Renaissance℠
Life & Health Insurance Company of America

Renaissance
North Carolina Group
Dental Policy

This Policy is a legal contract between the Policyholder and Renaissance Life & Health insurance Company of America. **Read your Policy carefully**

Important Cancellation Information-Please Read Section X Entitled, "Term and Termination"

THIS POLICY IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the company. Title II NCAC 12.0843 and Section 17.E.

P.O. Box 1596 • Indianapolis, Indiana 46206 • 800-894-4532 • www.RenaissanceDental.com

RENAISSANCE
NORTH CAROLINA GROUP DENTAL POLICY

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This Policy is a legal contract between the Policyholder and Renaissance Life & Health Insurance Company of America ("RLHICA"). **Read your Policy carefully.**

Renaissance Life & Health Insurance Company of America
Attention: Renaissance Administration
P.O. Box 30381
Lansing, Michigan 48909-7881
Administrative Direct Line: 1-800-745-7509
Customer Service Direct Line: 1-800-894-4532

Important Cancellation Information-Please Read Section X Entitled, "Term and Termination."

Renaissance Life & Health Insurance Company of America
Renaissance Group Dental Preferred Provider Policy

This Policy is effective the 1st day of January, 2022 by and between Arbor Acres United Methodist Retirement Community, hereinafter referred to as the Policyholder and RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF AMERICA, hereinafter referred to as RLHICA.

Section I. Declarations

The Benefits afforded are only with respect to such benefits as are indicated in this Policy. RLHICA's liability is limited to the Benefits stated herein; subject to all the terms of this Policy having reference thereto.

A. **Effective Date:** January 1, 2022

B. **First Renewal Date:** January 1, 2024

C. **Group Number:** MP0000137764 – Basic EPOS

D. **Eligibility (Certificate Holder and Eligible Dependents):**

All full-time and part-time employees of the Policyholder working at least 30 hours per week, retirees, members of an association or trust, and all individuals who are eligible for and elect Continuation Coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 or similar applicable state law ("COBRA").

Where two Certificate Holders are eligible under the same group and are legally married to each other, they will be enrolled under one application card and will receive Benefits under a single Certificate without coordination of benefits under the RLHICA Policy.

Eligible Dependents including Domestic Partners of above mentioned Certificate Holders are also eligible.

A Domestic Partner is defined as follows:

- each party is the sole Domestic Partner of the other;
- 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;
- both parties currently share a common legal residence and have shared said residence for at least six months prior to application for Domestic Partner coverage;
- neither party is married to anyone or related to the other by adoption or blood to a degree of closeness that would otherwise bar marriage in the state in which they legally reside;
- both parties are in a relationship of mutual support, caring, and commitment and they intend to remain in such a relationship in the indefinite future;
- both parties are jointly responsible for basic living expenses (basic living expenses are defined as the cost of basic food, shelter, and any other expenses of the common household. The partners need not contribute equally or jointly to the payment of these expenses as long as they agree that both are responsible for them); and
- neither party filed a Termination of Domestic Partnership within the preceding nine months.

E. Deductible:

$75 Deductible per person per Benefit Year limited to a maximum Deductible of $225 per family per Benefit Year on Basic and Major Services. The Deductible does not apply to Diagnostic and Preventive, including Sealants and Radiographs or Orthodontic Services.

F. Covered Services:

RLHICA will pay for Covered Services according to the schedule listed below. RLHICA will base payments on the lesser of the Submitted Amount or the Allowed Amount. If the Submitted Amount for an Out-of-Network Dentist is more than the Allowed Amount, the Certificate Holder is not only responsible for paying the Dentist that percentage listed in the "Certificate Holder Pays" column below, but is also responsible for paying the Dentist the difference between the Submitted Amount and the Allowed Amount.

	In-Network		Out-of-Network	
	RLHICA Pays	**Certificate Holder Pays**	**RLHICA Pays**	**Certificate Holder Pays**
Diagnostic and Preventive Services				
Diagnostic and Preventive Services	100%	0%	100%	0%
Brush Biopsy	100%	0%	100%	0%
Basic Services				
Emergency Palliative Treatment	80%	20%	80%	20%
Radiographs/Diagnostic Imaging/Diagnostic Casts	100%	0%	100%	0%
Minor Restorative Services	80%	20%	80%	20%
Simple Extractions	80%	20%	80%	20%
Sealants	100%	0%	100%	0%
Periodontal Maintenance	80%	20%	80%	20%
After-Hours Visits	80%	20%	80%	20%
Major Services				
Oral Surgery Services	80%	20%	80%	20%
Endodontic Services	80%	20%	80%	20%
Periodontic Services	80%	20%	80%	20%
Major Restorative Services	50%	50%	50%	50%
Prosthodontic Services	50%	50%	50%	50%
Relines and Repairs	50%	50%	50%	50%
Other Major Services	50%	50%	50%	50%
Orthodontic Services				
Orthodontic Services	50%	50%	50%	50%

Benefits for Orthodontic Services for Children are payable until the end of the calendar year of a Child's 19th birthday.

G. Waiting Period:

All new Certificate Holders (and their Eligible Dependents, if covered above) hired after the Effective Date of the Policy will be eligible for enrollment on the first of the month following 30 days after the date for which employment compensation begins.

H. Method of Benefit 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 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 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, the Certificate Holder is not only responsible for paying the Dentist that percentage listed in the "Certificate Holder Pays" column, but is also responsible for paying the Dentist the difference between the Submitted Amount and the Allowed Amount.

I. Maximum Payment:

$1,250 per person per Benefit Year on Diagnostic and Preventive, Basic, and Major Services collectively.

$1,000 per person per lifetime on Orthodontic Services.

Maximum Carryover – If at least one Covered Service is paid in a Benefit Year and the total benefit paid does not exceed $625 in that Benefit Year, $313 will carry over to the next Benefit Year's Maximum Payment. This amount will accumulate from one Benefit Year to the next, but will not exceed $1,250.

J. Rate:

Employee only - $24.73 per month per Certificate Holder.

Employee with Spouse - $44.74 per month per Certificate Holder.

Employee with Child(ren) - $53.64 per month per Certificate Holder.

Employee with Family - $79.65 per month per Certificate Holder.

Rates are contingent upon 75% Minimum Enrollment of the eligible group members and their Eligible Dependents as defined in Section I(D) with the entire cost of coverage paid by the Certificate Holder and remitted by the Policyholder.

Benefits will cease on the last day of the month in which the Certificate Holder's employment is terminated, subject to all applicable laws or regulations.

K. Benefit Year:

The Benefit Year shall be based on a calendar year, from January 1, to December 31.

L. Identification (ID) Cards:

ID cards mailed to each Certificate Holder's address of record.

Section II. Definitions

A. **Allowed Amount –** means the maximum dollar amount upon which RLHICA will base Benefits. 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.

B. **Benefit Year –** means the calendar year, unless the Policyholder elects the Policy Year to serve as the Benefit Year. The Benefit Year is specified in the Declarations Section.

C. **Benefits –** means payment for Covered Services.

D. **Certificate Holder –** means all people who:

1. are certified as being eligible by the Policyholder;

2. are members of the group specified in the Declarations Section; and

3. are enrolled by RLHICA to receive Benefits under the Policy.

