GEORGIA

CERTIFICATES OF INSURANCE

UBA VISION

Access Your Member Portal
https://members.ubaapplication.com
for Claim Forms, ID Cards and more.

CERTIFICATES OF INSURANCE
INCLUDED IN THIS PDF

	PAGE #S	GROUP CERTIFICATES OF INSURANCE
	02-26	Group Vision Insurance Certificates of Insurance underwritten by: Renaissance Life & Health Insurance Company of America

ATTENTION PLEASE

READ CAREFULLY FOR ALL LIMITATIONS, EXCLUSIONS, AGE LIMITS, DEFINITIONS AND SCHEDULE OF BENEFITS.
CALL **866-438-4274** WITH ANY QUESTIONS.

Renaissance®
Life & Health Insurance Company of America

Renaissance
Group Vision PPO Certificate

United Business Association

This Certificate Contains Copayments and other Cost Sharing Arrangements which may vary depending on whether services are received from a Preferred Provider or Non-Preferred Provider.

P.O. Box 30381 • Lansing, Michigan 48909-7881 • 888-358-9484 (TTY users call 711)•
www.RenaissanceDental.com

V-200A-2017-GA

RENAISSANCE

GROUP VISION PPO CERTIFICATE

Table of Contents

I. Renaissance Group Vision PPO Certificate 7

II. Definitions 7

III. General Eligibility Rules 9

IV. Benefits 10

V. Accessing Your Benefits 11

VI. Questions and Answers 11

VII. Coordination of Benefits 12

VIII. Claim Denial Appeals 15

IX. Termination of Coverage 16

X. Continuation of Coverage 16

XI. General Conditions 17

Important Cancellation Information – Please Read Section IX Entitled, "Termination of Coverage"

NOTE: This Group Vision PPO Certificate should be read in conjunction with the Summary of Vision Plan Benefits that is provided with the Certificate. The Summary of Vision Plan Benefits lists the specific provisions of your group vision plan. Your group vision plan is a legal contract between the Policyholder and Renaissance Life & Health Insurance Company of America ("RLHICA").

READ YOUR GROUP VISION PPO CERTIFICATE CAREFULLY

Renaissance Life & Health Insurance Company of America
Summary of Vision Plan Benefits – Choice Plan
For Group# 90112
United Business Association

This Summary of Vision Plan Benefits is part of, and should be read in conjunction with your Group Vision Certificate. Your Group Vision Certificate will provide you with additional information about your RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF AMERICA ("RLHICA") coverage, including information about exclusions and limitations.

Benefit Year – October 1 through September 30

Covered Services

RLHICA will provide vision care Benefits according to the Schedule listed below. This Summary lists the vision care Benefits to which Covered Persons of 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 Plan 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 Plan. If Benefits are available for Non-Preferred Provider services, as indicated by the reimbursement provisions below, Benefits may be received from any licensed eye care provider whether a Preferred or Non-Preferred Provider. This Summary forms a part of the Certificate to which it is attached.

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

When Benefits are received from Preferred Providers, Benefits appearing in the Preferred 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 Non-Preferred Providers, the Covered Person is reimbursed for such Benefits according to the schedule in the Non-Preferred 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 Non-Preferred Providers.

Copayment

Benefits received from Preferred Providers and Non-Preferred 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 Certificate, may have a separate Copayment. Please refer to COVERED SERVICES AND MATERIALS, below.

BENEFITS – PREFERRED AND NON-PREFERRED PROVIDERS

COVERED SERVICE OR MATERIAL	PREFERRED PROVIDER BENEFIT	NON-PREFERRED PROVIDER BENEFIT	FREQUENCY
Eye Examination	Covered in full*	Up to $45.00*	Available once every 12 Months**
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	PREFERRED PROVIDER BENEFIT	NON-PREFERRED PROVIDER BENEFIT	FREQUENCY
LENSES			Available once every 12 Months**
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	PREFERRED PROVIDER BENEFIT	NON-PREFERRED PROVIDER BENEFIT	FREQUENCY
FRAMES	Covered up to Plan Allowance*	Up to $70.00*	Available once every 12 Months**
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	PREFERRED PROVIDER BENEFIT	NON-PREFERRED PROVIDER BENEFIT	FREQUENCY
CONTACT LENSES			
Necessary			Available once every 12 Months**
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 12 Months**
	Materials Up to $130.00	**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 Preferred Provider or Non-Preferred Provider. Review and approval by RHLICA's claims administrator is not required for Covered Person 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 for 12 Months.

COVERED SERVICE OR MATERIAL	PREFERRED PROVIDER BENEFIT	NON-PREFERRED 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 Non-Preferred Providers (if covered) are subject to the same time and Copayment provisions described above for Preferred Providers. The Covered Person should pay the Non-Preferred Provider's full fee at the time of service. Covered Person will be reimbursed an amount not to exceed what would be paid to a Preferred Provider for the same services and/or materials.

EXCLUSIONS AND LIMITATIONS OF 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 Preferred 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.

