mailed to your address as it appears on our records. Our notice to you is deemed notice to all Covered Persons.

## Representations

In the absence of fraud, all statements made by you or any Covered Person, shall be deemed to be representations and not warranties. No such statement shall be used in defense to a claim under the Policy, unless it is contained in a written application.

## Change of Status

You must notify us of any event that changes the status of a Covered Person. Events that can affect the status of a Covered Person include, but are not limited to, marriage, birth, death, and divorce. We must be notified in writing of any changes in eligibility as soon as possible, but not later than 30 days from the date of the change in eligibility status.

We are not obligated to provide Benefits to persons no longer eligible for coverage. If you fail to notify us that a person is no longer eligible for coverage or if we accept premium for persons no longer eligible for coverage, we will not be obligated to pay any Benefits for such persons.

## Right of Recovery Due to Fraud

If we pay for dental services that were sought or received under fraudulent, false, or misleading pretenses or circumstances, pay a claim that contains false or misrepresented information, or pay a claim that is determined to be fraudulent due to acts of you and/or any Covered Person, we may recover that payment from you and/or the Covered Person. You authorize us to recover any payment determined to be based on false, fraudulent, misleading or misrepresented information by deducting that amount from payments properly due to you and/or a Covered Person. We will provide an explanation of the payment being recovered at the time the deduction is made.

## Typographical or Administrative Error

Typographical or administrative errors shall not deprive a Covered Person of Benefits. Neither shall any such errors create any rights to additional Benefits not in accordance with all of the terms, conditions, limitations**,** and exclusions of this Policy. A typographical or administrative error shall

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not continue ***c***overage beyond the date it is scheduled to terminate according to the terms of this Policy.

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