

SERFF Tracking Number: RENA-126310461 State: Arkansas  
Filing Company: Renaissance Life & Health Insurance Company of America State Tracking Number: 43537  
Company Tracking Number:  
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
Product Name: RLHICA-DWN Informational PPO Notification  
Project Name/Number: RLHICA-DWN Informational PPO Notification/RLHICA-DWN Informational PPO Notification

## Filing at a Glance

Company: Renaissance Life & Health Insurance Company of America

Product Name: RLHICA-DWN Informational PPO Notification SERFF Tr Num: RENA-126310461 State: Arkansas

TOI: H10G Group Health - Dental SERFF Status: Closed-Accepted State Tr Num: 43537  
For Informational Purposes

Sub-TOI: H10G.000 Health - Dental Co Tr Num: State Status: Filed-Closed  
Filing Type: Form Reviewer(s): Rosalind Minor

Authors: Denise Chadwell, Errick Phillips Disposition Date: 09/25/2009  
Date Submitted: 09/18/2009 Disposition Status: Accepted For Informational Purposes  
Implementation Date:

Implementation Date Requested: On Approval  
State Filing Description:

## General Information

Project Name: RLHICA-DWN Informational PPO Notification  
Project Number: RLHICA-DWN Informational PPO Notification  
Requested Filing Mode: Informational

Status of Filing in Domicile: Not Filed  
Date Approved in Domicile:  
Domicile Status Comments: This type of filing is not required in our domiciliary state of Delaware.

Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:  
Filing Status Changed: 09/25/2009

Market Type: Group  
Group Market Size: Small and Large  
Group Market Type: Employer, Other  
Explanation for Other Group Market Type: All Approved PPO Policies  
State Status Changed: 09/25/2009  
Created By: Errick Phillips  
Corresponding Filing Tracking Number:

Deemer Date:  
Submitted By: Errick Phillips  
Filing Description:  
September 18, 2009

Arkansas Insurance Department

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Project Name/Number: RLHICA-DWN Informational PPO Notification/RLHICA-DWN Informational PPO Notification  
1200 West Third Street  
Little Rock, AR 72201-1904

Re: Renaissance Life & Health Insurance Company of America (N.A.I.C. No. 61700)  
FEIN# 47-0397286, Group No. 0477  
Dental Wellness Network, LLC  
Notification of Use of Dental PPO Network  
SERFF Tracking Number – RENA-

Dear Sir or Madam:

Upon contacting your offices to inquire if any registration was required to use a Dental PPO network in your state, we were informed that an informational notification is required. It is our intention to utilize Dental Wellness Network, LLC in your state in coordination with our filed and approved PPO products. We are submitting the following items in SERFF for your records:

1. A copy of a sample agreement between Dental Wellness Network, LLC and insurer that allows the insurer to utilize DWN's network; and
2. A copy of the contract and application used by DWN to recruit providers.

Please note that although this filing was submitted under Group, it will also be used for our individual products, but both options could not be selected at the same time.

Should you have any questions or require any additional information, please contact me directly at (517) 347-5352, or by e-mail at [ephillips@renaissancefamily.com](mailto:ephillips@renaissancefamily.com). Thank you for your assistance.

Sincerely,

Errick Phillips  
Regulatory Specialist  
Renaissance Life & Health Insurance Company of America

Enclosures

**Company and Contact**

SERFF Tracking Number: RENA-126310461 State: Arkansas  
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**Filing Contact Information**

Errick Phillips, Regulatory Specialist ephillips@renaissancefamily.com  
 P.O. Box 30381 517-347-5352 [Phone]  
 Lansing, MI 48909-7881 517-347-5433 [FAX]

**Filing Company Information**

Renaissance Life & Health Insurance Company CoCode: 61700 State of Domicile: Delaware  
 of America  
 Group Code: 477 Company Type: Life & Health  
 P.O. Box 30381 Group Name: State ID Number:  
 Lansing, MI 48909-7881 FEIN Number: 47-0397286  
 (800) 745-7509 ext. [Phone]  
 -----

**Filing Fees**

Fee Required? No  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Renaissance Life & Health Insurance Company of America	\$0.00	09/18/2009	

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Accepted For Rosalind Minor Informational Purposes		09/25/2009	09/25/2009

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Fees	Note To Reviewer	Errick Phillips	09/21/2009	09/21/2009

SERFF Tracking Number: RENA-126310461 State: Arkansas  
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## Disposition

Disposition Date: 09/25/2009

Implementation Date:

Status: Accepted For Informational Purposes

Comment:

Rate data does NOT apply to filing.

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Accepted for Informational Purposes	Yes
<b>Supporting Document</b>	Application	Accepted for Informational Purposes	Yes
<b>Supporting Document</b>	Cover Letter	Accepted for Informational Purposes	Yes
<b>Form</b>	Provider Network Participation Packet	Accepted for Informational Purposes	Yes
<b>Form</b>	Network Access Agreement	Accepted for Informational Purposes	Yes

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**Note To Reviewer**

**Created By:**

Errick Phillips on 09/21/2009 01:37 PM

**Last Edited By:**

Rosalind Minor

**Submitted On:**

09/25/2009 08:08 AM

**Subject:**

Fees

**Comments:**

Hello,

I was unable to find any information requiring fees on this type of filing. Please let me know the amount of the appropriate fee and I will add this to the filing via EFT.

