Renaissance℠
Life & Health Insurance Company of America

Renaissance
Group Vision Policy

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

V-100A-2014-NC

RENAISSANCE
GROUP VISION 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
Customer Service Direct Line: 1-800-894-4532

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

Renaissance Life & Health Insurance Company of America
Renaissance Group Vision Policy – Choice Plan

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, exceptions, limitations and exclusions of this Policy as set forth herein.

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

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

C. **Group Number:** MP0000137765 – 10/25 Plan C 150

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

All full-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 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 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. **Covered Services:**

RLHICA will provide vision care Benefits according to the Schedule listed below. This Schedule lists the vision care Benefits to which Covered Persons of Renaissance Life & Health Insurance Company of America ("RLHICA") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. Administrative Services for the adjudication of claims and the payment of Benefits under this Policy will be provided by Vision Service Plan Insurance Company ("VSP"), using a VSP network of Providers. VSP is sometimes referred to as

the claims administrator for this Policy. If Benefits are available for Out-of-Network Provider services, as indicated by the reimbursement provisions below, Benefits may be received from any licensed eye care provider whether an In-Network or Out-of-Network Provider. This Schedule forms a part of the Policy to which it is attached.

In-Network Providers are those Providers who have agreed to participate in the VSP Choice Network.

When Benefits are received from In-Network Providers, Benefits appearing in the In-Network Benefit column below are applicable subject to any applicable Copayments and other conditions, limitations and/or exclusions as stated below. When Benefits are received from Out-of-Network Providers, the Covered Person is reimbursed for such Benefits according to the schedule in the Out-of-Network Provider Benefit column below, less any applicable Copayment. The Covered Person pays the Provider the full fee at the time of service and submits an itemized bill to RLHICA's claims administrator for reimbursement. Discounts do not apply for Benefits obtained from Out-of-Network Providers.

COPAYMENT

Benefits received from In-Network Providers and Out-of-Network Providers require Copayments.

There shall be a Copayment of $10.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional $25.00 Copayment payable at the time materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

Lens Options, if covered under this Policy, may have a separate Copayment. Please refer to COVERED SERVICES AND MATERIALS, below.

BENEFITS – PPO AND NON-PPO PROVIDERS

COVERED SERVICE OR MATERIAL	PPO PROVIDER BENEFIT	NON-PPO PROVIDER BENEFIT	FREQUENCY
Eye Examination	Covered in full*	Up to $ 45.00*	Available once every calendar year**
Complete initial vision analysis: includes appropriate examination of visual functions and prescription of corrective eyewear where indicated.			
*Less any applicable Copayment. **Beginning with the first date of service.			

COVERED SERVICE OR MATERIAL	PPO PROVIDER BENEFIT	NON-PPO PROVIDER BENEFIT	FREQUENCY
LENSES			Available once every calendar year**
Single Vision	Covered in full *	Up to $ 30.00*	
Lined Bifocal	Covered in full *	Up to $ 50.00*	
Lined Trifocal	Covered in full *	Up to $ 65.00*	
Lenticular	Covered in full *	Up to $ 100.00*	
Benefits for lenses are per complete set, not per lens.			
*Less any applicable Copayment. **Beginning with the first date of service.			

COVERED SERVICE OR MATERIAL	PPO PROVIDER BENEFIT	NON-PPO PROVIDER BENEFIT	FREQUENCY
FRAMES	Covered up to Plan Allowance*	Up to $ 70.00`*	Available once every calendar year**
Benefits for lenses and frames include reimbursement for the following necessary professional services:			
1. Prescribing and ordering proper lenses; 2. Assisting in frame selection; 3. Verifying accuracy of finished lenses; 4. Proper fitting and adjustments of frames; 5. Subsequent adjustments to frames to maintain comfort and efficiency; 6. Progress or follow-up work as necessary.			
*Less any applicable Copayment. **Beginning with the first date of service.			

