Renaissance®
Life & Health Insurance Company of America

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Indianapolis, Indiana 46206-1596]
[(888) 791-5995 (TTY users call 711)]
[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" or "Company") 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 the Company as of its Effective Date.

Secretary, Renaissance Life & Health Insurance Company of America	President & CEO, Renaissance Life & Health Insurance Company of America

THIS DENTAL POLICY IS CONDITIONALLY RENEWABLE
REFER TO THE TERMINATION SECTION

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

Notice to Buyer: This Policy provides dental benefits only.

["Para asistencia en español, llame al número de servicio al cliente (customer service) que aparece en el reverso de su tarjeta para miembros".

This document is also available in alternative formats upon request and at no cost to persons with disabilities.]

RENAISSANCE
INDIVIDUAL DENTAL POLICY

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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.

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 or provided by third party vendors 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 calendar year beginning on January 1, unless otherwise shown on 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 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. This Policy also provides for coverage of a dental hygiene therapist and independent practice dental hygienist. This definition controls over any exclusion to the contrary.

Eligible Dependents

Means (a) your Legal Spouse and (b) your Child(ren); and (c) 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 this Policy was issued; or (b) your partner through a civil union legally recognized by the state in which this Policy was issued[.][; or] [(c) your Domestic Partner 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 under your coverage for a proposed dental treatment. 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 before you receive dental care. It is not a prerequisite or condition for approval of future dental benefits payment. You will receive the same Benefits under this Policy whether or not a Pre-Treatment estimate is requested. The benefits estimate provided on a Pre-Treatment Estimate notice is based benefits available 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 your treatment 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 your treatment. A request for a Pre-Treatment Estimate is not a claim for Benefits or a preauthorization, precertification or other reservation of future benefits.

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 Qualified Individual or Eligible Dependent 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. There is no limiting age for Eligible Dependents. Students/college students who are disabled qualify as an Eligible Dependent.

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
- Individual and Two Children Plan
- Individual and Three or more Children Plan
- One Child Family Plan – Insured, Legal Spouse and one Child
- Two Child Family Plan – Insured, Legal Spouse and two Children
- Three or More Children Family Plan – Insured, Legal Spouse, and three 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 the terms and conditions of this Policy, including, but not limited to, the categories of services, exclusions and limitations listed below.

Unless otherwise specified in the Summary of Dental Plan Benefits Section, Covered Services may be divided into the following categories, and are subject to the exclusions and limitations listed below. Please see the Summary of Dental Plan Benefits Section for additional Benefits, exclusions and limitations applicable under your Policy.

Please note that certain Covered Services provided to individuals under the age of 19 are considered Essential Health Benefits and are subject to specific rules concerning applicable Copayments, Out-of-Pocket Maximums, Maximum Payments, Deductibles, Waiting Periods and frequency limitations. For a complete list of those Covered Services designated as Essential Health Benefits, as well as the applicable rules governing Essential Health Benefits, please see your Summary of Dental Plan Benefits. In the event an individual under the age of 19 receives a Covered Service designated as an Essential Health Benefit, the specific Copayments, Out-of-Pocket Maximums, Maximum Payments, Deductibles, Waiting Periods and frequency limitations found in your Summary of Dental Plan Benefits shall be controlling. In no event will the general frequency limitations set forth in this Policy apply to any of the Covered Services listed as Essential Health Benefits in your Summary of Dental Plan Benefits. The remaining general exclusions and limitations found in this Policy shall only apply to Covered Services designated as Essential Health Benefits to the extent those general exclusions and limitations do not conflict with the specific Copayments, Out-of-Pocket Maximums, Maximum Payments, Deductibles, Waiting Periods and frequency limitations found in your Summary of Dental Plan Benefits.

All time limitations are measured from the prior dates of service in our records for any RLHICA plan.

DIAGNOSTIC AND PREVENTIVE SERVICES

Services and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease are Covered Services. These services include, but are not limited to, 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 individuals under the age of 19;

(2) Oral examinations 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 for individuals 19 years of age or older;

(5) Bitewing X-rays are payable once every 6 months for individuals under the age of 19;

(6) Space maintenance services are payable for individuals under the age of 19;

(7) 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;

(8) 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 Section or in this Policy; and

(9) Pre-diagnostic services submitted as a patient screening are payable once in any Benefit Year. Pre-diagnostic services submitted as a patient assessment are not Covered Services.