Thanks,

Errick Phillips

Regulatory Specialist

Renaissance Life and Health Insurance Company of America

517-347-5352

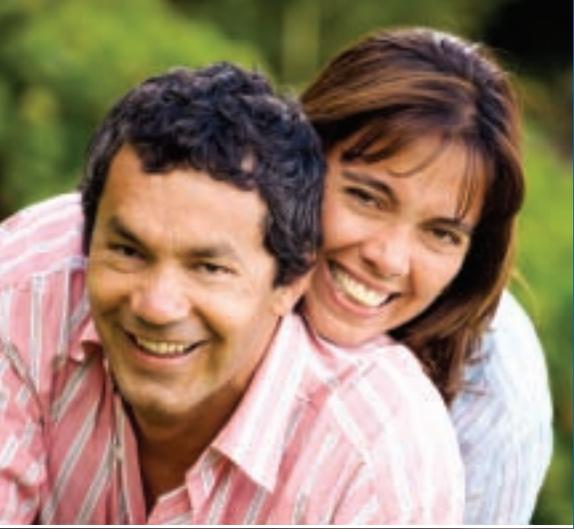
EPhillips@RenaissanceFamily.com

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## Form Schedule

### Lead Form Number: NA

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Accepted for Information al Purposes 09/25/2009	NA	Other	Provider Network Participation Packet	Initial			D01-07 Network Participation Packet_Provider.pdf
Accepted for Information al Purposes 09/25/2009	NA	Other	Network Access Agreement	Initial			Network Access Agreement.pdf



Dental  
Wellness  
Partners<sup>SM</sup>

## Network Participation Forms



Dental  
Wellness  
Partners<sup>SM</sup>

**Dental Wellness Partners (DWP)** is a preferred provider organization of dental professionals, dedicated to meeting the needs of national employers who want to work with a single network that can serve their employees nationwide. Participating dentists agree to accept the DWP fee schedule as the maximum amount they will charge covered members. DWP is not an insurance company.

DWP recognizes that the best dental plans are a combination of both the highest quality panel and the most efficient administration. DWP is affiliated with one of the nation's largest not-for-profit dental benefit companies.

### **Benefits of Participation**

Excellent reimbursement  
(fee schedule enclosed)

Fast and accurate payment

90%—claims processed in  
10 working days

99%—claim payment accuracy

Discounts on products and services from  
Renaissance Systems & Services  
for claim submission, patient statements,  
UCR reports, and online data backup

Free vision discount benefits for you and  
your entire staff and their families

Active promotion of your office to our enrollees online,  
via telephone, and in printed directories thus creating  
a great way to bring new patients into your practice

## Getting Started

To become a participating provider with Dental Wellness Partners, you must complete the enclosed forms and submit certain additional information. It is important that the forms be complete and accurate.

Please use the checklist below to ensure we have all of the information we need to process your application efficiently.

- Provider Agreement (tear-out)**  
If owner is signing for a group practice, only one agreement is necessary. However, all dentists who wish to participate must complete the Dentist Credentialing Information form and sign the Attestation Statement.
- Office Profile (tear-out)**  
Complete one Office Profile form for each service address to be listed.
- Dentist Credentialing Information (tear-out)**  
Each dentist in your practice who wishes to participate must complete one of these forms. Copies of this form are permitted.
- Copy of current state dental license**  
Please provide a copy for each dentist applying.
- Copy of professional liability insurance**  
Please send a copy of the face sheet showing coverage amounts, expiration date, and provider/business name for each dentist.
- W-9 Form (tear-out)**  
Please be sure to indicate your practice/business start date.

*Upon acceptance as a Dental Wellness Partners participating provider, a copy of the fully executed Network Participation Agreement will be mailed to the service address for your records.*



## Frequently Asked Questions

### Is Dental Wellness Partners (DWP) an insurance plan?

No. DWP is a national network of participating dentists who agree to accept our fee schedule as the maximum amount they will charge covered patients. The network is leased to insurance companies, employer groups, and third-party administrators to enhance their dental benefits programs.

### How do I become a participating dentist in the DWP network?

Just fill out, sign, and mail/fax the application, along with copies of the requested documents. You can download application forms from our Web site at [www.dwp-llc.com](http://www.dwp-llc.com), or call (866) 335-4892 to receive them in the mail.

### Can I elect to participate only for specific groups or employers?

No. The DWP participation agreement applies to all groups that contract with the network.

### Does the agreement include credentialing?

Yes. The application form includes credentialing information, and DWP updates this information every four years.

### What does DWP do with my information?

Credentialing information is used during the application review process. All information collected as part of the credentialing process is considered strictly confidential by DWP.

### What if I decide to terminate my participating agreement with DWP?

Written notification to DWP is required at least 30 days prior to the date of termination. If you choose to terminate your agreement, you are obligated to complete treatment started prior to the effective date of your termination at the fees listed in the DWP fee schedule.

### Where do I send my claims?

Claims should be sent to the member's benefits administrator.

### How will I be reimbursed?

The member's benefits administrator will send the payment to participating dental offices. Participating dentists agree to accept the DWP Fee Schedule as payment in full and cannot balance bill the member. The member is responsible for any copayments, coinsurance, deductibles, and payments for non-covered services.

### How does the dental office verify members' eligibility and benefits?

Contact information to verify eligibility and benefits can typically be found on the back of a member's benefits identification card. If a member does not have an identification card, dental offices may contact the benefits administrator for the information.

### How often is the DWP fee schedule reviewed?

The fee schedule is reviewed periodically, no less than once per year, and updated as necessary.

### Whom do I contact to set up electronic claims submission?

As an added value, Renaissance Systems and Services (RSS) offers discounts to new customers that are participating with DWP. RSS can submit e-claims to all benefit administrators—even if the dental office doesn't have Internet access—and they offer many easy-to-use, cost-effective services. For more information, call RSS at (866) 712-9584 or visit their Web site at [www.rss-llc.com](http://www.rss-llc.com) and let them know you are participating with DWP to receive your discount.



## Network Participation Agreement

### 1. Dental Wellness Partners (“DWP”)

This agreement is between Dental Wellness Network, LLC, and the dentist, professional corporation, or group practice (hereafter “Dentist”). Dentist shall become a participating dentist in Dental Wellness Partners preferred dental network (hereafter “DWP Network”). This Participation Agreement, along with the attached Application/Credentialing Form and Attestation Statement (collectively referred to as “this Agreement”), shall govern the obligations of DWP Network participating dentists.