COVERED SERVICE OR MATERIAL	PPO PROVIDER BENEFIT	NON-PPO PROVIDER BENEFIT	FREQUENCY
CONTACT LENSES			
Necessary			Available once every calendar year**
Professional Fees/Materials	Covered in full*	Up to $ 210.00*	
Elective	Elective Contact Lens fitting and evaluation*** services are covered in full once every calendar year**, after a maximum $ 60.00 Copayment.		Available once every calendar year**
	Materials Up to $ 150.00	**Professional Fees/Materials** Up to $ 105.00	

*Less any applicable Copayment.
**Beginning with the first date of service.

Necessary Contact Lenses are a Covered Services when specific benefit criteria are satisfied and when prescribed by Covered Person's In-Network Provider or Out-of-Network Provider. Review and approval by RHLICA's claims administrator is not required for Covered Persons to be eligible for Necessary Contact Lenses.

Contact Lenses are provided in lieu of all other lens and frame benefits available herein.
When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again until the next calendar year.

COVERED SERVICE OR MATERIAL	PPO PROVIDER BENEFIT	NON-PPO PROVIDER BENEFIT	FREQUENCY
LOW VISION			
Professional services for severe visual problems not correctable with regular lenses, including:			
Supplemental Testing (Includes evaluation, diagnosis and prescription of vision aids where indicated.)	Covered in full	Up to $ 125.00	*
Supplemental Aids	75% of amount up to $ 1000.00*	75% of amount up to $ 1000.00*	*

*Maximum benefit for all Low Vision services and materials is $ 1000.00 every two (2) years.

Low Vision benefits secured from Out-of-Network Providers (if covered) are subject to the same time and Copayment provisions described above for In-Network Providers. The Covered Person should pay the Out-of-Network Provider's full fee at the time of service. Covered Person will be reimbursed an amount not to exceed what would be paid to an In-Network Provider for the same services and/or materials.

THERE IS NO ASSURANCE THAT THE AMOUNT REIMBURSED WILL COVER 75% OF THE PROVIDER'S FULL FEE.

EXCEPTIONS AND REDUCTIONS BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their In-Network Provider or by calling the Member Services Department at 1-800-877-7195.

PATIENT OPTIONS

This Plan is designed to cover visual needs rather than cosmetic materials. When the Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and the Covered Person will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

NOT COVERED

There are no Benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (less than a ± .50 diopter power).
- Two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Plan that are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an Experimental Nature.
- Costs for services and/or materials above stated allowances.
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where RLHICA or its claims administrator is required by law to pay.
- Replacement of lost or damaged contact lenses, except at the normal intervals when services are otherwise available.

F. Rate:

Employee only - $5.52 per month per Certificate Holder.

Employee plus Spouse - $10.47 per month per Certificate Holder.

Employee plus Child(ren) - $11.00 per month per Certificate Holder.

Employee plus Family - $16.19 per month per Certificate Holder.

Rates are contingent upon Minimum Enrollment—as agreed upon by and between RLHICA and the Policyholder—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.

G. Benefit Year:

The Benefit Year shall be based on Calendar Year, January 1 to December 31.

Section II. Definitions

A. **Additional Benefit Rider –** means a document, attached as a rider to this Policy (when purchased by the Policyholder) which lists selected supplemental vision care services and vision care materials which a Covered Person is entitled to receive under this Policy. Additional Benefits are only available when purchased by the Policyholder in conjunction with the Benefit designs offered in the Declarations Section.

B. **Assignment of Benefits –** means a written order signed by a Covered Person eighteen (18) years of age or older and included with each claim, directing RLHICA's claims administrator to pay available Benefits to a named Non-PPO Provider.

C. **Benefit Authorization –** means a process used to confirm eligibility of an individual named as a Covered Person and identifying those Benefits to which the Covered Person is entitled.