[Brush Biopsy

Oral brush biopsy procedure and laboratory analysis to detect oral cancer, an important tool that identifies and analyzes precancerous and cancerous cells, is a Covered Service.]

[BASIC SERVICES

Emergency Palliative Treatment

Emergency treatment to temporarily relieve pain is a Covered Service when done in conjunction with X-rays, tests or examinations. If not performed in conjunction with X-rays, tests or examinations, emergency palliative treatment is not a Covered Service.

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

X-rays as required for routine care or as necessary for the diagnosis of a specific condition are Covered Services, 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) For individuals 19 years of age or older, cephalometric films, oral/facial photographic images or diagnostic casts are not payable, except in conjunction with Orthodontic Services, and all such charges for the same will be your responsibility.

(5) For individuals under the age of 19, cephalometric films, oral/facial photographic images or diagnostic casts are Covered Services;

(6) 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, including amalgam (silver) and composite resin (white) restorations (fillings) are Covered Services, subject to the following exclusions and limitations:

(1) For individuals 19 years of age or older, amalgam (silver) and composite (white) 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 per tooth in a 24 month period for individuals age 19 or older. Crown, inlay and onlay repair are Covered Services. Resin infiltration of incipient smooth surface lesions is not a Covered Service and all charges for the same will be your responsibility.

Simple Extractions

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

Sealants

Sealants are payable once in any three year period, only for the occlusal (biting) surface of unrestored permanent molars for individuals under the age of 19. The surface must be free from decay and restorations.

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 prophylaxes, including periodontal maintenance procedures are payable twice in any Benefit Year for individuals 19 years of age or older, or four times in any Benefit Year for individuals under the age of 19.

Other Basic Services

After hours visits, not to exceed once per Benefit Year, are a Covered Service.

MAJOR SERVICES

Oral Surgery Services

Surgical extractions and dental surgery are Covered Services, including, but not limited to, 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 Section: 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. Notwithstanding the foregoing, general anesthesia, intravenous sedation and therapeutic drug injections are Covered Services for individuals under the age of 19.

Endodontic Services

The treatment of teeth with diseased or damaged nerves (for example, root canals), is a Covered Service 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, for individuals 19 years of age or older;

(2) Endodontic therapy, endodontic retreatment, and apicoectomy/periradicular services are Covered Services for individuals under the age of 19;

(3) Root canal fillings on primary teeth are limited to primary teeth without succedaneous (replacement) teeth;

(4) We will not make payment for pulp caps and all charges for the same will be your responsibility;

(5) Pulpotomy is a Covered Service only for Children under age 19; and

(6) Pulpal therapy (resorbable filling) for an anterior, primary tooth (excluding restoration) is a Covered Service, but is limited to primary incisor teeth for Children up to age 6 and primary molars and cuspids up to age 11, and is limited to once per tooth per lifetime.

Maxillofacial Prosthetics

We 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 a Covered Service, subject to the following exclusions and limitations:

(1) Full mouth debridement will be payable once in an individual's lifetime;

(2) Scaling and root planning are payable once per area in any 24 month period;

(3) Periodontal surgery is payable once per area in any 3 year period;

(4) Gingivectomy or gingivoplasty is not a Covered Service when performed in conjunction with the preparation of a crown or other restoration.

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 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 5 year period for individuals under the age of 19. The same services and procedures shall be payable only once in any 7 year period for individuals 19 years of age and older;

(2) Substructures and indirect restorations, including, porcelain/ceramic substrate, porcelain/resin processed to metal, and cast restorations, are not payable for Children under the age of 12 and all charges for the same will be your responsibility. Core buildups and other substructures are a Covered Service, but only when needed to retain a crown on a tooth with extensive breakdown due to decay or fracture;

(3) Substructures when done for inlays, onlays and veneers;

(4) Optional treatment: If you or your Eligible Dependent 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) Inlays, regardless of the material used will be payable, but only at the applicable amount that we would have paid for a resin-based composite restoration. You will be responsible for any additional charges;

(6) We will not make payment for the following services and items and all charges for the same will be your responsibility: charges related to the hospitalization or general anesthesia and/or intravenous sedation for restorative dentistry or surgical procedures unless specified need is shown. Notwithstanding the foregoing, general anesthesia, intravenous sedation and therapeutic drug injections are Covered Services for individuals under the age of 19;

(7) We will not make payment for dentistry for aesthetic reasons and all charges for the same will be your responsibility.