### 2. Services to be Provided

By signing this Agreement, Dentist agrees to provide dental treatment to eligible subscribers on the basis of two components: 1) A subscriber's eligibility for services from DWP Network dentists via contractual agreements with an employer, insurance company, third-party payor, or other entity (collectively referred to as the “Payor”) or 2) A subscriber's eligibility for services from DWP Network dentists via the use of an Access Card (both components collectively referred to as “DWP Programs”). During Dentist's participation in DWP Network, Dentist shall personally furnish all reasonably required professional dental services of a quality and frequency called for according to generally accepted patterns of practice of dentistry in a timely manner to eligible individuals (hereafter “DWP Subscribers”) who present themselves to Dentist under DWP Programs, and shall provide other dental services customarily provided by dental offices, such as prophylaxes and radiographs, in accordance with generally accepted patterns of practice of dentistry.

### 3. Dentist Compensation

Dentist agrees that Dentist's charges to DWP Subscribers shall be the fees specified in the attached fee schedule (which will be updated from time to time), regardless of whether the service is a covered benefit or not. Dentist agrees to accept this as payment-in-full, including any applicable co-payments, coinsurance, or deductibles that Dentist is obligated to collect and agrees not to waive. Dentist agrees:

- A. When Dentist accepts payment from a Payor, Dentist may not charge or collect from the DWP Subscriber any amount obligated to be paid by the Payor or in contradiction of any provision of this Agreement or the attached fee schedule, provided this does not prohibit Dentist from charging and collecting applicable co-payments, coinsurance, or deductibles authorized by DWP Programs.
- B. When Dentist accepts the presentation of an Access Card from a DWP Subscriber, Dentist may collect fees directly from the DWP Subscriber but not in contradiction of any provision of this Agreement, the attached fee schedule, or the applicable DWP Program.
- C. When Dentist provides dental treatment for a non-covered service, Dentist may collect fees directly from the DWP Subscriber. Dentist expressly agrees not to charge or collect any fees from the DWP Subscriber above the allowed amount provided on the fee schedule for non-covered services.
- D. Dentist acknowledges that DWP shall not be liable for any payments due to Dentist including, but not limited to, claim payments from Payor or payments from DWP Subscribers.
- E. Dentist shall not charge or collect any fees from a DWP Subscriber or Payor for completing paperwork or any late fees on amounts due from Payors.

### 4. Dentist Records and Cooperation

Dentist shall maintain complete and detailed patient treatment and financial records which shall be made available to Payor or DWP for review upon request. Such records shall be preserved for seven years. Dentist shall cooperate with DWP's utilization review, credentialing, and re-credentialing, as well as with any grievance procedures that may follow.

### 5. Eligible Subscribers

Persons who present proof of eligibility in a DWP Program at the time services are rendered will be deemed by Dentist to be DWP Subscribers.

### 6. Assignment

Dentist may not assign this Agreement or any rights accruing to Dentist under this

Agreement to any other party without the written consent of DWP. DWP may assign this Agreement to one or more affiliated entities or subsidiaries and may make other entities third-party beneficiaries to this Agreement. Any such action shall be effective when Dentist receives written notice from DWP.

### 7. Non-exclusive Agreement

This Agreement is non-exclusive and DWP may enter into similar agreements with other dentists, and Dentist may enter into similar agreements with other parties.

### 8. Independent Contractor

Dentist is an independent contractor with DWP. Dentist shall maintain the customary dentist-patient relationship for eligible DWP Subscribers treated by Dentist.

### 9. General Requirements of DWP Network Participation

Dentist may not submit or cause to be submitted to Payor any Dental Claim Form for dental services or any other statement which contains false or misrepresented information. False or misrepresented information includes, but is not limited to, misinformation concerning dates services are performed. Only completion dates for services are acceptable: for example, the delivery date of partial or complete dentures, the cementation date of crowns or bridgework, or the date of the final fill of a root canal. Dentist agrees to cooperate fully with DWP Network credentialing committee and/or consultants designated by DWP to review professional standards relative to care provided by Dentist to an DWP Subscriber. The decision of any such consultant or committee, subject to any applicable appeal process, shall be binding on Dentist. DWP reserves the right to terminate Dentist's Participation Agreement for violation of any of the below listed items.

- A. Dentist shall submit claims for services within six (6) months after the date the service is provided. If Payor denies a claim due to late submission, the DWP Subscriber shall not be liable to Dentist for the amount that would have been payable by Payor had the claim been submitted in a timely fashion, provided the DWP Subscriber advised Dentist of DWP Program coverage at the time of treatment.
- B. Any violation of this Agreement may be deemed to be a breach of this Agreement and may result in termination.
- C. A Dentist who has lost his/her participating status, after complying with any and all conditions imposed by DWP, may apply for reinstatement in the same manner as if the dentist were a first-time applicant.
- D. Termination of Dentist's Participation Agreement shall not relieve Dentist of any obligation incurred under the Participation Agreement while it was in force.
- E. Dentist authorizes Payor to deduct from any payments due him/her such sums as Payor reasonably determines to be properly due and owing to Payor as a refund of payments incorrectly made to or claimed by Dentist.

### 10. Entire Agreement

This Participation Agreement along with the Application/Credentialing Form and Attestation Statement constitute the entire contract between DWP and Dentist.

### 11. Termination

This Agreement may be terminated by either party, with or without cause, upon thirty (30) days written notice to the other. This Agreement will automatically terminate in the event Dentist's license to practice dentistry in the state of practice is limited in any way or if Dentist's conduct may result in immediate injury or damage to the health, safety, or well-being of any DWP Subscriber, subject to a final determination by DWP Network credentialing committee. All notices of termination are to be sent to the last known address of the other party with the postage prepaid and by certified mail, return receipt requested.

### 12. Changes

DWP will notify Dentist in writing of any change to this Agreement. The change will become effective immediately unless Dentist notifies DWP that the change is unacceptable. DWP will deem such a notice by Dentist as a request to terminate this Agreement.