D. **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.

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

F. **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 of the Certificate Holder who has not yet reached the end of the calendar year of his or her 26th birthday; or

2. A Child of the Certificate Holder who: (a) is under the age of 26; (b) is a full-time student; (c) is dependent upon the Certificate Holder or the Certificate Holder's Legal Spouse for support; (d) does not have coverage, other than coverage as a dependent, under another vision insurance plan; or,

3. A Child of the Certificate Holder or the Certificate Holder's Legal Spouse if, pursuant to a court decree, the Certificate Holder or the Certificate Holder's Legal Spouse is financially responsible for the vision care of the child; or

4. A Child of the Certificate Holder who has reached the end of the calendar year of his or her 26th 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.

G. **Certificate** – means a summary of the provisions of this Policy, prepared by RLHICA and provided to the Policyholder for distribution to Certificate Holders.

H. **Certificate Holders (also referred to as Enrollees) –** 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.

I. **Complaints and Grievances** – means disagreements regarding access to care, quality of care or treatment and services to be covered hereunder.

J. **Confidential Information** – means all confidential materials concerning the medical, personal, financial and business affairs of Covered Persons acquired by RLHICA in the course of providing the Benefits hereunder.

K. **Copayment –** means those amounts required to be paid by or on behalf of a Covered Person for vision services and materials which are not fully covered, and which are payable at the time services are rendered or materials are ordered.

L. **Covered Person –** means a Certificate Holder or Eligible Dependent (if dependent coverage is selected), who meets the eligibility criteria and on whose behalf premiums have been paid to RLHICA, and who is covered under this Policy.

M. **Covered Service(s) –** means the unique vision care service(s) and vision care materials selected for coverage as described in the Declarations Section and subject to the terms and conditions of this Policy.

N. **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.

O. **Foster Children** -- Foster child means a minor (i) over whom a guardian has been appointed by the clerk of 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.

P. **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 ; or (c) the Domestic Partner of the Certificate Holder, so long as the requirements listed in the Declarations Section are met and proof that those requirements are met is provided to RLHICA at its request.

Q. **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.

R. **Non-PPO Provider**– means a Provider who has not entered into a contract to provide Covered Services for pre-negotiated fees.

S. **Open Enrollment Period –** means the period of time as determined by the Policyholder, which shall be no less than 30 days, during which an eligible person as indicated in the Declarations Section may enroll or be enrolled to receive Benefits.

T. **Policy –** means this document, under which Certificate Holders and their Eligible Dependents (if dependent coverage is selected), are entitled to become Covered Persons and receive Benefits in accordance with the terms hereof. The Policy includes, if applicable, the Policyholder Application, the Certificate and any appendices, supplements, riders, successor agreements, or renewals now or hereafter issued or executed.

U. **Policyholder –** means the employer, organization, or plan sponsor who holds the contract with RLHICA to provide coverage for its Certificate Holders and Eligible Dependents (if dependent coverage is selected).

V. **Policyholder Application –** means the form signed by an authorized representative of the Policyholder to apply for coverage under this Policy.

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

X. **PPO Provider** – means a preferred provider who has entered into a contract to provide Covered Services for pre-negotiated fees that the Provider has agreed to accept as payment in full. A current list of PPO Providers will be provided to each Certificate Holder.

Y. **Provider –** means an optometrist, optician or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials in the state or jurisdiction in which vision care services are rendered or vision care materials are provided.

Z. **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, under the paragraph captioned "Rates".

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

BB. **State of Delivery –** means the state in which this Policy is being issued, delivered or renewed.

CC. **Urgent Condition –** means a condition with sudden onset and acute symptoms which requires the Covered Person to obtain immediate care; or an unforeseen occurrence calling for immediate action.