E. **Child or Children –** means the Certificate Holder's natural children, stepchildren, adopted children, foster children or children by virtue of legal guardianship during the waiting period for legal adoption or guardianship who are or meet one of the following:

1. A Child who has not yet reached the end of the calendar year of his or her 26th birthday;

2. A Child who meets all of the following criteria: (a) has not yet reached his or her 26th birthday; (b) is a full-time student; (c) and does not have coverage, other than coverage as a dependent, under another dental insurance plan; or,

3. A Child for whom the Certificate Holder or the Certificate Holder's Legal Spouse is financially responsible for the dental care of the Child under terms of a court decree; or

4. A Child of the Certificate Holder who has reached the end of the calendar year of his or her 19th birthday and is both (a) incapable of self-sustaining employment by reason of a mental or physical condition and (b) chiefly dependent upon the Certificate Holder for support and maintenance, provided proof of such incapacity and dependency is furnished to RLHICA by the Certificate Holder within 31 days of the child's attainment of the Limiting Age and subsequently as required by RLHICA, but not more than annually after the child's attainment of the Limiting Age. In the event that RLHICA denies a claim under this Policy for the reason that the child has attained the Limiting Age for dependent children, the Certificate Holder has the burden of establishing that the child continues to meet the two criteria specified above. If requested by RLHICA, the Certificate Holder shall submit medical reports confirming that the child meets the two criteria specified above.

5. Coverage shall be continued for an Eligible Dependent's medically necessary leave of absence from school for a period not to exceed 12 months or the date on which coverage would otherwise end pursuant to the terms and conditions of the policy, whichever comes first. Any breaks in the school semester shall not disqualify the Eligible Dependent from continued coverage. The students attending physician must submit documentation and certification of the medical necessity of a leave of absence to RLHICA. The date of the documentation and certification of the medical necessity of a leave of absence shall be the date continued coverage commences.

F. **Coinsurance –** means the percentage of the Allowed Amount for Covered Services that the Certificate Holder must pay toward treatment.

G. **Completion Date -** means the date that treatment is complete. Treatment is complete:

1. for dentures and partial dentures, on the delivery date;

2. for crowns and bridgework, on the permanent cementation date;

3. for root canals and periodontal treatment, on the date of the final procedure that completes treatment.

H. Copayment – means the dollar amount that the Certificate Holder must pay toward treatment.

I. Covered Service(s) – means the unique dental service(s) selected for coverage as described in the Declarations Section and subject to the terms and conditions of this Policy.

J. 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. If the Policyholder has selected a Deductible, it will be indicated in the Declarations Section.

K. Dentist – means a person licensed to practice dentistry in the state or jurisdiction in which dental services are rendered.

L. Eligible Dependent – means (a) the Certificate Holder's Legal Spouse; (b) the Certificate Holder's Child(ren); and (c) any other dependents who meet the criteria for eligibility set forth in the Declarations Section. A Child need not be claimed as a dependent on the Certificate Holder's income tax return or reside with the Certificate Holder or in RLHICA's service area to be an Eligible Dependent. If dependent coverage has been selected, it will be indicated in the Declarations Section.

M. Foster Child(ren) – means a minor (i) over whom a guardian has been appointed by the clerk of the superior court of any county in North Carolina or (ii) the primary or sole custody of whom has been assigned by order of a court of competent jurisdiction.

N. Legal Spouse – means a person who is any of the following: (a) the spouse of the Certificate Holder through a marriage legally recognized by the state in which this Policy was issued; or (b) the partner of the Certificate Holder through a civil union legally recognized by the state in which this Policy was issued.

O. Limiting Age – means the age at which a Child of the Certificate Holder is no longer eligible for Benefits under this Policy pursuant to the definition of Child above.

P. Maximum Payment – means the maximum dollar amount RLHICA will pay in any Benefit Year or lifetime for Covered Services. The Maximum Payments are specified in the Declarations Section.

Q. Open Enrollment Period – means the period of time as determined by the Policyholder during which an eligible person as indicated in the Declarations Section may enroll or be enrolled to receive Benefits.

R. Policy – means this document, including, if applicable, the application, any appendices, supplements, riders, successor agreements, or renewals now or hereafter issued or executed.

S. Policyholder – means the employer, organization, or plan sponsor who holds the contract with RLHICA.

T. Policy Year – means the 12-month period beginning on the Effective Date of the Policy and each 12-month renewal period thereafter.

U. Rate – means the amount, per Certificate Holder and Certificate Holder class, the Policyholder agrees to pay RLHICA each month. This amount, or the information necessary to compute it, is specified in the Declarations Section.

V. RLHICA – means Renaissance Life & Health Insurance Company of America.

W. Submitted Amount – means the fee a Dentist bills to RLHICA for a specific service or item.

Section III. Eligibility for Coverage

A. General Eligibility Rules

No person will be eligible for Benefits under this Policy unless the Policyholder has either currently enrolled that person as a Certificate Holder or currently listed that person as an Eligible Dependent and unless the enrollment or listing is allowed under this Policy.

B. Nondiscrimination

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.

C. Effective Date of Eligibility

1. **Initial Effective Date:** All Certificate Holders on the Effective Date of this Policy are immediately eligible for Benefits. If Eligible Dependents of the Certificate Holder are covered by this Policy, their eligibility commences on the same date as the Certificate Holder.

2. **After the initial Effective Date**: For all Certificate Holders (and their Eligible Dependents, if dependent coverage is selected) not associated with the Policyholder on the initial Effective Date of this Policy, eligibility for Benefits will begin, unless otherwise stated, as follows:

   a. Newly hired or rehired employees: Date for which employment compensation begins or, if applicable, that date plus the number of days specified as a waiting period in the Declarations Section;

   b. Spouse: Date of marriage, civil union;

   c. Newborn: A newborn Child will be covered from the moment of birth. Coverage will be extended to a newborn Child without requirements for prior notification unless an additional premium charge to add the Eligible Dependent is due. If an additional premium charge is due to cover the Dependent, RLHICA shall cover the newborn Child from the moment of birth if the newborn is enrolled within 30 days after the date of birth.

   d. Foster Children, Legal Adoptions: An adopted Child will be covered from the moment of birth or the placement for adoption. A Foster Child will be covered from the date of placement in the foster home. RLHICA shall extend coverage to a Foster Child or adopted Child without requirements for prior notification unless an additional premium charge to add the Foster Child or adopted child is due. If an additional premium charge is due to cover the Foster Child or adopted Child upon placement in the foster home or placement for adoption if the Foster Child or adopted Child is enrolled within 30 days after the placement in the foster home or placement for adoption.

   Guardianships: A Child for whom the Certificate Holder or the Certificate Holder's 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 this Policy, until the 30th day after that date, unless the guardianship is disrupted prior to the date the court appoints the Certificate Holder or the Certificate Holder's Legal Spouse as guardian and the Child is removed from the Certificate Holder or the Certificate Holder's Legal Spouse's physical custody. The Child may continue as an Eligible Dependent after the 31st day only if RLHICA has received both written notice of the Child's pending guardianship status and any additional premium if required;

   e. Stepchild: Date that the Child's natural parent becomes an Eligible Dependent;

f. All others: Date that RLHICA approves in writing the enrollment or listing of those people, unless compelled by a court or administrative order to otherwise provide Benefits for a Child or Eligible Dependent.

Once eligible, Certificate Holders and their Eligible Dependents must enroll for coverage under this Policy within 30 days from the date upon which such Certificate Holder or Eligible Dependents become eligible for Benefits under the terms of Section III C immediately above. A Certificate Holder properly enrolls for coverage by completing all enrollment forms required by RLHICA, and submitting such forms to the Policyholder. If the Certificate Holder or Eligible Dependent is not properly enrolled for coverage within 30 days from the date upon which he/she becomes eligible for Benefits, then such Certificate Holder or Eligible Dependent must wait until the next Open Enrollment Period to enroll.

If a Certificate Holder is required to enroll a Child due to court or administrative order, RLHICA must allow the Certificate Holder to enroll the Child as an Eligible Dependent without regard for any enrollment period restrictions. RLHICA must enroll the Child upon application of the Child's other parent of the Department of Health and Human Services in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the parent is enrolled but fails to make application to obtain coverage for the Child. RLHICA may disenroll or eliminate coverage of the Child if RLHICA is provided satisfactory written evidence that the court or administrative order is no longer in effect, or the Child is or will enroll in comparable health benefit plan coverage through another insurer, which coverage will take effect not later than the effective date of disenrollment.