### 13. Group Practices

If a group practice is a party to this Agreement:

- A. The group practice assumes all the duties and obligations of “Dentist” in this Agreement.
- B. The group practice shall keep a record of the persons who perform dental services for each DWP Subscriber, the nature of such dental services, and the date such services were performed.

- C. The group practice shall identify all dentists performing dental services at the group practice and provide DWP with any changes as they occur. The group practice, whether a corporation, an assumed name, a partnership, a limited partnership, a joint venture, or other form of legal entity, shall be the responsible party for complying with this Agreement.
- D. All payments for services rendered to DWP Subscribers treated at the group practice shall be paid to the group practice. The group practice shall make its own financial arrangements with individuals, both dentists and non-dentists, who provide dental and related services, and Payor shall have no responsibility to such individuals.

**14. Severability of Unlawful Provisions and Effect of Waiver**

If any of the provisions of this Agreement are or become contrary to law, such provisions shall be inoperative, but the remainder of this Agreement shall remain in full force and effect. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as, nor be construed as, a waiver of any subsequent breach.

**15. Headings**

Section headings are for convenience only and are not to be used in construing the intent of this Agreement.

**16. Dentists Continued Representations and Warranties**

Dentist represents and warrants that Dentist is licensed to practice dentistry in the state of practice and that such license has not been suspended, revoked, limited, or sanctioned within the past five (5) years. Dentist further represents and warrants that Dentist's staff and facilities are licensed as required under law. All of Dentist's rights and obligations under this Agreement are conditioned on the continued maintenance of Dentist's license with no restrictions. Dentist agrees to notify DWP immediately if there is any change in Dentist's or staff's licensure, representations, or warranties. Dentist agrees to notify DWP in writing within 10 business days of said changes.

**17. Confidentiality**

Dentist shall not, except with DWP's express consent, use or disclose to any person, firm, or corporation, whether in competition with DWP Network or not, any knowledge or information not in the public domain concerning DWP Network. It is also understood that neither Dentist nor Dentist's employees will disclose to DWP other confidential information belonging to any third party. Dentist's obligation with respect to confidentiality, as set forth immediately above, shall remain in force for a period of three years following termination of this Agreement. Dentist agrees that DWP may include the following in its directories and lists of DWP Network participating dentists: Dentist's name, business name, address, telephone number, professional designations, and other pertinent information regarding hours, access, and services provided. DWP does not guarantee in any way that DWP Subscribers will use Dentist or that Dentist will receive any minimum number of DWP Subscribers. Dentist also agrees and consents that DWP may share this information with Payor.

**18. Indemnification**

DWP and Dentist agree to indemnify, defend, and hold harmless the other, its directors, officers, employees, agents, parents, affiliates, subsidiaries, successors, and assigns from and against any and all liabilities, claims, suits, actions, demands, settlements, losses, judgments, costs, damages, and expenses (including reasonable attorneys' fees) arising out of or resulting from, in whole or in part, any acts, errors, or omissions of the other, its employees, agents, or contractors in performing or failing to perform under this Agreement, or any inaccuracy or breach of any representation or warranty of the parties.

**19. Network Use**

By signing the Application/Credentialing Form, Dentist agrees to be included in the directories and lists of DWP Network participating dentists that will be made available to current and prospective DWP Subscribers and clients.

**20. Notice**

Except as otherwise provided, all notices required or deemed necessary under this Agreement shall be in writing and be served either 1) by facsimile, 2) by electronic signature, or 3) by first class mail. Until notice of a change of address is given, all such notices and documents should be given or addressed to Dentist at the address provided on the Application/Credentialing Form and to DWP at the following address:

Dental Wellness Partners  
 PO Box 17160  
 Indianapolis, IN 46217

**21. Arbitration**

Any disputes arising from this Agreement shall be referred and decided by binding arbitration as governed by the American Arbitration Association with each party bearing equal costs of the proceeding.

**22. Governing Law**

This Agreement shall be governed under the laws of the state of Michigan provided that this Agreement shall be deemed to incorporate any terms and provisions required to be included by statute or regulation of the state where Dentist is located, and such required terms and conditions shall supersede any conflicting provisions herein.

**23. Professional Liability Coverage**

Dentist agrees to have in full force and effect during and after the term of this agreement, professional liability insurance with respect to the services provided hereunder ("Malpractice Insurance"). Dentist shall immediately notify DWP of any restrictions of such Malpractice Insurance.

**24. Membership**

Dentist shall become a member of the DWP Network and shall be entitled to all rights and privileges of such membership, including access to all products and services which DWP has arranged to be provided to DWP Network Dentists from time to time, for so long as this Agreement is in effect.

**25. Attestation Statement**

The signed attestation statement must be read in conjunction with this agreement.

*A photocopy or fax of this agreement shall be as valid as the original.*

IN WITNESS WHEREOF, Dental Wellness Network, LLC, and Dentist have executed this Agreement as of the latest date shown below.

**Dentist**

By \_\_\_\_\_  
 (Authorized Signature)

\_\_\_\_\_  
 (Name/Title of Above - Please Print)

Date \_\_\_\_\_

\_\_\_\_\_  
 (Name of Practice, Group or Corporation) - Please Print

SS# \_\_\_\_\_ Tax ID# \_\_\_\_\_

State License # \_\_\_\_\_

**Dental Wellness Network, LLC**

By \_\_\_\_\_  
 (Authorized Signature)

\_\_\_\_\_  
 (Name/Title)

Date \_\_\_\_\_



## Office Profile

Please type or print all of the information requested on this form. Incomplete forms cannot be accepted and will be returned for completion. List only the locations at which you will treat members under this Agreement. ***If multiple locations, copy form and complete for each location.***

### Section 1: Participating Dental Office Information

Business Name \_\_\_\_\_ (W-9 business name) NPI \_\_\_\_\_ (Practice Identifier)

Practice/Dentist Name \_\_\_\_\_ (As will be listed in directory) Practice Start Date \_\_\_\_\_