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 eligible 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 or domestic partnership;

   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. For the special enrollment periods provided under ERISA Section 701(f)(3)(A)(i) and IRC Section 9801(f)(3)(A)(i), relating to the loss of coverage under a state Medicaid program or a subsidy under either of those programs under ERISA Section 701(f)(3)(A)(ii) and IRC Section 9801(f)(3)(A)(ii), the enrollment period will be 60 days following the loss of coverage under either state program or the date you are determined to be eligible for a premium assistance subsidy. For coverage under ERISA Section 701(f)(3)(A)(ii) and IRC Section 9801(f)(3)(A)(ii) on account of eligibility for a premium assistance subsidy, the group health plan must be "Qualified Employer-Sponsored Coverage," which means that (i) the Plan constitutes creditable coverage for HIPAA purposes, (ii) the Policyholder's contribution toward the cost of any premium or premium equivalent is at least 40 percent, and (iii) the coverage under the group health plan is available on a non-discriminatory basis under IRC Section 105(h);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 B 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 or 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.

Section IV. Continuation of Coverage

A. 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 . 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. In the event the Policyholder continues to provide eligibility information to RLHICA for a Covered Person during the COBRA election period, as opposed to terminating coverage and then retroactively reinstating the Covered Person upon the Covered Person's election of COBRA coverage, Policyholder shall be liable for any Benefits paid or Rates due during that period if the Covered Person ultimately does not elect COBRA coverage.

The monthly Rate that the Policyholder must pay on behalf of any individual who is provided coverage under this Section IV A 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 vision care Certificate as long as coverage is provided under this Section IV A. 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 A does not apply. Employers should consult with their legal counsel to determine how and when the law applies.

B. 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 IX of this Policy.

C. Continuation Coverage – Eligible Dependents

Eligible Dependents may elect to continue coverage under this Policy in the event of the divorce or 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.

D. 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 (if dependent coverage is selected) 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 in the Declarations Section.

Unless otherwise specified in the Declarations Section, Covered Services will be subject to the following terms and conditions:

A. General

This Policy provides Benefits for Certificate Holders and their Eligible Dependents, if dependent coverage is selected by the Policyholder.

B. Copayments for Covered Services

Any Copayments required under this Policy shall be the personal responsibility of the Covered Person receiving Benefits. Copayments are to be paid at the time services are rendered or materials ordered. Amounts which exceed the Policy allowances, annual maximum benefits or any other stated reductions are not considered Copayments, but are also the responsibility of the Covered Person.

C. Obtaining Covered Services from PPO Providers

To receive Covered Services from a PPO Provider, Covered Persons should select a PPO Provider, schedule an appointment and inform the Provider's office that they are a Covered Person under this Policy. The PPO Provider will then obtain a Benefit Authorization prior to the time services are rendered or materials ordered. RLHICA's claims administrator shall provide a Benefit Authorization to the PPO Provider. Each Benefit Authorization will contain an expiration date and must be used by the Covered Person to obtain Benefits prior to the date the Benefit Authorization expires. RLHICA's claims administrator shall issue Benefit Authorizations in accordance with the latest eligibility information furnished by Policyholder and the Covered Person's past service utilization, if any. Any Benefit Authorization so issued shall constitute a certification to the PPO Provider that payment will be made to the PPO Provider, irrespective of a later loss of eligibility of the Covered Person, as long as the services are rendered or materials provided prior to the Benefit Authorization expiration date. If a Covered Person receives Covered Services from a PPO Provider without a Benefit Authorization, any services or materials received from the PPO Provider will be treated as if they were obtained from a Non-PPO Provider. Covered Persons may obtain information on PPO Providers through our website www.RenaissanceDental.com, the Member Services toll-free number 1-800-877-7195 or by written request.

D. Obtaining Covered Services from Non-PPO Providers

If required by state law, or if purchased by the Policyholder, this Policy will provide Benefits for services and materials received from Non-PPO Providers, based on the Non-PPO Provider fee schedule. The Non-PPO Provider may bill Covered Persons for that Provider's standard rates, regardless of the amount of this Policy's Benefits. If a Covered Person is eligible for and obtains Benefits from a Non-PPO Provider, Covered Person remains liable for the Non-PPO Provider's full fee. Covered Persons or Non-PPO Providers may submit requests for reimbursement. RLHICA's claims administrator will pay available Benefits to Covered Persons, or directly to Non-PPO Providers when claims include a valid Assignment of Benefits. RLHICA's claims administrator may deny any claims received after one hundred and eighty (180) calendar days from the date services are rendered and/or materials provided.