D. Termination of Eligibility

Eligibility for Benefits will terminate for all Certificate Holders and Eligible Dependents under this Policy at the earlier of:

1. The termination of this Policy; or

2. The last day of the month for which payment has been made if the Policyholder fails to make the payments required by this Policy.

Eligibility of an individual Certificate Holder, and of the Eligible Dependents of that Certificate Holder, will also terminate if that Certificate Holder ceases to be a Certificate Holder as defined by this Policy. An Eligible Dependent's eligibility also terminates upon lack of compliance with the eligibility requirements of this Policy.

E. Conversion to an Individual Policy

A person whose eligibility under this Policy is terminated or who loses coverage under this Policy may be eligible to apply for an individual direct payment policy. Any request to obtain such a policy will be subject to applicable state law.

Section IV. Continuation of Coverage

A. Loss of Eligibility During Treatment

1. If a Certificate Holder and/or Eligible Dependent lose eligibility while receiving dental treatment, only Covered Services received while that individual was eligible under the Policy will be payable.

2. Certain procedures begun before the loss of eligibility may be covered if the services were completed within a 30 day period measured from the date of termination. In those cases, RLHICA evaluates those services in progress to determine what portion may be paid by RLHICA. The difference between RLHICA's payment and the total fee for those procedures is the Certificate Holder's responsibility.

B. Continuation Coverage – COBRA

The other provisions of this Policy notwithstanding, eligibility for Benefits will continue for an individual who is required to be provided with and elects continuation coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 or similar applicable state law ("COBRA") provided:

1. The Certificate Holder or Eligible Dependent elects COBRA coverage under this Policy;

2. Continuation coverage is required to be provided under COBRA;

3. The Policyholder notifies RLHICA that the individual is eligible for Benefits under COBRA.

Continuation coverage shall only be in effect up to the first day of the month after the individual notifies the Policyholder that he or she no longer wants coverage from RLHICA, the date a COBRA premium payment was due and was not remitted by the end of the COBRA Grace Period or until the end of the individual's continuation coverage period, whichever occurs first.

Further, coverage shall only remain in effect until the last day of the month for which payment has been made to RLHICA by the Policyholder, provided, however that any payment for COBRA continuation coverage received during a period that is 30 days following the date the COBRA premium payment was due (the "COBRA Grace Period") will provide continuation coverage from the due date. An individual's coverage may be retroactively reinstated for the 60-day COBRA "election" period if the Policyholder pays the applicable Rate for the period within the 45-day period following the date of the COBRA election. RLHICA may continue coverage, if legally required.

Continuation coverage will not continue beyond the termination of this Policy.

The individual is responsible for the costs of any service provided after an individual is no longer eligible for continuation coverage under this Section IV B. Proper and timely notification by the Policyholder should be given to RLHICA to terminate the individual's coverage. The Policyholder will be liable to RLHICA for any Rate payments due on account of any untimely, improper or inaccurate notice.

The monthly Rate that the Policyholder must pay on behalf of any individual who is provided coverage under this Section IV B will be based on the COBRA continuation coverage rates then in effect during that month.

An individual who continues coverage will be considered to be either a Certificate Holder or an Eligible Dependent under this Policy and the dental care certificate as long as coverage is provided under this Section IV B. RLHICA does not assume any of the obligations assigned by COBRA to the Policyholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA), and the Policyholder agrees that it will perform those obligations in full.

Not all employers are subject to the continuation coverage requirements contained in COBRA. For those that are not, the above language in Section IV B does not apply. Employers should consult with their legal counsel to determine how and when the law applies.

C. Continuation Coverage – Death of Certificate Holder

Upon the death of the Certificate Holder, coverage for Eligible Dependents (if any) shall continue for a period of 90 days, subject to the termination provisions found in Section III or Section X of this Policy.

D. Continuation Coverage – Eligible Dependents

Eligible Dependents may elect to continue coverage under this Policy in the event of the divorce, retirement or death of the Certificate Holder. To elect coverage, Eligible Dependents should contact the Certificate Holder's employer or organization immediately following the occurrence of one of the above-mentioned events.

E. Continuation Coverage – Total Disability

In the event this Policy is terminated for any reason, the Benefits paid pursuant to this Policy shall continue for a period of 90 days in the event of total disability (on the date of such termination) of the Certificate Holder or an Eligible Dependent.

Section V. Benefits

COVERED SERVICES

RLHICA agrees to provide Benefits to Certificate Holders and Eligible Dependents under the policies and procedures of RLHICA and under the terms and conditions of this Policy, including, but not limited to, the categories of services, exceptions and reductions listed below.

Unless otherwise specified in the Declarations Section, Covered Services may be divided into the following categories, and are subject to the exceptions and reductions listed below. **Please see the Declarations Section for Benefits, exceptions and reductions applicable under your Policy.**

All time reductions are measured either from the last date of service in any RLHICA Plan or, at the request of the Policyholder, from the last date of service in any dental 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 exceptions and reductions:

i. Topical fluoride treatments are payable twice in any Benefit Year for Children, under age 15;

ii. Oral examinations submitted as a consultation or evaluation are payable twice in any Benefit Year, whether provided under one or more RLHICA plans;

iii. Prophylaxes, including periodontal maintenance procedures, are payable twice per Benefit Year;

iv. Bitewing X-rays are payable once in any Benefit Year;

v. Space maintenance services are payable once per lifetime, per area on posterior teeth, for Children under age 15;

vi. RLHICA 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 the responsibility of the Certificate Holder;

vii. RLHICA 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 the responsibility of the Certificate Holder, unless otherwise indicated in the Declarations Section or in this Policy; and

viii. 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 used 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 not a Covered Service when done in conjunction with any services except 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 exceptions and reductions:

i. 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 3 year period;

ii. 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;

iii. Any supplemental films with full mouth X-rays are part of the complete procedure;

iv. Cephalometric film, oral/facial images or diagnostic casts are not payable except in conjunction with Orthodontic Services, and all such charges for the same will be the responsibility of the Certificate Holder;

v. 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 the responsibility of the Certificate Holder.

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 exceptions and reductions:

i. Amalgam and composite resin restorations are payable once per tooth surface within a 24 month period regardless of the number of combination of restorations placed on a surface; composite resins are not payable per posterior surfaces;

ii. RLHICA will not make payment for dentistry for aesthetic reasons and all charges for the same will be the responsibility of the Certificate Holder.

Simple Extractions

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

Sealants

Sealants are payable only for the occlusal surface of first permanent molars for Children to age 15 and second permanent molars for Children to age 15. 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, 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 exceptions and reductions:

i. RLHICA will not make payment for the following services and items and all charges for the same will be the responsibility of the Certificate Holder unless otherwise specified in the Declarations Section: appliances, restorations, X-rays or other services for the diagnosis or treatment of temporomandibular disorders ("TMD") including myofunctional therapy;

ii. RLHICA will not make payment for the following services and items and all charges for the same will be the responsibility of the Certificate Holder: 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 a Covered Service subject to the following exceptions and reductions:

i. Endodontic therapy, endodontic retreatment, and apicoectomy/periradicular services are payable once per tooth in any 24 month period;

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

iii. RLHICA will not make payment for pulp caps and all charges for the same will be the responsibility of the Certificate Holder.