Service Office Street \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_ Phone \_\_\_\_\_

Fax \_\_\_\_\_ Email \_\_\_\_\_ Tax ID \_\_\_\_\_

Payment address (if different than service address)

Street \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_ Phone \_\_\_\_\_

Physically Disabled Access:  Yes  No Languages other than English (list) \_\_\_\_\_

Do you follow the current recommendations of the American Dental Association and the Centers for Disease Control and Prevention regarding infection control? . . . . .  Yes  No

If no, explain: \_\_\_\_\_

Do you comply with the Occupational Exposure to Blood borne Pathogens Standards of the OSHA regulations? . . .  Yes  No

If no, explain: \_\_\_\_\_

### Section 2: Group Practice Members, Partners, and Associates

The following agree to be bound by all provisions of this Agreement. Dentist is responsible and agrees to notify Dental Wellness Partners of any changes in this list. ***A Dentist Credentialing Information sheet and Attestation must be completed for each provider.***

First Name	Last Name	MI	Degree	License #	Specialty
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

BLANK  
Back of Office Profile



### Dentist Credentialing Information

Please complete all items to avoid having the application returned.  
This form may be copied for each additional dentist in the practice who wishes to participate.

Please provide the following information:

- Current Professional Liability Face Sheet showing coverage amounts, expiration date, and provider name
- Copy of Current State Dental License
  - Current State License Number \_\_\_\_\_ State \_\_\_\_\_ Expiration Date \_\_\_\_\_
  - Other Current State License Number \_\_\_\_\_ State \_\_\_\_\_ Expiration Date \_\_\_\_\_
  - Federal DEA # (if applicable) \_\_\_\_\_ Expiration Date \_\_\_\_\_
  - State DEA # (if applicable) \_\_\_\_\_ Expiration Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ DDS/DMD/Other \_\_\_\_\_  
 Specialty \_\_\_\_\_ SSN# \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_  
 National Provider Identifier (NPI) \_\_\_\_\_

**Professional Liability Insurance**

Carrier(s) Name \_\_\_\_\_ Policy # \_\_\_\_\_  
 Limits of Coverage \$ \_\_\_\_\_ / \$ \_\_\_\_\_ Effective Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

**Professional Information**

- Have you ever been involved in a malpractice suit or claim or do you have any claims pending?  
(Include dates, nature of suit, amount of the settlement, and explanation) .....  Yes  No
- Has your license to practice dentistry in any state ever been revoked, suspended, restricted, limited,  
or placed in a probationary state?.....  Yes  No
- Have you ever been reprimanded, disciplined, counseled, or been subject to similar action by any  
state licensing agency with respect to your license to practice? .....  Yes  No
- Are you currently under any investigation with respect to your Drug Enforcement Agency (DEA)  
license or has your DEA license ever been revoked, suspended, or placed on probation? .....  Yes  No
- Have you ever been subject to sanctions by Medicare, Medicaid or any other state or federal program? .....  Yes  No
- Have you ever been convicted of a felony or do you have any criminal charges pending other than for minor traffic offenses? ...  Yes  No

*If you answered yes to any of these questions, please provide an explanation on a separate sheet.  
If possible, please supply an NPDB self queried report(s).*

### Dentist Attestation Statement

By signing below, I hereby apply to become a participating dentist in Dental Wellness Partners (DWP) dental network. I understand and agree that my execution and submission of the Agreement grants me no rights or privileges of participation until such time as I receive written notification from DWP signifying DWP's acceptance of me or my group practice as a participating dentist(s). By signing this document I agree to bind myself, my professional corporation and my group practice, including all locations, to the terms as set forth in this Agreement. I certify that the information in this Application is complete and accurate. I understand that my application may require DWP to review information related to me, my professional corporation and/or members of my group practice on file with other entities and regulating bodies. I hereby consent to and authorize the release of such information by any such entity that requires authorization. In the case of an application for a group practice, I attest that I am authorized to make this consent on behalf of all members of the group practice.

I authorize the State Board (or other dental licensing agencies in any state in which I am licensed to practice dentistry) and any health care facility, health maintenance organization or professional organization with whom I have had employment, practice, association or privileges, to release information to DWP regarding my professional skills, any pending or final disciplinary action or malpractice action, and any other information relevant to my character or professional competence. I authorize and request my professional liability (malpractice) insurance carrier to release information to DWP regarding any claims or actions for damages pending or closed during the previous ten years whether or not there has been a final disposition. I release from liability: a) any person or entity who, in good faith and without malice, provides information to DWP for the purpose of evaluating my application, credentials and qualifications; and b) DWP for their acts performed, in good faith and without malice, in connection with the evaluation of my application, credentials and qualifications.

I understand that DWP may require me to provide credentialing information, as necessary, in connection with this application.

I certify that all of the information herein is accurate and true to the best of my knowledge and agree to notify DWP, in writing, of any changes in this document within 10 days of their occurrence. I understand that information that is found to be false could result in denial/termination of participation status with DWP.

Applicant Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Date \_\_\_\_\_

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Back of Dentist  
Credentialing

Please complete the following information. Federal law requires Dental Wellness Network, LLC to obtain this information when making reportable payment(s) to you. Failure to provide this information may result in a 28 percent federal income tax backup withholding applied to your payments, and you may be subject to a \$50.00 penalty imposed by the Internal Revenue Service under section 6723.

Instructions: Complete Part 1: Complete the row of boxes that corresponds to your tax status  
 Complete Part 2: Complete only if you are exempt from Form 1099 reporting  
**Complete Part 3: Sign and date the form, and return it to Dental Wellness Partners in the enclosed envelope.**

**PART 1 Tax Status** (Complete one row of boxes only)

**Individuals**

Individual's Name	Individual's Social Security Number
-------------------	-------------------------------------

**Sole Proprietor**

Note: A sole proprietor may have a "doing business as" trade name, but the legal name is the name of the business owner as it appears on your Social Security card

Business Owner's Name (legal name as it appears on tax documents)	Business Owner's Social Security Number or TIN	Doing Business As or Trade Name
--	--	---------------------------------

**Partnership**

Name of Partnership (legal name as it appears on tax documents)	Partnership's Employer Identification Number	Doing Business As or Trade Name
--	--	---------------------------------

**Corporation, Exempt Charity or Other Entity**

Note: A corporation may use an abbreviated name or its initials elsewhere, but its legal name is the name as it appears on the IRS EIN (employer identification number) confirmation letter.