If a Certificate Holder or an Eligible Dependent receive Covered Services from a Non-PPO Provider, Benefits may be less than the amount that would have otherwise been payable from a PPO Provider.

However, benefits for Covered Services received from a Non-PPO Provider will be paid as if received from a PPO Provider in the following situations:

1. If a Certificate Holder or an Eligible Dependent requires emergency treatment;.
2. If a Certificate Holder or Eligible Dependent receives Covered Services that are not of the type provided by any PPO Provider;
3. If a Certificate Holder or Eligible Dependent requires services to meet their health needs that cannot be provided by a PPO Provider without an unreasonable delay.

E. Urgent Vision Care

When vision care is necessary for Urgent Conditions, Covered Persons may obtain such care by contacting a PPO Provider or a non-PPO Provider (if Non-PPO benefits are available). Services for conditions of a medical nature are covered by RLHICA only under supplemental eye care plans. If Policyholder purchases one of these plans, such coverage will be evidenced by an Additional Benefit Rider attached hereto. If Policyholder has not purchased one of these plans, then Covered Persons are not covered by RLHICA for such care and should contact a physician under the Covered Persons' medical insurance plan for care. For situations of a non-medical nature, such as lost, broken or stolen glasses, Covered Person may call the Member Service's toll-free number 1-800-877-7195 for assistance. Reimbursement and eligibility are subject to the terms and conditions of this Policy.

Section VI. 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 address, 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

E. 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.

F. Complaints and Grievances

Complaints and Grievances may be submitted by Covered Persons in writing, by telephone, online or through Covered Persons' Provider, as explained in the Certificate for this Policy. All Complaints and Grievances will be resolved within thirty (30) calendar days following receipt unless special circumstances require an extension of time. Where such extension is required, Complaints and Grievances will be resolved as soon as possible, but not later than one hundred twenty (120) calendar days after receipt. If it is determined that a Complaint or Grievance cannot be resolved within thirty (30) calendar days, the Covered Person will be notified of the expected resolution date. Notification to the Covered Person will be made in writing of the final resolution of all Complaints and Grievances.

G. Claim Denial Appeals

If a claim is denied in whole or in part, under the terms of this Policy, a request may be submitted by the Covered Person or Covered Person's authorized representative for a full review of the denial. The Covered Person may designate any person, including their Provider, as their authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

1) Initial Appeal: All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. The Covered Person may review, during normal business hours, any documents held by RLHICA's claims administrator pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in the review. A response to the initial appeal, including specific reasons for the decision, shall be communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal.

2) Second Level Appeal: If a Covered Person disagrees with the response to the initial appeal of the denied claim, Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to within sixty (60) calendar days after receipt of the response to the initial appeal. Communication of a final determination to the Covered Person shall be provided within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. The communication to the Covered Person shall include the specific reasons for the determination.

3) Other Remedies: When a Covered Person has completed the appeals process provided for herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U.S. Department of Labor or the insurance regulatory agency for Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a) (1) (B) 29 U.S.C. 1132(a) (1) (B), a Covered Person has the right to bring a civil action when all available levels of review, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and Covered Person disagrees with the outcome of such appeals.

H. Time of Action

No action in law or in equity shall be brought to recover on this Policy prior to the Covered Person exhausting his/her rights under this Policy and/or prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of this Policy.

I. Insurance Fraud

Any Covered Person who intends to defraud, knowingly facilitates a fraud, submits a claim containing false or deceptive information, or who commits any other similar act as defined by applicable state or federal law is guilty of insurance fraud. Such an act is grounds for immediate termination of the coverage under this Policy of the Covered Person committing such fraud.