Maxillofacial Prosthetics

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

Periodontic Services

The treatment of diseases of the gums and supporting structures of the teeth is a Covered Service subject to the following exceptions and reductions:

i. Full mouth debridement will be payable once in the Certificate Holder's or Eligible Dependent's lifetime;

ii. Scaling and root planing are payable once per area in any 24 month period;

iii. Periodontal surgery is payable once per area in any 3 year period.

iv. 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 exceptions and reductions:

i. 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 substructures on the same tooth are payable once in any 5 year period;

ii. Substructures and indirect restorations, including, porcelain/ceramic substrate, porcelain or resin processed to metal, and cast restorations are not payable for Children under age 12 and all charges for the same will be the responsibility of the Certificate Holder. 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;

iii. Optional treatment: If the Certificate Holder or Eligible Dependent selects a more expensive service than is customarily provided, RLHICA may make an allowance based on the fee for the customarily provided service. The Certificate Holder will be responsible for the difference in cost;

iv. Inlays, regardless of the material used will be payable but only at the applicable amount that would have been paid for a resin-based composite restoration. The Certificate Holder will be responsible for any additional charges;

v. RLHICA will not make payment for the following services and items and all charges for the same will be the responsibility of the Certificate Holder: charges related to hospitalization or general anesthesia and/or intravenous sedation for restorative dentistry or surgical procedures unless a specified need is shown;

vi. RLHICA will not make payment for dentistry for aesthetic reasons and all charges for the same will be the responsibility of the Certificate Holder;

vii. Veneers are payable once per 5 year period.

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 exceptions and reductions:

i. One complete upper and one complete lower denture is payable once in any 5 year period;

ii. A partial denture, fixed bridge, endosteal implants and any associated services are payable once in any 5 year period;

iii. Fixed bridges, endosteal implants and cast metal partial dentures are not payable for Children under age 16 and all charges for the same will be the responsibility of the Certificate Holder;

iv. Optional treatment: If the Certificate Holder or Eligible Dependent selects a more expensive service than is customarily provided or for which RLHICA does not determine that a valid dental need is shown, RLHICA may make an allowance based on the fee for the customarily provided service. The Certificate Holder is responsible for the difference in cost;

v. Services for tissue conditioning are payable once per denture unit in any 2 year period;

vi. Endosteal implants are payable once per tooth, per lifetime. RLHICA will not make payment if the implant is placed within 5 years following prosthodontic or major restorative services involving that tooth and all charges for the same will be the responsibility of the Certificate Holder;

vii. RLHICA will not make payment for specialized implant surgical techniques, removal of an implant, implant maintenance procedures, or implant repairs, and all charges for the same will be the responsibility of the Certificate Holder unless otherwise specified in the Declarations Section;

viii. Bone replacement grafts in conjunction with an implant are not a Covered Service;

ix. RLHICA will not make payment for the following services and items and all charges for the same will be the responsibility of the Certificate Holder: lost, missing or stolen appliances of any type; temporary, provisional, or interim prosthodontic appliances; precision or semi-precision attachments, copings or myofunctional therapy; and

x. RLHICA will not make payment for posterior bridges done in conjunction with partial dentures in the same arch. RLHICA will not make payment for the replacement of teeth beyond the normal compliment of teeth. All charges for the foregoing will be the responsibility of the Certificate Holder.

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 limited to once in any 2 year period per appliance.

Other Major Services

i. An occlusal guard is a payable 1 in a lifetime;

ii. Limited occlusal adjustments are limited to 1 in a lifetime; and

iii. RLHICA will not make payment for the following services and items and all charges for the same will be the responsibility of the Certificate Holder: repair, relines, or adjustments of occlusal guards.

ORTHODONTIC SERVICES

Orthodontic Services

No person will be eligible for Orthodontic Services under this Policy unless Orthodontic Services are provided for in the Declarations Section. Services, treatment, and procedures to correct malposed teeth (for example, braces), are subject to the following exceptions and reductions:

i. RLHICA's payment for Orthodontic Services will be limited to the lifetime Maximum Payment specified in the Declarations Section of this Policy;

ii. Orthodontic Services are payable until end of the calendar year of the 19th birthday of a Certificate Holder or Eligible Dependent unless otherwise specified in the Declarations Section;

iii. RLHICA's 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;

iv. If the treatment plan is terminated before completion of the case for any reason, RLHICA's obligation will cease with payment up to the date of termination;

v. The Dentist may terminate treatment, with written notification to RLHICA and to the patient, for lack of patient interest and cooperation. In those cases, RLHICA's obligation for payment ends on the last day of the month in which the patient was last treated;

vi. RLHICA will not make payment for the following services and items and all charges for the same will be the responsibility of the Certificate Holder: lost, missing, or stolen appliances of any type and replacement or repair of an orthodontic appliance.

Section VI. Exceptions and Reductions

Exceptions:

In addition to the exceptions listed in the Covered Services Section, RLHICA will not make payment for the following services, items or supplies and all charges for the same will be the responsibility of the Certificate Holder, unless otherwise specified in the Declarations Section.

1. Services or supplies for the treatment of an Occupational Injury or Sickness which are payable under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or Workers' Compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

2. Charges for services or appliances incurred prior to the date the person became covered 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 RLHICA;

6. Services, items or supplies that are specialized techniques, as determined by RLHICA;

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 RLHICA;

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 excepted by RLHICA's policies and procedures;

10. Services, items or supplies which are not provided in accordance with accepted standards of dental practice, as determined by RLHICA;

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 RLHICA 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. This exception does not apply to acts of terrorism;

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 Benefits that have been selected and shown in the Declaration Section;

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 adjustments, enamel microabrasions, odontoplasty or bleaching.

16. Correction of congenital or developmental malformations as determined by RLHICA, except the correction of congenital defects or anomalies (including treatment and care for cleft lip or cleft palate) with respect to newborn Children, adopted Children, and Foster Children, or covered Children by reason of court or administrative order;

17. Cosmetic surgery or dentistry for aesthetic reasons as determined by RLHICA except the correction of congenital defects or anomalies (including treatment and care for cleft lip or cleft palate) with respect to newborn Children, adopted Children, and Foster Children, or covered Children by reason of court or administrative order;

18. Any appliance, restoration or surgical procedure used to (a) change vertical dimension; (b) restore or maintain occlusions; (c) replace tooth structure lost as a result of abrasion, attrition, abfraction or erosion; and (d) splint or stabilize teeth for periodontal reasons; and

19. RLHICA will make no payment for local anesthesia and all charges for the same will be the responsibility of the Certificate Holder.

Reductions:

In addition to the reductions listed above in the Benefits Section, the following reductions apply under this Policy, unless otherwise specified in the Declarations Section:

1. RLHICA's obligation for payment of Benefits ends on date that this Policy terminates;

2. When services in progress are interrupted and completed later by another Dentist, RLHICA will review the claim to determine the amount of payment, if any, to each Dentist;

3. Care terminated due to the death of the Certificate Holder or Eligible Dependent will be paid to the limit of RLHICA's liability for the services completed or in progress;

4. The Maximum Payment will be limited to the amount specified in the Declarations Section of this Policy;

5. If a Deductible amount is specified in the Declarations Section, RLHICA 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.

Section VII. Claims

A. Notice of Claim

Written notice of claim must be given to RLHICA within 20 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 of the Certificate Holder or the beneficiary to RLHICA P.O. Box 1596, Indianapolis, IN 46206-1596, or to any authorized agent of RLHICA shall be deemed notice to RLHICA.

B. Claim Forms

Upon request, RLHICA will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after such request the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

C. Proof of Loss

All claims for Benefits must be filed within 180 days of the date the services were completed. Failure to submit a claim within the time required shall not invalidate nor reduce any claim if it was not reasonably possible for the claim to be filed within such time, provided such claim is submitted as soon as reasonably possible and in no event, except in the case of legal incapacity, later than one year from the time submittal of the claim is otherwise required.

D. Time of Payment of Claims

Claims payable under this Policy for any loss other than loss for which this Policy provides any period payment will be paid immediately upon receipt of due written proof of such loss. Subject to the written proof of loss, all accrued claims for loss for which this Policy provides periodic payment will be paid within 30 days and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of due written proof.