Name of Corporation or Entity (legal name)	Employer Identification Number
--	--------------------------------

**PART 2 Exemption** If exempt from form 1099 reporting, check the box and circle the qualifying reason below.

1. Corporation – however, there is NO exemption for medical and health care payments or payments for legal services
2. Tax Exempt Charity under 501(a), or IRA
3. The United States or any of its agencies or instrumentalities
4. A state, the District of Columbia, a possession of the United States or any of their political subdivisions
5. A foreign government or any of its political subdivisions

**PART 3 Certification**

Effective date for above business (practice start date) \_\_\_\_\_

Signature of person completing this form \_\_\_\_\_

Name and title of person completing this form (please type or print) \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date \_\_\_\_\_ Telephone number \_\_\_\_\_ Fax number \_\_\_\_\_

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Back of W-9



## Free Vision Benefits for the Entire Dental Office and Family Members



Dental Wellness Partners has chosen EyeMed Vision Care® as your provider for quality eye care services. EyeMed offers the choice and service you expect in a vision care plan, all at a great value.

Your plan provides:

- Great scheduled discounts for savings up to 35%
- Nationwide access to thousands of private practice and retail providers including LensCrafters®, Target Optical®, Sears® Optical, and most Pearle Vision® locations
- Choice of any product, including designer brand name frames
- Savings on laser vision correction
- Replacement contact lenses by mail

Save up to 35% off frames, lenses, and lens options.

Use this program as often as you wish—no limit to your savings!

[www.dwp-llc.com](http://www.dwp-llc.com)

(866) 335-4892

## A Free Continuing Education Opportunity

CDx Laboratories is pleased to offer dental professionals a free, user-friendly online continuing education course with CE credit administered by the State University of New York at Buffalo School of Dental Medicine.

**Course Module 1:** OralCDx in Practice

**Course Module 2:** Performing a Brush Biopsy and Understanding the Results

## Oral CDx — Its Role in the Prevention of Oral Cancer

This CE course guides dentists in the use of the OralCDx brush biopsy, used to detect precancer and early oral cancer. Not only does it provide instruction on what the test is for, it also offers useful information on technique and billing.

OralCDx's oral brush biopsy allows dentists to easily and painlessly test common, harmless-looking, unexplained red and white spots that may in fact be precancer or cancer. OralCDx is a system that combines a painless oral brush biopsy, which is taken in the dental office, with advanced computer analysis.

The OralCDx oral brush biopsy has been incorporated into tens of thousands of dental offices, and the technique has been used to diagnose thousands of precancers and cancers among spots that typically would not have been biopsied at time of discovery. The OralCDx oral brush biopsy is now being taught as standard practice in the majority of all US dental schools.



"The ADA Council on Scientific Affairs® Acceptance of Oral CDx Computer-Assisted Brush Biopsy Analysis Method is based on its finding that the product is an effective adjunct to the oral cavity examination in the early detection of precancerous and cancerous oral lesions, when used as directed. All Oral CDx 'atypical' and 'positive' results must be confirmed by incisional biopsy and histology to completely characterize the lesion. Persistent lesions even with negative results must receive adequate follow-up evaluations, when used as directed."

Renaissance Systems and Services (RSS) is the fastest growing claim service in the country with 15,000 dental offices in all 50 states. RSS continually works to provide value for each and every one of their clients. Working with RSS enables the leverage of thousands of dental offices to make the claim submission process better for all. And, RSS takes it a step further by providing a complete suite of support systems and services that can make a difference in your bottom line. Are you ready to experience the RSS difference?

## Systems and Services from RSS



### Remote Lite

- Submit ALL dental claims with or without Internet
- Claim status, eligibility, daily reports, attachments
- Unlimited claim submissions for a flat monthly rate—No commitments or requirements



### Remote Fax

- No more folding forms, stuffing envelopes, envelope or postage expense, or long distance phone call expenses
- Receive faster reimbursement
- No commitment, required volumes, or hidden fees—you can stop using this service at anytime



### R-Statements *Statement Processing Service*

- Simple as printing a patient statement
- Sent with a return envelope enclosed
- Captures statement without “double-entry”
- Saves time and money (stamps, envelopes, toner, paper, etc.)



### R-Fees *Dental UCR Reports*

- Zip-3 geographically based with 6 percentiles for every code—available in all areas
- Most accurate available—based on millions of actual claims vs. inaccurate survey methods offered by alternatives



### R-Backup *Data Backup Service*

- A HIPAA-compliant data backup service—keeping critical information secure, up-to-date, and readily accessible
- Manual or automatic backups with security more stringent than federal law dictates—you have total control over what data gets stored, when, and how often it gets done

To find out more about any of these services,  
please call toll free (866) 712-9584.



Dental  
Wellness  
Partners<sup>SM</sup>

#### **How to Contact Us**

DWP is committed to providing excellent service and support. If you have questions or need assistance, please contact us. Customer service is available Monday through Friday, 8:00 a.m. to 5:30 p.m. Eastern.