Section VII. Agreements

A. RLHICA Agrees:

1. To enroll for coverage, as directed by the Policyholder, each eligible person and his or her dependents (if dependent coverage has been selected).

2. 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 VII B.2;

3. To make payments in the following manner for Covered Services provided to the Certificate Holder and Eligible Dependents. RLHICA will send payment either to the Certificate Holder who is responsible for paying the Provider whatever he or she charges, or directly to the Provider if the Certificate Holder or Eligible Dependent has submitted an Assignment of Benefits for the Provider who rendered Covered Services under this Policy;

4. To hold in strictest confidence all Confidential Information and exercise its best efforts to prevent any of its employees or agents, from disclosing any Confidential Information, except to the extent that such disclosure is permitted or required under 45 CFR Part 160, 162 and 164 ("HIPAA Privacy Rule") and in accordance with applicable law;

5. 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;

6. 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;

7. To provide to the Policyholder, for submission to the Certificate Holder, a standard certificate of the Benefits provided pursuant to this Policy, as well as all privacy notices as may be required pursuant to any applicable federal or state laws;

8. 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, in a mutually agreed upon format and medium, of the total number and names of all Certificate Holders and, if applicable, all Eligible Dependents;

3. To advise RLHICA of eligibility changes in a timely fashion, including limiting retroactive eligibility changes to the month in which notification is received by RLHICA, plus two prior months. RLHICA may refuse retroactive termination of a Covered Person if Benefits have been obtained by, or authorized for, the Covered Person after the effective date of the requested termination.

4. To provide RLHICA with written notification of any changes that will significantly impact utilization of Benefits. Any such changes must be agreed upon by RLHICA.

5. 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;

6. 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;

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

8. 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 VIII. General Terms

A. Contesting Validity of Policy

After 2 years from the Effective Date, no misstatements in the Policyholder Application may be used to void the Policy or deny any claim for loss incurred or disability starting after the 2 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.

B. 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.

C. 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.

D. 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.

E. **Legal Actions**: No action on a legal claim arising out of or related to this Certificate will be brought until 60 days after the time written proof of loss is required to be given. No legal action can be more than three (3) years after the time written proof of loss was 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.

F. **Change of Beneficiary:** Unless the Certificate Holder makes and 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.

G. **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.

H. **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.

I. **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.

J. **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 IX. 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, at a premium rate specified in the renewal notice. 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 VII(A)7 of this Policy; or

C. The Policyholder fails to furnish RLHICA with accurate enrollment data pursuant to Section VII(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 VII(B)5; 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. 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 statues 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. 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.

A. Applicability

1. 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.

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

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

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

B. Definitions

1. "Allowable Expense" means an 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 for services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

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

3. "Plan" is any of these which provides benefits or services for vision care or treatment:

a. 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.

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

Each contract or other arrangement for coverage under (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.

4. "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.

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

C. Order Of Benefit Determination Rules

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

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

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

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

a. Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, member, or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

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

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

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

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

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

However, if the other Plan does not have the rule described in (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.

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

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

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

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

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

If the other Plan does not have this subparagraph 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.

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

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

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

D. Effect On The Benefits Of This Plan

1. When This Paragraph Applies. This Paragraph 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.

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

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

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

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

E. Right To Receive And Release Needed Information

Certain facts are needed to apply these COB rules. RLHICA's claims administrator 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's claims administrator need not tell, or get the consent of, any person to do this. Each person claiming Benefits under This Plan must give RLHICA's claims administrator any facts it needs to pay the claim.

F. Facility Of Payment

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, RLHICA's claims administrator 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's claims administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

G. Right Of Recovery

If the amount of the payments made by RLHICA is more than it should have paid under this COB provision, it may recover the excess from one or more of the following:

1. The persons it has paid or for whom it has paid;

2. Insurance companies; or

3. Other organizations.

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

A. This Policy constitutes the entire contract between the Policyholder and RLHICA. No agent has authority to change any part of this Policy or to waive any of its provisions. 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. All statements made by the Policyholder or by the Certificate Holders or Eligible Dependents, shall be deemed to be representations and not warranties.