(8) 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 Covered Services, subject to the following exclusions and limitations:

(1) One complete upper and one complete lower denture is payable once in any 5 year period for individuals under the age of 19;

(2) One complete upper and one complete lower denture is payable once in any 7 year period for individuals 19 years of age and older;

(3) A partial denture, fixed bridge, implant supported crowns and any associated services are payable once in any 5 year period for individuals under the age of 19;

(4) A partial denture, fixed bridge, implant supported crowns and any associated services are payable once in any 7 year period for individuals 19 years of age and older;

(5) Optional treatment: If you or your Eligible Dependent 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;

(6) Periapical X-rays are not covered when done within 7 days of panoramic or full mouth X-rays;

(7) Services for tissue conditioning are a Covered Service without limitation for individuals under the age of 19. Such services are payable only twice per denture unit in any 3 year period for individuals 19 years of age and older;

(8) Endosteal implants are payable once per tooth, per lifetime, for individuals age 19 and older and once every 5 years for individuals under the age of 19. We will not make payment if the implant is placed within 5 years (for those under 19 years of age) or 7 years (for those age 19 and older), following prosthodontic or major restorative services involving that tooth and all charges for the same will be your responsibility;

(9) Bone replacement grafts in conjunction with an implant are not a Covered Service and all charges for the same will be your responsibility;

(10) 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; and

(11) We will not make payment for posterior bridges done in conjunction with partial dentures in the same arch. We will not make payment for the replacement of teeth beyond the normal compliment of teeth. All charges for the foregoing will be your responsibility.

Relines and Repairs

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

Other Major Services

(1) An occlusal guard is payable only once in a lifetime for individuals 19 years of age or older.

(2) An occlusal guard is payable once in any 12 month period for an individual who is at least 13 years of age, but under 19 years of age;

(3) Limited occlusal adjustments are limited to [3] in a [5] year period; and

(4) 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.

ORTHODONTIC SERVICES

Orthodontic Services

Medically necessary Orthodontic Services, including treatment and procedures to correct malposed teeth (for example, braces) are Covered Services, payable for individuals under the age of 19. No person 19 years of age or older will be eligible for Orthodontic Services unless Orthodontic Services are provided for in the Summary of Dental Plan Benefits Section and then will be subject to the lifetime Maximum Payment set forth therein. All Orthodontic Services are subject to the following exclusions and limitations:

(1) Our payment for Orthodontic Retention Services (removal of appliances, construction and placement of retainer) is included in our payment of overall Orthodontic Services. If a Dentist bills these services separately, payment will be denied;

(2) 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;

(3) 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;

(4) 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.]

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. Pursuant to MRSA Section 2847-A, there is no authorization required for emergency treatment and RLHICA will impose no penalty for your failure to notify us prior to seeking such treatment. 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. If an In-Network Dentist is not readily available within a

reasonable period of time or driving distance, it may be possible to receive Covered Services from an Out-of-Network Dentist and be reimbursed at the same benefit level as if provided by an In-Network Dentist. If you feel this may be the case, please call RLHICA's customer service department, toll free at [(888) 791-5995 (TTY users call 711)] or write to us at [P.O. Box 1596, Indianapolis, Indiana 46206]. We will review your situation and, if appropriate, authorize payment for an Out-of-Network Dentist at the In-Network Dentist benefit level.

To verify that a Dentist is In-Network, you can use our online Dental Directory at [www.RenaissanceDental.com] or call [(888) 791-5995 (TTY users call 711)].

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.

Provider Listing

You can find a list of In-Network Providers by going to our website, [www.RenaissanceDental.com], or calling our Customer Service number at [(888) 791-5995 (TTY users call 711)].

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;
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 (TTY users call 711).]

A Pre-Treatment Estimate is not required to receive payment, but it allows claims to be processed more efficiently and 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 treatment. Once treatment is complete, the dental office will submit a claim to us for payment. Because the amount of your Benefits is not conditioned on a Pre-Treatment Estimate decision by us, all claims under this Policy are post-service claims.

Claim Forms

Upon request, we will furnish to you, a Covered Person, or your dental office, forms for filing proofs of loss. If these forms are not furnished within 15 days after the giving of such notice, you will be deemed to have met the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section. Claim forms are also available at our website, [www.RenaissanceDental.com].