Phone: 866-335-4892

Fax: 866-335-4893

E-mail: [info@dwp-llc.com](mailto:info@dwp-llc.com)



Dental  
Wellness  
Partners<sup>SM</sup>

Dental Wellness Partners  
1502 W Edgewood Ave, Suite F  
Indianapolis, IN 46217

Phone: 866-335-4892

Fax: 866-335-4893

E-mail: [info@dwp-llc.com](mailto:info@dwp-llc.com)

[www.dwp-llc.com](http://www.dwp-llc.com)

***NETWORK ACCESS AGREEMENT***  
***BY AND BETWEEN***  
***DENTAL WELLNESS PARTNERS, LLC***  
***AND***  
***XYZ Insurance Company***

***April 24, 2009***

## **AGREEMENT**

This Agreement is entered into by Dental Wellness Partners, LLC (hereinafter referred to as “DWN”) and XYZ Insurance Company (hereinafter referred to as “Company”). Hereafter, DWN and Company may be collectively referred to as the “parties”.

DWN provides a Preferred Provider Network known as the DWN network of dentists.

Company wishes to utilize the network for the use of its individual Customers and group Customers (collectively referred to as “Customer(s)”).

Therefore, DWN and Company mutually agree to the provisions and covenants as follows:

### **I. DUTIES AND OBLIGATIONS OF DWN**

- 1.1 DWN has established and will maintain a network of dentists to provide services to Company’s Members.
- 1.2 DWN will make available to Company through standard means as outlined in the DWN Technical Guide (Attachment C) a current list of dentists participating in the network and updates containing changes to the network. Company has the ability to access the dentist listing and updates at-will through the DWN Administrator Portal as outlined in the Technical Guide. Company will access and load updated provider listings to its system at least once per month, with a recommendation that new updates are loaded twice per month, after the first and fifteenth of each month.
- 1.3 DWN will provide Company with the DWN Fee Schedules paid to participating dentists. The Fee Schedules shall be updated annually and dental fees may be increased starting January 1 of each year. Company will be informed of fee increases approximately 30 days prior to the effective date.
- 1.4 DWN will uphold and enforce the terms and conditions as set forth in the DWN Credentialing Policy and Procedure Document (Attachment B), with respect to network providers utilized by Company.

### **II. DUTIES AND OBLIGATIONS OF COMPANY**

- 2.1 Company acknowledges that it is authorized to contract for DWN’s services on behalf of its Customer(s).
- 2.2 Company agrees to notify DWN of new Customers by providing contract holder enrollment counts and, when applicable, group names to DWN prior to their effective date.
- 2.3 Company agrees to have full responsibility for confirming benefits and eligibility, when appropriate to both Customers and dentists as needed, and to include its 800 number on Customer ID cards.
- 2.4 When applicable, Company agrees to utilize its best and timely efforts in the receipt and processing of claims, and of requesting funding for eligible claims, and of the release of payment for eligible claims once received from the applicable health plans by Company.
- 2.5 Company agrees to provide access so Customers may obtain information of any changes to the network including additions and deletions of dentists and notify patients of the advantages of using

network providers.

- 2.6 Company agrees to download or accept, and promptly implement, all DWN Network Updates and Fee Schedule changes. Annual Fee Schedule Updates will be loaded within 60 days of receipt but not later than their effective date.
- 2.7 DWN and/or its agent shall have the right, with forty eight (48) hours written notice to Company, and at a time mutually convenient for the parties, to audit the books and records of Company that pertain to business specific to the utilization of the DWN network and to conduct such investigation only as necessary to verify the fees payable to DWN for any period during the term of this Agreement.
- 2.8 Company agrees that it will utilize the DWN network for self insured dental plans, fully insured dental plans, third party administrator activity, preferred provider organization purposes, and access or discount card product offerings, where DWN is the primary dental network utilized and offered. Company agrees that it will not resell, lease, sublease or in any other fashion offer the DWN network or services for a profit or otherwise to a non-affiliated entity, without prior written approval from DWN. Company acknowledges the importance of DWN wishing to maintain control over its network and agrees it will not utilize the DWN network for any other purpose than above stated outside of Renaissance Holding Company, its subsidiaries and successor organizations.

### **III. FEES, PAYMENTS & SERVICES REQUESTED**

- 3.1 Network access fees (Attachment A) to be charged to the Company will be per Member per month, and are the responsibility of the Company. Network access fees will be based on the total number of eligible Members who have access to the network. For the purpose of this Agreement, a "Member" is defined as an individual contract holder or employee who receives dental benefits or access to the DWN network under the terms of a contract or policy with Company. For the purposes of calculating network access fees for this Agreement, a "Member" does not include dependents and/or family members also covered under the contract or policy.
- 3.2 Company shall pay all network access fees within thirty (30) days of receipt of an invoice by DWN or be subject to an accrued interest rate of one and one half percent (1.5%) per month of late unpaid balances. Company agrees to pay all fees based on the actual number of Members enrolled in its plans for the applicable month regardless of the invoiced amount presented by DWN. In the event there remains a dispute with regard to the invoiced amount, this provision shall be unenforceable with regard to the assessment and collection of interest for the amount in dispute.
- 3.3 Company agrees to pay DWN the direct costs associated with the printing and distribution of directories and other printed materials provided by DWN, if requested by the Company.
- 3.4 The parties agree and acknowledge the DWN network access fees may not be adjusted for the initial term of this Agreement unless agreed to in writing by both parties.

### **IV. PROPRIETARY RIGHTS**

- 4.1 The parties to this agreement are and will remain independent contractors of each other.
- 4.2 Company and its group(s) acknowledge DWN is the exclusive owner of the network.