Section VIII. Agreements

A. RLHICA Agrees:

1. To make no payments from the money received from the Policyholder for any services rendered to a person who is not eligible for Benefits provided, however, that RLHICA receives timely information from the Policyholder regarding the eligibility of each Certificate Holder and Eligible Dependent as set forth in Section VIII B.2;

2. To make payments in the following manner for Covered Services provided to the Certificate Holder and Eligible Dependents: RLHICA will base payment on the lesser of the Submitted Amount, and the Allowed Amount. RLHICA will send payment to either the Certificate Holder who is responsible for paying the Dentist whatever he or she charges, or directly to the Dentist if the Certificate Holder or Eligible Dependent has assigned Benefits to the Dentist who rendered Covered Services under this Policy;

3. Consistent with any applicable law, protecting the confidentiality of a patient's health records, data or information to provide standard reports to the Policyholder upon request for no additional charge and to provide agreed to non-standard reports on a time and materials basis;

4. To provide to the Policyholder, for submission to the Certificate Holder, a standard certificate of the Benefits provided pursuant to this Policy;

5. That no agent has authority to change the Policy or waive any of its provisions and that no change in the Policy shall be valid unless approved by an officer of RLHICA and evidenced by endorsement on the Policy, or by amendment to the Policy signed by the Policyholder and RLHICA;

6. To provide the Policyholder 45 days prior written notice of any adjustment in Rates, Benefits, or Copayments payable under this Policy. Adjustments to Rates may be made at the end of the first year, or at any time during any subsequent year based upon at least 12 months of experience, provided that any such adjustment after the first year shall not be made any more frequently than once every six months. Such adjustments may be made by RLHICA to correct potential adverse group experience resulting from the following:

a. Information provided upon enrollment proves to be in error;

b. Terms and provisions of the Policy are violated; or

c. Initial size or composition of the group changes to the extent it adversely affects the Rates.

If the Policyholder refuses to accept this adjustment, RLHICA may implement the adjustment or an alternative adjustment or cancel this Policy.

B. Policyholder Agrees:

1. To pay RLHICA the monthly Rate specified in the Declarations Section of this Policy, in advance, unless otherwise specified in the Declarations Section. If payment is not received by the due date, RLHICA shall have the right to suspend claims processing;

2. To list as Certificate Holders all eligible employees or members of the Policyholder and, if covered, all Eligible Dependents of those Certificate Holders, to the extent required under the Policy. The Policyholder will provide RLHICA an accurate monthly statement of the total number and names of all Certificate Holders and, if applicable, all Eligible Dependents;

3. To permit RLHICA, by its auditors or other authorized representatives, on reasonable advance written notice, to inspect the Policyholder's records to verify the accuracy of lists of Certificate Holders and Eligible Dependents submitted to RLHICA. Clerical errors or delays in keeping or relaying data will not invalidate eligibility that would otherwise be validly in force or continue eligibility that would otherwise be validly terminated, if, after discovery of the errors or delays, an equitable adjustment of the Policyholder's payment can be made in a reasonable period of time;

4. To collect and pay to RLHICA any amounts that the Policyholder's Certificate Holders are required to pay to RLHICA under this Policy or any written employment contracts, including amounts for COBRA continuation coverage. Any amounts not collected will be the responsibility of the Policyholder;

Should the Policyholder collect any amounts paid by Certificate Holders and not remit them to RLHICA in a timely fashion, with the result being an eligible person's coverage is lost, the Policyholder, not RLHICA, will be liable for any Benefits to which the person may have been entitled but for the Policyholder's tardy remittance or failure to remit, unless, after discovery of the errors or delays, an equitable adjustment of the Policyholder's payment can be made in a reasonable period of time;

5. To pay for any agreed to non-standard reports on a time and materials basis;

6. To provide each Certificate Holder with a standard certificate of the Benefits provided under this Policy and all privacy notices as may be required pursuant to any applicable federal or state law, at such intervals as may be required by law from time to time. RLHICA will provide said documents to the Policyholder for copying and distribution, at the Policyholder's expense.

Section IX. General Terms

A. **Entire Contract; Changes:** This Policy together with the Group Dental Certificate, Summary of Dental Plan Benefits and any application is the entire contract between the Policyholder and RLHICA. No agent has authority to change any part of this Policy. No changes to this Policy will be effective until approved in writing by an officer of RLHICA. This approval must be noted on or attached to the Policy. RLHICA shall have the discretion to assign its rights and responsibilities under this Policy to an affiliated entity. If RLHICA chooses to assign its rights and responsibilities, it shall assign them to an appropriately licensed entity capable of performing similar functions at similar levels as RLHICA. RLHICA shall serve written notice of the assignment to Policyholder and said notice shall provide the name and address of the assignee. Except as otherwise provided herein, neither this Policy nor any part of it shall be assigned by Policyholder without the prior written consent of RLHICA and any attempt at assignment by Policyholder without such consent by RLHICA shall be null and void. Subject to the foregoing limitation, this Policy shall be binding upon the parties and their respective successors and assigns.

B. **Time Limit on Certain Defenses:** The recovery of overpayments or offsetting of future payments shall be made within the two years after the date of the original claim payment. This provision shall be read in conjunction with state insurance laws and is not applicable in all jurisdictions and may only apply to non-payment of premium after 2 years from the issue date. After two years from the date of issue or reinstatement of this Policy no misstatements made by the applicant in the application for this Policy shall be used to void the Policy or deny a claim for loss incurred or disability (as defined in the Policy) commencing after the expiration of such two-year period. Nothing in the foregoing shall be deemed to preclude the assertion at any time of defenses based upon a person's ineligibility for coverage under the Policy or based on any other provisions of the Policy.

C. **Grace Period:** This Policy has a 31 day grace period (the "Grace Period"). This provision means that if a premium installment is not paid on or before the date it is due, it may be paid during the following 31 days. The Grace Period will not apply if, at least 45 days before the premium due date, RLHICA has delivered or mailed to the Policyholder's last address shown in RLHICA's records, written notice of RLHICA's intent not to renew this Policy. During the Grace Period, the Policy will stay in force.

D. **Reinstatement:** If the premium installment is not paid before the Grace Period ends, the Policy will lapse. Later acceptance of the premium by RLHICA, or by an agent authorized to accept payment without requiring an application for reinstatement, will reinstate this Policy. If RLHICA or its agent requires an application, the Policyholder 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 45th day after the date of the conditional receipt unless RLHICA has previously written the Policyholder of its disapproval. The reinstated Policy will cover only loss that results from an injury sustained after the date of reinstatement or sickness that starts more than 10 days after such date. In all other respects, the rights of the Policyholder and RLHICA will remain the same, subject to any provisions noted on or attached to the reinstated Policy. Any premiums RLHICA accepts 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 before the reinstatement date.

E. **Physical Examination:** RLHICA, at its own expense, shall have the right and opportunity to examine the person of the Certificate Holder or Eligible Dependent when and as often as it may reasonably require during the pendency of a claim hereunder.

F. **Legal Actions:** No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished. This provision does not preclude the Policyholder or Certificate Holder from seeking a decision from a jury trial once all administrative appeals have been exhausted.

G. **Change of Beneficiary:** Unless the Certificate Holder makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the Certificate Holder and the consent of the beneficiary

or beneficiaries shall not be requisite to surrender or assignment of this Policy, to any change of beneficiary or beneficiaries, or to any other changes in this Policy.

H. **Misstatement of Age:** If the age of the Certificate Holder or Eligible Dependent has been misstated, and age was a factor in determining premium paid, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

I. **Conformity with State Law:** Any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Certificate Holder or Eligible Dependent resides on such date is hereby amended to conform to the minimum requirements of such laws.

J. **Illegal Occupation:** RLHICA shall not be liable for any loss to which a contributing cause was the Certificate Holder's or Eligible Dependent's commission of or attempt to commit a felony or to which a contributing cause was the Certificate Holder's or Eligible Dependent's being engaged in an illegal occupation.