C. If this Policy is in violation of the laws of the State of Delivery, 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. If any matter arises in connection with this Policy which becomes the subject of arbitration or legal process, the law of the State of Delivery shall be the applicable law.

D. RLHICA does not itself directly furnish vision care services or supply materials. Providers rendering services are independent contractors, and neither the Policyholder nor RLHICA will be liable for any act or omission of any Provider, his or her employees or agents or any person providing vision or other professional services under this Policy.

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

F. No materials will be published or distributed by the Policyholder concerning this Policy until the material is first approved by RLHICA.

G. 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.

H. RLHICA and Policyholder agree to defend, indemnify and hold harmless the other and its shareholders, directors, officers, agents and employees (who are acting in the course of their employment, but not as claimants) from any liability, claim, loss, injury, cause of action, 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 shareholders, directors, officers, agents or employees, unless liability for such act or omission is expressly assigned elsewhere in this Policy.

I. 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 vision records.

J. The RLHICA Board of Directors or its delegee will establish procedures for resolving all questions raised by a Provider, 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 Provider, 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 Section of this Policy.

K. 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.

L. 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.

M. 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.

N. 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.

O. 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 Provider 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.

P. 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:  DATE: January 1, 2022

President and CEO

POLICYHOLDER

BY: _____ BY: _____

Authorized Signature Witnessed By

TITLE: _____ TITLE _____

DATE: _____ DATE: _____

ADDITIONAL BENEFIT RIDER

SUPPLEMENTAL PRIMARY EYECARE PLAN

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of Renaissance Life & Health Insurance Company of America ("RLHICA") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. Plan Benefits under the Supplemental Primary EyeCare Plan are available to Covered Persons only after all other benefits under their group medical plan have been exhausted, or when Covered Person is not covered under a group medical plan. This Rider forms a part of the Policy and Certificate of Coverage to which it is attached.

The Supplemental Primary EyeCare Plan is designed for the detection, treatment and management of ocular conditions and/or systemic conditions that produce ocular or visual symptoms. Under the Plan, Eyecare Professionals provide treatment and management of urgent and follow-up services. Primary EyeCare also involves management of conditions that require monitoring to prevent future vision loss.

The Eyecare Professional is responsible for advising and educating patients on matters of general health and prevention of ocular disease. If consultation, treatment, and/or referral are necessary, it is the responsibility of the Eyecare Professional, to manage and coordinate on behalf of the patient to assure appropriateness of follow-up services.

Covered Persons with the following symptoms and/or conditions (see DEFINITIONS, below) will be covered for certain Primary EyeCare services in accordance with the optometric scope of licensure in the Eyecare Professional's state.

SYMPTOMS

Examples of symptoms which may result in a patient seeking services on an urgent basis under the Primary EyeCare Plan include, but are not limited to:

- ocular discomfort or pain
- transient loss of vision
- flashes or floaters
- ocular trauma
- diplopia
- recent onset of eye muscle dysfunction
- ocular foreign body sensation
- pain in or around the eyes
- swollen lids
- red eyes

CONDITIONS

Examples of conditions which may require management under the Primary EyeCare Plan include, but are not limited to:

- ocular hypertension
- retinal nevus
- glaucoma
- cataract
- pink-eye
- macular degeneration
- corneal dystrophy
- corneal abrasion
- blepharitis
- sty

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated.

ELIGIBILITY

Covered Persons as defined in the Policy and Certificate are eligible for coverage when the Supplemental Primary EyeCare Plan is purchased.

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated.

COPAYMENT

A Copayment amount of $10.00 shall be payable by the Covered Person at the time of each Supplemental Primary EyeCare office visit.