- 4.3 Customer(s) of the Company shall use the DWN network solely for the purposes of this Agreement during the term. Upon termination of this Agreement, Company, its Customer(s), its Members, employees, subsidiaries or agents may not continue to use the DWN network or parts thereof as prescribed in this Agreement. This does not preclude Company and/or its group(s) from using other organized independent dental networks, which may happen to contain any or all providers in the DWN network.
- 4.4 Each party to this Agreement agrees to keep information obtained from the other party confidential and not use or share such information for any purpose other than for the mutual benefit of Company and/or its Customer(s) and DWN. Neither party will (except to the extent expressly authorized by this Agreement) disclose Confidential Information of the other party to anyone outside of Company or DWN, nor will either party copy or reproduce any Confidential Information of the other party unless expressly authorized to do so by such party in writing. Each party will disclose Confidential Information of the other party only to its employees who have a need to know the Confidential Information in order to accomplish the purpose of this Agreement and who (i) have been informed of the confidential and proprietary nature of the Confidential Information, and (ii) have agreed not to disclose it to others. In order to preserve and protect the confidential or proprietary nature of any Confidential Information and to prevent it from falling into the public domain or into the possession of persons not bound to maintain its confidentiality, each party will handle the Confidential Information of the other party with the same degree of care that it applies with respect to its own information that it considers as confidential and proprietary, but in no event with less than reasonable care.
- 4.5 Subject to DWN's prior review and written approval in each case, DWN hereby grants to the Company the right to use such names, logos, or trade names as DWN may designate from time to time in connection with the Company's marketing and promotional activities (e.g. ID cards, information materials provided by Company to Members, advertising, website information, etc.).

## V. TERMS AND TERMINATION

- 5.1 This Agreement shall become effective on May 1, 2009, and shall continue for an initial term of thirty six (36) months unless terminated, modified or amended according to the terms contained herein. Thereafter, the term of this Agreement will automatically extend for successive twelve (12) month terms, unless earlier terminated.
- 5.2 Notwithstanding anything contained in this Agreement to the contrary, either party may terminate this Agreement at any time: (i) without cause upon one hundred eighty (180) days' prior written notice; and (ii) with cause if the breaching party receives prior written notice of breach and fails to cure such breach within thirty (30) days of the receipt of notice.
- 5.3 Company is responsible for promptly informing its Customer(s) of a termination by either party.

## VI. GENERAL PROVISIONS

- 6.1 Assignment. Either party hereunder shall not assign this Agreement or any rights without prior written consent of the other.
- 6.2 Independent Contractor. Nothing contained herein shall be construed to create the relationship of employer/employee, partner, joint venture or principal/agent between the parties hereto. Company shall be and remain an independent contractor, solely responsible for its Customer(s), its employees





the State of Michigan.

- 6.10 Practice of Dentistry. It is expressly understood that neither DWN nor Company is a provider of dental care services. Neither party shall be held liable for the acts, omissions, representations or other conduct of any such provider of dental care services, and such providers will be solely and exclusively responsible for the quality and level of frequency of dental services provided. DWN shall establish criteria and shall select providers to participate in the DWN network. DWN agrees that the Company is not involved in and has no responsibility for selection of credentialing of DWN network dentists or for the negotiation of any alternative payment arrangements.
- 6.11 Multiple Copies. This Agreement may be executed in multiple copies, each of which will be deemed an original and all of which taken together shall constitute one original, and may be executed in counterparts as if the parties have signed a single instrument.
- 6.12 Modification or Waiver. No modifications or waiver of any provision of this Agreement or any right or duty hereunder will be effective for any purpose unless in writing, and signed by the party against whom such modification or waiver is sought to be enforced. The waiver of any breach of any provision of this Agreement will not be construed to be a waiver of any succeeding breach of the same or any other provision of this Agreement.

*Signature Page To Follow*

**EXECUTION OF AGREEMENT**

**XYZ Insurance Company**  
123 Main Street  
Anytown, USA 12345-6789

**Dental Wellness Partners, LLC**  
4100 Okemos Road  
Okemos, Michigan 48864

BY: \_\_\_\_\_  
Officer

BY: \_\_\_\_\_  
Officer

TITLE: Officer

TITLE: Officer

DATE: April 24, 2009

DATE: April 24, 2009

**ATTACHMENT A**

**NETWORK ACCESS FEES**

The network access fee shall be \$0.XX per member per month.

**ATTACHMENT B**

**CREDENTIALING POLICY AND PROCEDURE DOCUMENT**

**ATTACHMENT C**

**TECHNICAL GUIDE**

SERFF Tracking Number: RENA-126310461 State: Arkansas  
 Filing Company: Renaissance Life & Health Insurance Company State Tracking Number: 43537  
 of America  
 Company Tracking Number:  
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
 Product Name: RLHICA-DWN Informational PPO Notification  
 Project Name/Number: RLHICA-DWN Informational PPO Notification/RLHICA-DWN Informational PPO Notification

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Flesch Certification	Accepted for Informational Purposes	09/25/2009
<b>Bypass Reason:</b>	These are not consumer forms, therefore they do not require readability certification.		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Application	Accepted for Informational Purposes	09/25/2009
<b>Bypass Reason:</b>	This is not a policy filing.		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Cover Letter	Accepted for Informational Purposes	09/25/2009
<b>Comments:</b>			
<b>Attachment:</b>	DWN Informational Cover Letter 9-18-09.pdf		



**Renaissance**<sup>SM</sup>

Life & Health Insurance Company of America

September 18, 2009

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, AR 72201-1904

**Re: Renaissance Life & Health Insurance Company of America (N.A.I.C. No. 61700)  
FEIN# 47-0397286, Group No. 0477  
Dental Wellness Network, LLC  
Notification of Use of Dental PPO Network  
SERFF Tracking Number – RENA-**

Dear Sir or Madam:

Upon contacting your offices to inquire if any registration was required to use a Dental PPO network in your state, we were informed that an informational notification is required. It is our intention to utilize Dental Wellness Network, LLC in your state in coordination with our filed and approved PPO products. We are submitting the following items in SERFF for your records:

1. A copy of a sample agreement between Dental Wellness Network, LLC and insurer that allows the insurer to utilize DWN's network; and
2. A copy of the contract and application used by DWN to recruit providers.

Please note that although this filing was submitted under Group, it will also be used for our individual products, but both options could not be selected at the same time.

Should you have any questions or require any additional information, please contact me directly at (517) 347-5352, or by e-mail at [ephillips@renaissancefamily.com](mailto:ephillips@renaissancefamily.com). Thank you for your assistance.

Sincerely,

Errick Phillips  
Regulatory Specialist  
Renaissance Life & Health Insurance Company of America

Enclosures