K. **Notice to Fiduciaries.** UNDER NORTH CAROLINA GENERAL STATUTE Section 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

Section X. Term and Termination

This Policy shall remain in full force and effect for the initial term of one (1) year from the Effective Date and may be renewed for subsequent one year terms beginning on the First Renewal Date as specified in the Declarations Section. RLHICA will give the Policyholder at least 45 days advance notice of cancellation, expiration, or nonrenewal. RLHICA shall have the option of terminating this Policy if:

A. The Policyholder fails to make a required payment prior to expiration of the Grace Period specified; or

B. RLHICA elects to cancel pursuant to Section VIII(A)6 of this Policy; or

C. The Policyholder fails to furnish RLHICA with accurate enrollment data pursuant to Section VIII(B)2; or

D. The Policyholder permits voluntary enrollment of Certificate Holders and/or their Eligible Dependents unless otherwise specified in the Declarations Section; or

E. The Policyholder refuses to allow RLHICA (by its auditors or other authorized representatives) to inspect the Policyholder's records to verify the accuracy of the Certificate Holder and Eligible Dependent list pursuant to Section VIII(B)3; or

F. The Policyholder has otherwise breached this Policy.

The Policyholder may cancel this Policy if the Policyholder provides RLHICA with 30 days written notice of intent to cancel.

During the first year coverage is in force under the Policy, or during the first year following any lapse and reinstatement of the Policy, a period of 30 days notice will be provided before the termination date. After one continuous year of coverage under the Policy and acceptance of premium for any portion of the second or subsequent year, the notice period will be the number of full months most nearly equivalent to one fourth the number of continuous months the Policy has been in effect from the inception date of the Policy to the date of mailing of the notice: Provided no period of required notice shall exceed two years.

The Policyholder is entitled to a Grace Period of 31 days for the payment of any premium installment due except the first, during which period the Policy will remain in force.

Section XI. Coordination of Benefits

All of the Benefits under this Policy, if applicable, will be subject to a Coordination of Benefits ("COB") provision that is designed to provide maximum coverage, but not result in payment of more than 100 percent of the total fee for a given treatment.

1. Applicability

a. This COB provision applies to This Plan when a Certificate Holder or the Certificate Holder's Eligible Dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

b. 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:

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

ii. May be reduced when, under the order of benefits determination rules, another Plan determines its benefits first. The above reduction is described in Paragraph 4. "Effect on the Benefits of This Plan."

2. Definitions

a. "Allowable Expense" means a necessary, reasonable and customary item of expense 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 in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. Total benefits paid must be equal to 100 percent of necessary expenses covered by both Plans.

b. "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.

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

i. Group insurance 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, blanket, franchise individual, automobile and homeowner coverage.

ii. 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 (i) or (ii) 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.

d. "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.

e. "This Plan" means the dental coverage established for the Certificate Holders and their Eligible Dependents pursuant to this Policy.

3. Order Of Benefit Determination Rules

a. 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:

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

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

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

i. 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:

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

(b) 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.

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

(a) 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,

(b) 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 (a) 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.

iii. 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:

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

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

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

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

If the other Plan does not have this subparagraph b (iii) and if, as a result, the Plans do not agree on the order of benefits, this subparagraph b (iii) 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 b (ii) above.

iv. 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 b (iv) is ignored.

v. 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 b (v) shall be ignored.

vi. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member, or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

4. Effect On The Benefits Of This Plan

a. When This Paragraph Applies. This Paragraph 4. applies when, in accordance with Paragraph 3. "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 4. Such other Plan or Plans are referred to as "the other Plans" in subparagraph b. immediately below.

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

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

ii. 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.

5. Right To Receive And Release Needed Information

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

6. Facility Of Payment

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

That amount will then be treated as though it were a Benefit under This Plan. RLHICA 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.

7. Right Of Recovery

If the amount of the payments made by RLHICA is more than it should have paid under this COB provision, it may recover the excess from the persons it has paid or for whom it has paid.

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

The recovery of overpayments or offsetting of future payments shall be made within the two years after the date of the original claim payment unless RLHICA has reasonable belief of intentional misconduct.

The recovery of underpayments or nonpayments shall be made within the two years after the date of the original claim adjudication.

Section XII. Miscellaneous Provisions

A. All statements, made by the Policyholder or by the Certificate Holders or Eligible Dependents, shall be deemed to be representations and not warranties.

B. 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. When any provision in this Policy is in conflict with such laws, the rights, duties and obligations of RLHICA, the Policyholder, Certificate Holder and Eligible Dependents shall be governed by such laws.

C. Dentists providing services are independent contractors, and neither the Policyholder nor RLHICA will be liable for any act or omission of any Dentist, his or her employees or agents or any person providing dental or other professional services under this Policy.

D. All Dentists, Certificate Holders, and Eligible Dependents, by performing or receiving services under this Policy, are bound by all its terms.

E. No materials will be published or distributed by the Policyholder concerning this Policy until the material is first approved by RLHICA. Unless otherwise provided in this Policy, RLHICA 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 RLHICA within 12 months after the date that the services, items or supplies are provided.

F. RLHICA and Policyholder agree to defend, indemnify and hold harmless the other and its directors, officers and employees (who are acting in the course of their employment, but not as claimants) from any loss, cost, or expense (including reasonable attorney fees and court costs) resulting from or arising out of or in connection with its breach of this Policy or any negligent act or omission of any of its directors, officers or employees, unless liability for such act or omission is expressly assigned elsewhere in this Policy.

G. While the Certificate Holder and/or Eligible Dependent are covered by RLHICA, the Certificate Holder and/or Eligible Dependent agree to provide RLHICA with any information it needs to process the claims and administer the Benefits. This includes allowing RLHICA to have access to his or her dental records.

H. The RLHICA Board of Directors or its delegee will establish procedures for resolving all questions raised by a Dentist, a Policyholder, a Certificate Holder, or an Eligible Dependent in regard to claims for Benefits allowed or rejected under the terms of this Policy. These procedures will be used both for the initial determination of those questions and for the resolution of appeals made on the basis of those initial determinations. All determinations made according to these procedures will be final and binding on the Dentist, the Policyholder, the Certificate Holder, and the Eligible Dependent; provided, however that Certificate Holders and Eligible Dependents may exercise their legal rights after this determination as described in the Claims Appeal Procedure.

I. RLHICA may from time to time provide additional services or coverages by rider or other notice. Those additional services or coverages may be withdrawn at any time after notice given by RLHICA.

J. Any notice required or permitted to be given pursuant to this Policy will be considered given if in writing and personally delivered, or if in writing and deposited in the United States mail with postage prepaid, addressed to the person at their last address of record.

K. If RLHICA pays a claim for which another person or company is liable, RLHICA has the right to recover its payment from the other person or company. The Policyholder must do whatever is necessary to enable RLHICA to exercise its rights and do nothing to prejudice them. If the Policyholder recovers damages from any party or through any coverage named above, the Policyholder must reimburse RLHICA from that recovery to the extent of payments made under the Policy.

L. If RLHICA pays for services, items or supplies that were sought or received under false or misleading pretenses or circumstances, pays a claim that contains false or misrepresented information, or pays a claim that is determined to be false due to the acts of the Policyholder, Certificate Holder and/or Eligible Dependent, it may recover that payment from the Policyholder, Certificate Holder, and/or Eligible Dependent. The Policyholder, Certificate Holder, and/or Eligible Dependent authorizes RLHICA to recover any payment determined to be based on false, misleading, or misrepresented information by deducting that amount from any payments properly due to the Policyholder, Certificate holder, and/or Eligible Dependent. RLHICA will provide an explanation of the payment being recovered at the time the deduction is made.

M. Neither RLHICA (including its agents, directors, officers and employees) nor Policyholder shall be liable for delays in performance due to circumstances beyond their reasonable control. Each party shall be excused from performance under this Policy and shall have no liability to the other party for any period during which it is prevented from performing any of its obligations (other than payment obligations), in whole or in part, as a result of delays caused by the other party or by an act of God, war, terrorism, civil unrest, civil disturbance, court order, labor dispute, or other cause beyond is reasonable control, including failures or fluctuations in electrical power, heat, light, or telecommunications and such nonperformance shall not be a default under or grounds for termination of this Policy.