PLAN BENEFITS

SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT*
Eye Examination	Covered in full, less Copayment	Up to current Out-of-Network Schedule of Allowances
Consultation	Covered in full, less Copayment	Up to current Out-of-Network Schedule of Allowances
Urgent/Emergency Care	Covered in full, less Copayment	Up to current Out-of-Network Schedule of Allowances
Special Ophthalmological Services	Covered in full, less Copayment	Up to current Out-of-Network Schedule of Allowances
Eye and Ocular Adnexa Services	Covered in full, less Copayment	Up to current Out-of-Network Schedule of Allowances
*Services from an Out-of-Network provider are in lieu of services from an In-Network Provider. There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full. RLHICA's claims administrator is unable to require Out-of-Network Providers to adhere to its quality standards.		

IN-NETWORK PROVIDER REFERRALS

The In-Network Provider will refer the Covered Person to another doctor under the following circumstances:

1. If the Covered Person requires additional services which are covered by the Primary EyeCare Plan but cannot be provided in the In-Network Provider's office, the Provider will refer the Covered Person to another In-Network Provider or to a physician under the Group's medical plan whose offices provide the necessary services.
2. If the Covered Person requires services beyond the scope of the Supplemental Primary EyeCare Plan, the In-Network Provider will refer the Covered Person to a physician under the Group's medical plan.

Referrals are intended to ensure that Covered Persons receive the appropriate level of care for their presenting condition. Covered Persons do not require a referral from an In-Network Provider in order to obtain Plan Benefits.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Primary EyeCare Plan is designed to cover Primary EyeCare services only. There is no coverage provided under the Policy for the following:

- Costs associated with securing materials such as lenses and frames.
- Orthoptics or vision training and any associated supplemental testing.
- Surgical or pathological treatment.
- Any eye examination, or any corrective eyewear required by an employer as a condition of employment.
- Medication.
- Pre- and post-operative services.
- Services and/or materials not indicated on this Rider as covered Plan Benefits.
- Frames, spectacle lenses, contact lenses or any other ophthalmic materials
- Surgery, and any pre- or post-operative services, except as an ocular adnexa service included herein.
- Treatment for any pathological conditions.
- Insulin or any medications or supplies of any type.
- Local, state and/or federal taxes, except where RLHICA or its vision administrator is required by law to pay.

DEFINITIONS

Blepharitis	Inflammation of the eyelids.
Cataract	A cloudiness of the lens of the eye obstructing vision.
Conjunctiva	The mucous membrane that lines the inner surface of the eyelids and is continued over the forepart of the eye.
Corneal Abrasion	Irritation of the transparent, outermost layer of the eye.
Corneal Dystrophy	A disorder involving nervous and muscular tissue of the transparent, outermost layer of the eye.
Diplopia	The observance by a person of seeing double images of an object
Eyecare Professional	Any duly licensed optometrist, ophthalmologist or other doctor of medicine (M.D.), or doctor of osteopathy (O.D.).
Eye Muscle Dysfunction	A disorder or weakness of the muscles that control the eye movement.
Flashes or Floaters	The observance by a person of seeing flashing lights and/or spots.
Glaucoma	A disease of the eye marked by increased pressure within the eye which causes damage to the optic disc and gradual loss of vision.
Macula	The small, sensitive area of the central retina, which provides vision for fine work and reading.
Macular Degeneration	An acquired degenerative disease which affects the central retina.
Ocular	Of or pertaining to the eye or the eyesight.
Ocular Conditions	Any condition, problem, or complaint relating to the eyes or eyesight.
Ocular Hypertension	Unusually high blood pressure within the eye.
Ocular Trauma	A forceful injury to the eye due to a foreign object.
Pink eye	An acute, highly contagious inflammation of the conjunctiva.
Retinal Nevus	A pigmented birthmark on the sensory membrane lining the eye that receives the image formed by the lens.
Systemic Condition	Any condition or problem relating to a person's general health.
Sty	An inflamed swelling of the fatty material at the margin of the eyelid.
Transient Loss of Vision	Temporary loss of vision.

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.	