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

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 unless the claimant is legally incapacitated. 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.

Payment of Claims

After receiving all required claim information and in accordance with prompt payment of claims laws, we will pay within 30 days of receipt of the claim, all Benefits then due for Covered Services. If applicable, failure to pay within that period 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 before the end of the original 30 day period 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.

Physical Examination

We shall have the right and opportunity to examine any Covered Person as often as reasonably necessary while a claim is pending or while a dispute over the claim is pending.

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. 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 company is liable, we have the right to recover our payment from the other company. The “amount of payments made” includes the reasonable cash value of any benefits provided in the form of services.

VII. Claims Appeal 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 calling the toll-free number, [1-888-791-5995 (TTY users call 711)] 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 [Maine Bureau of Insurance, 34 State House Station, Augusta, ME 04333-0034]. Complaints may be filed electronically at [http://www.maine.gov/pfr/insurance/complaint.htm].

VIII. Coordination of Benefits

COORDINATION OF THE POLICY BENEFITS WITH OTHER BENEFITS

A. APPLICABILITY

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, 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

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. We will accept monthly premium payment if paid by credit card or direct debit from your checking account or annually if paid by credit card, direct debit from your checking account, by check, or money order.

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 60 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 renewal premium is not paid on or before the date it is due, it may be paid during the following 31days. The Grace Period will not apply if, at least 31 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. During the Grace Period your Policy shall continue in force.

C. REINSTATEMENT

If the renewal premium is not paid before the Grace Period ends, your Policy will lapse. Later acceptance of the premium by us or by an agent authorized to accept payment, without requiring an application for reinstatement, will reinstate the Policy. If we or our agent requires an application for reinstatement, you will be given a conditional receipt for the premium. If the application is approved the Policy will be reinstated as of the approval date. Lacking such approval, the Policy will be reinstated on the forty-fifth day after the date of the conditional receipt unless we have previously written you of its disapproval.

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 the rights of you and us will remain the same, subject to any provisions noted or attached to the reinstated Policy.

Any premiums we accept for a reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than 60 days prior to the date of reinstatement.

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. 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:

7. nonpayment of premiums when due, subject to the Grace Period provision;
8. the date we receive a written request from you to terminate the Policy, or any later date stated in your request;
9. the date we decline to renew the Policy as provided by the above renewal clause; or
10. 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 he or she reaches any limiting age provided for herein, or when 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.

C. THIRD-PARTY NOTICE OF CANCELLATION

Maine Law provides for Third-Party Notice of Cancellation, which means the Insured is allowed the right to designate an additional person to receive notice of any intent to cancel a contract of coverage. The purpose of this rule is to reduce the danger that persons suffering from cognitive impairment or functional incapacity will lose their dental coverage because their medical condition caused them to neglect their premium payment obligations or made them unaware that their coverage would be terminating.

Under this Rule, the Insured is provided the right to:

1. Designate a third party to receive notice of cancellation;
2. Change the designation; and
3. Have the policy reinstated if the Insured suffers from cognitive impairment or functional incapacity and the grounds for cancellation was nonpayment of premium or other lapse or default on the part of the Insured.

To exercise this option, the Insured must request a Third-Party Notice Request Form; the forms will be mailed directly to the Insured within 10 days following receipt of the request.

At any time after submitting a completed Third-Party Notice Request Form, the designation may be changed upon written request of the Insured.

At least 10 days prior to cancellation of the policy, in addition to giving notice to the Insured in a manner consistent with the applicable law, we will give notice of the pending cancellation to the designated third party, if any, at the last address(es) provided. Such notice will state the reason for cancellation and the date coverage is to terminate. If cancellation is due to nonpayment of premium, the notice will include the amount of unpaid premium and the date by which payment must be made. If cancellation is for reasons beyond the Insured's control, the notice will so advise and explain the rights of continuation or conversion to individual coverage, if applicable.

XI. General Conditions

Entire Contract; Changes

This Policy is the entire contract of insurance between you and us. No change in this Policy shall be effective until approved by an executive officer of RLHICA and unless such approval is endorsed hereon or attached hereto. No agent or broker has the authority to change this Policy or to waive any of its provisions.

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.

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 reside 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 three (3) 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 not continue coverage beyond the date it is scheduled to terminate according to the terms of this Policy.