N. Benefits to Certificate Holders or Eligible Dependents are for the personal benefit of those people and cannot be transferred or assigned. However, a Certificate Holder or Eligible Dependent may assign Benefits to the Dentist who rendered Covered Services under this Policy. Benefits paid pursuant to such assignment shall discharge the obligation of RLHICA with respect to the amount of the Benefits so paid.

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

ACCEPTED:

RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF AMERICA

BY: _____
President and CEO

DATE: January 1, 2022

POLICYHOLDER

BY: _____
Authorized Signature

TITLE: _____

DATE: _____

BY: _____
Witnessed By

TITLE _____

DATE: _____

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted *in the box* below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
Post Office Box 10218
Raleigh, North Carolina, 27605

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, NC 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. *On the back of this page* is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed the average rate specified in the law;
- dividends;
- experience or other credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

(1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
(2) Except as provided in (4) and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter the number of policies or types of policies issued by the insolvent company.
(3) Except as provided in (4) and (5) below, the guaranty association will pay an aggregate maximum of $500,000 with respect to any one individual affected by multiple insolvencies.
(4) The guaranty association will pay a maximum of $1,000,000 with respect to any one structured settlement annuity contract holder.
(5) The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.

POLICY IN-NETWORK DENTIST BENEFIT RIDER

By attachment of this rider, the Policy is amended as follows:

This Policy is amended to provide Benefits that are based on whether a Certificate Holder or an Eligible Dependent receives dental services from an In-Network Dentist or an Out-of-Network Dentist.

If a Certificate Holder or an Eligible Dependent receive 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 Certificate Holder or an Eligible Dependent 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 Certificate Holder or Eligible Dependent receives Covered Services that are not of the type provided by any In-Network Dentist or Covered Services required to meet your health needs that cannot be obtained from an In-Network Dentist without unreasonable delay, these Covered Services will be treated as if they had been provided by an In-Network Dentist.

The Benefits for Covered Services rendered by both In-Network and Out-of-Network Dentists are shown in the Declaration Section.

Payment of Dental Bills When You See an In-Network Dentist

If a Certificate Holder or an Eligible Dependent 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. The Certificate Holder 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 Section for In-Network Dentists for the categories of services rendered.

The Certificate Holder is also responsible for any charges for optional treatment or specific exceptions/reductions of the Policy.

Payment of Dental Bills When You See an Out-of-Network Dentist

If a Certificate Holder or an Eligible Dependent 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 Section. The Certificate Holder 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 Section 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, the Certificate Holder will also be responsible for paying the Dentist the difference between the Submitted Amount and the Allowed Amount.

The Certificate Holder is also responsible for any charges for optional treatment or specific exceptions/reductions of the Policy.

Definitions (As used in this rider):

Allowed Amount – is revised to mean 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 codes and nomenclature developed and maintained by the American Dental Association.

In-Network Covered Services – means covered health care services that are received according to the rules of the health benefit plan from providers employed by, under contract with, or approved in advance by the insurer; and means emergency health care services regardless of the status or affiliation of the provider of such services.

In-Network Dentist – means a preferred provider Dentist who has entered into a contract 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 will be provided to each Certificate Holder.

Out-of-Network Covered Services – means non-emergency, medically necessary covered health care services that are not received according to the rules of the health benefit plan, including services from affiliated health providers that are received without the approval of the insurer.

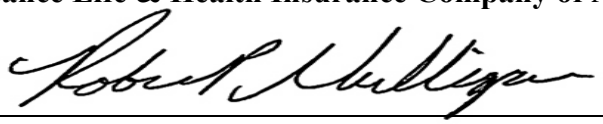
Out-of-Network Dentist – means a Dentist who has not entered into a contract to provide Covered Services for pre-negotiated fees.

Out-of Network Service – means a Covered Service that is not obtained from an In-Network Dentist.

This rider does not change, waive or extend any part of the Policy other than as set forth above.

This rider is effective at the same time as the Policy.

Renaissance Life & Health Insurance Company of America



Robert P. Mulligan, President and Chief Executive Officer

NOTICE OF PRIVACY PRACTICES

Date of This Notice: February 12, 2020

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes the privacy practices of Delta Dental Plan of Michigan, Inc., Delta Dental Plan of Ohio, Inc., Delta Dental Plan of Indiana, Inc., Delta Dental Plan of Arkansas, Inc., Delta Dental of Kentucky, Inc., Delta Dental Plan of New Mexico, Inc., Delta Dental of North Carolina, Delta Dental of Tennessee, Renaissance Life & Health Insurance Company of America, Renaissance Life & Health Insurance Company of New York (collectively, "we" or "us" or the "Plan"). These entities have designated themselves as a single affiliated covered entity for purposes of the privacy rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and each has agreed to abide by the terms of this Notice and may share protected health information with each other as necessary for treatment, payment or to carry out health care operations, or as otherwise permitted by law.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information" ("PHI"). Generally, PHI is individually identifiable health information, including demographic information, collected from you or received by a health care provider, a health care clearinghouse, a health plan or your employer on behalf of a group health plan that relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

We are required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information. We are committed to protecting your health information.

We comply with the provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act. We maintain a breach reporting policy and have in place appropriate safeguards to track required disclosures and meet appropriate reporting obligations. We will notify you promptly in the event a breach occurs that may have compromised the security or privacy of your PHI. In addition, we comply with the "Minimum Necessary" requirements of HIPAA and the HITECH amendments. We also comply with all applicable laws relating to retention and destruction of your PHI.

For more information concerning this Notice please see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we may use or disclose your PHI.

For Treatment We may use or disclose your PHI to facilitate medical treatment or services by providers. We may disclose PHI about you to providers, including dentists, doctors, nurses, or technicians, who are involved in taking care of you. For example, we might disclose information about your prior dental X-ray to a dentist to determine if the prior X-ray affects your current treatment.

For Payment We may use or disclose PHI about you to obtain payment for your treatment and to conduct other payment related activities, such as determining eligibility for Plan benefits, obtaining customer payment for benefits, processing your claims, making coverage decisions, administering Plan benefits, and coordinating benefits.

For Health Care Operations We may use and disclose PHI about you for other Plan operations, including setting rates, conducting quality assessment and improvement activities, reviewing your treatment, obtaining legal and audit services, detecting fraud and abuse, business planning and other general administration activities. In accordance with the Genetic Information and Nondiscrimination Act of 2008, we are prohibited from using your genetic information for underwriting purposes.

To Business Associates We may contract with individuals or entities known as Business Associates to perform various functions or to provide certain types of services on the Plan's behalf. In order to perform these functions or provide these services, Business Associates may receive, create, maintain, use and/or disclose your PHI, but only if they agree in writing with the Plan to implement appropriate safeguards regarding your PHI. For example, the Plan may disclose your PHI to a Business Associate to administer claims or provide support services, such as utilization management, quality assessment, billing and collection or audit services, but only after the Business Associate enters into a Business Associate Agreement with the Plan.

Health-Related Benefits and Services We may use or disclose health information about you to communicate to you about health-related benefits and services. For example, we may communicate to you about health-related benefits and services that add value to, but are not part of, your health plan.

To Avert a Serious Threat to Health or Safety We may use and disclose PHI about you to prevent or lessen a serious and imminent threat to the health or safety of a person or the general public.

Military and Veterans If you are a member of the armed forces, we may release PHI about you if required by military command authorities.

Worker's Compensation We may release PHI about you as necessary to comply with worker's compensation or similar programs.

Public Health Risks We may release PHI about you for public health activities, such as to prevent or control disease, injury or disability, or to report child abuse, domestic violence, or disease or infection exposure.

Health Oversight Activities We may release PHI to help health agencies during audits, investigations or inspections.

Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We also may disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement We may release PHI if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

National Security and Intelligence Activities We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

To Plan Sponsor We may disclose your PHI to certain employees of the Plan Sponsor (i.e., the Company) for the purpose of administering the Plan. These employees will only use or disclose your PHI as necessary to perform Plan administrative functions or as otherwise required by HIPAA.

Disclosure to Others We may use or disclose your PHI to your family members and friends who are involved in your care or the payment for your care. We may also disclose PHI to an individual who has legal authority to make health care decisions on your behalf.

REQUIRED DISCLOSURES

The following is a description of disclosures of your PHI the Plan is required to make:

As Required By Law We will disclose PHI about you when required to do so by federal, state or local law. For example, we may disclose PHI when required by a court order in a litigation proceeding, such as a malpractice action.

Government Audits The Plan is required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with HIPAA.

Disclosures to You Upon your request, the Plan is required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits.

WRITTEN AUTHORIZATION

We will use or disclose your PHI only as described in this Notice**. It is not necessary for you to do anything to allow us to disclose your PHI as described here.** If you want us to use or disclose your PHI for another purpose, you must authorize us in writing to do so. For example, we may use your PHI for research purposes if you provide us with written authorization to do so. You may revoke your authorization in writing at any time. When we receive your revocation, it will be effective only for future uses and disclosures. It will not be effective for any PHI that we may have used or disclosed in reliance upon your written authorization. We will never sell your PHI or use it for marketing purposes without your express written authorization. We cannot condition treatment, payment, enrollment in a Health Plan, or eligibility for benefits on your agreement to sign an authorization.

ADDITIONAL INFORMATION REGARDING USES OR DISCLOSURES OF YOUR PHI

For additional information regarding the ways in which we are allowed or required to use of disclosure your PHI, please see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

YOUR RIGHTS REGARDING PHI THAT WE MAINTAIN

You have the following rights regarding PHI we maintain about you:

Your Right to Inspect and Copy Your PHI You have the right to inspect and copy your PHI. You must submit your request in writing and if you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request. A copy will be provided within 30 days of your request.

The Plan may deny your request to inspect and copy PHI in certain limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed by submitting a written request to the Contact Person listed below.

Your Right to Amend Incorrect or Incomplete Information If you believe that the PHI the Plan has about you is incorrect or incomplete, you may request that we change your PHI by submitting a written request. You also must provide a reason for your request. We are not required to amend your PHI but if we deny your request, we will provide you with information about our denial and how you can disagree with the denial within 60 days of your request.

Your Right to Request Restrictions on Disclosures to Health Plans. Where applicable, you may request that restrictions be placed on disclosures of your PHI.

Your Right to an Accounting of Disclosures We Have Made You may request an accounting of disclosures of your PHI that we have made, except for disclosures we made to you or pursuant to your written authorization, or that were made for treatment, payment or health care operations. You must submit your request in writing. Your request may specify a time period of up to six years prior to the date of your request. We will provide one list of disclosures to you per 12-month period free of charge; we may charge you for additional lists.

Your Right to Request Restrictions on Uses and Disclosures You have the right to request restrictions or limitations on the way that we use or disclose PHI. You must submit a request for such restrictions in writing, including the information you wish to limit, the scope of the limitation and the persons to whom the limits apply. We may deny your request.

Your Right to Request Confidential Communications Through a Reasonable Alternative Means or at an Alternative Location You may request that we direct confidential communications to you in an alternative manner (i.e., by facsimile or e-mail). You must submit your request in writing. We are not required to agree to your request, however we will accommodate your request if doing otherwise would place you in any danger.

Your Right to a Paper Copy of This Notice

To obtain a paper copy of this Notice or a more detailed explanation of these rights, send us a written request at the address listed below. You may also obtain a copy of this Notice at one of our websites:
www.deltadentalmi.com,
www.deltadentaloh.com,
www.deltadentalin.com,
www.deltadentalar.com
www.deltadentalky.com,
www.deltadentalnc.com,
www.deltadentalnm.com,
www.deltadentaltn.com, or
www.renaissancedental.com.

Your Right to Appoint a Personal Representative

Upon receipt of appropriate documentation appointing an individual as your personal representative, medical power of attorney or legal guardian, that individual will be permitted to act on your behalf and make decisions regarding your healthcare.

CHANGES TO THIS NOTICE

We may amend this Notice of Privacy Practices at any time in the future and make the new Notice provisions effective for all PHI that we maintain. We will advise you of any significant changes to the Notice. We are required by law to comply with the current version of this Notice.

COMPLAINTS

If you believe your privacy rights or rights to notification in the event of a breach of your PHI have been violated, you may file a complaint with us or with the Office of Civil Rights. Complaints about this Notice or about how we handle your PHI should be submitted in writing to the Contact Person listed below.

A complaint to the Office of Civil Rights should be sent to Office of Civil Rights, U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, 1-877-696-6775. You also may visit OCR's website at http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html for more information.

You will not be penalized, or in any other way retaliated against for filing a complaint with us or the Office of Civil Rights.

SEND ALL WRITTEN REQUESTS REGARDING THIS PRIVACY NOTICE TO:

Chief Privacy Officer
P.O. Box 30416
Lansing, MI 48909-7916
517-347-5451 (TTY users call 711)

FACTS	**WHAT DOES RENAISSANCE FAMILY OF COMPANIES DO WITH YOUR PERSONAL INFORMATION?**

Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: ▪ Social Security Number and Insurance claim information ▪ Transaction history and Medical information ▪ Credit card payments and Employment information When you are *no longer* our customer, we continue to share your information as described in this notice.
Why?	All financial companies need to share members' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their members' personal information; the reasons Renaissance Family of Companies chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	**Does Renaissance Family of Companies share?**	**Can you limit this sharing?**
For our everyday business purposes – such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	**Yes**	**No**
For our marketing purposes – to offer our products and services to you	**Yes**	**No**
For joint marketing with other financial companies	**No**	**We do not share**
For our affiliates' everyday business purposes – information about your transactions and experiences	**Yes**	**No**
For our affiliates' everyday business purposes – information about your creditworthiness	**No**	**We do not share**
For nonaffiliates to market to you	**No**	**We do not share**

For Privacy Concerns:	Call 517-347-5451 (TTY users call 711). All other questions must be answered by calling your general customer service number.

Who we are	
Who is providing this notice?	All of the members of the Renaissance Family of Companies listed as Affiliates in the Definitions section located on the back of this notice.

Page 2	
What we do	
How does Renaissance Family of Companies protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings.
How does Renaissance Family of Companies collect my personal information?	We collect your personal information, for example: ▪ When you apply for insurance ▪ When you file an insurance claim ▪ When you give us your contact information ▪ When you use your credit or debit card ▪ When we pay your insurance claims
Why can't I limit all sharing?	Federal law gives you the right to limit only: ▪ Sharing for affiliates' everyday business purposes—information about your creditworthiness ▪ Affiliates from using your information to market to you ▪ Sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing.
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. ▪ *Our affiliates include companies with the Delta Dental name in Michigan, Ohio, Indiana, Kentucky, Tennessee, New Mexico, Arkansas and North Carolina; insurance companies such as Renaissance Life & Health Insurance Company of America and Renaissance Life & Health Insurance Company of New York.*
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. ▪ *Renaissance Family of Companies does not share your personal information with nonaffiliates so they can market to you.*
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. ▪ *Renaissance Family of Companies does not jointly market with nonaffiliated financial companies.*
Other important information	
For customers in AZ, CA, CT, GA, IL, ME, MA, MN, MT, NV, NJ, NC, OH, OR and VA: To review your personal information, write to Privacy Officer, 4100 Okemos Road, Okemos, MI 48864. You must state your full name, address, policy number (if applicable) and the information you would like to see. We will tell you what information we have, and you may review and copy it at our office or ask that we mail a copy to you for a fee. If you think that personal information that we have about you is wrong, you may write to us. We will tell you what actions we take because of your letter. If you do not agree with our actions, you may send us a statement.	