BENEFITS – AFFILIATE PROVIDERS

GENERAL

Affiliate Providers are providers of Covered Services and materials who are not contracted as Preferred Providers but who have agreed to bill RLHICA's claims administrator directly for Covered Services provided pursuant to this Schedule. However, some Affiliate Providers may be unable to provide all Covered Services included in this Schedule. Covered Persons should discuss requested services with their Provider or contact the Member Services Department for details.

COPAYMENT

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 the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

COVERED SERVICES AND MATERIALS

Eye Examination	Covered in full *	Available once every 12 Months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

Spectacle Lenses Single Vision, Lined Bifocal or Lined Trifocal	Covered in Full*	Available once every 12 Months**
Frames	Covered up to the Plan allowance*	Available once every 12 Months**

CONTACT LENSES

Elective Contact Lenses (Materials Only)	Up to $105.00	Available once every 12 Months**

The Elective Contact Lens fitting and evaluation services are covered in full once every 12 Months, after a maximum $[60.00] Copayment.

Necessary Contact Lenses	Up to $210.00*	Available once every 12 Months**

Necessary Contact Lenses are a Covered Service when specific benefit criteria are satisfied and when prescribed by

Covered Person's Provider. Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

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

When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again until the next 12 months.

LOW VISION

Professional services for severe visual problems not correctable with regular lenses, including:

Supplemental Testing: Up to $ 125.00†
-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of Affiliate Provider's fee up to $1000.00†

†Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period

Low Vision Services are a Covered Service when specific benefit criteria are satisfied and when prescribed by Covered Person's Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for Preferred Providers shall also apply to services rendered by Affiliate Providers.

2. Services from an Affiliate Provider are in lieu of services from a Preferred Provider or a Non-Preferred Provider.

3. RLHICA's claims administrator is unable to require Affiliate Providers to adhere to its quality standards.

4. Where Affiliate Providers are located in membership retail environments, Covered Persons may be required to purchase a membership in such entities as a condition of obtaining Benefits.

Eligibility (Certificate Holder and Eligible Dependents) –All dues paying members in good standing are eligible for and elect coverage hereunder.

Also eligible are your Legal Spouse and any individuals who meet the definition of Child(ren) as set forth in you Group Vision Certificate.

Where two individuals are eligible under the same group policy 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 Certificate.

You pay the full cost of this coverage.

I. Renaissance Group Vision PPO Certificate

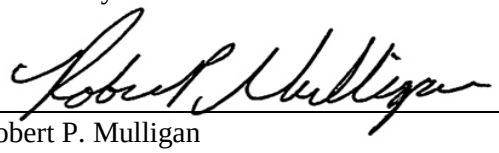
RLHICA issues this Renaissance Group Vision PPO Certificate to you, the Certificate Holder. The Certificate is a summary of your vision benefits coverage. It reflects and is subject to the agreement between RLHICA and your employer or organization (the "Policyholder").

The Benefits provided under This Plan may change if any state or federal laws change.

RLHICA agrees to provide Benefits as described in this Certificate.

All the provisions in the following pages, read in conjunction with the Summary of Vision Plan Benefits and all attachments and addendums, form a part of this document as fully as if they were stated over the signature below.

IN WITNESS WHEREOF, this Certificate is executed by an authorized officer of RLHICA.



Robert P. Mulligan
President and CEO

Home Office:

RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF AMERICA

Attn: Renaissance Administration
P.O. Box 30381
Lansing, Michigan 48909-7881

Administrative Direct Line: 1-800-745-7509
Customer Service Direct Line: 1-888-358-9484
(TTY users call 711)

II. Definitions

Additional Benefit Rider

Means a document, attached as a rider to this Certificate (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 Certificate.

Adverse Benefit Determination

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

Assignments 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-Preferred Provider.

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.

Benefit Year

Means the calendar year, unless your employer or organization elects a different Benefit Year. The Benefit Year is specified in the Summary of Vision Plan Benefits Section.

Benefits

Means payment for Covered Services.

Certificate

Means this document. RLHICA will provide vision Benefits as described in this Certificate. Any changes in this Certificate will be based on changes to the Policy. Changes to the Certificate may be set forth in the Summary of Vision Plan Benefits Section.

Certificate Holder

Means you, when your employer or organization certifies to RLHICA that you are eligible to receive Benefits under This Plan.

Children

Means your 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:

- Your child(ren) who has not yet reached the end of the calendar year of his or her 26th birthday; or
- Your child(ren) for whom you or your Legal Spouse are financially responsible for medical, health, or vision care under terms of a court decree; or,
- Your children who has not yet 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 if the disabled child was physically or mentally disabled before age 26. In the event that RLHICA denies a claim for the reason that the child has attained the Limiting Age for dependent children, you have the burden of establishing that the child continues to meet the two criteria specified above. If requested by RLHICA, you must submit medical reports confirming that the child meets the two criteria specified above.

Complaints and Grievances

Means disagreements regarding access to care, quality of care or treatment and services to be covered hereunder.

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.

Copayment

Means the dollar amount you must pay toward vision services or materials which are not fully covered, and which are payable at the time services are rendered or materials are ordered.

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 Certificate.

Covered Services

Means the unique vision care services and vision care materials selected for coverage by your employer or organization under This Plan. The Summary of Vision Plan Benefits Section lists your Covered Services.

Eligible Dependent

Means (a) your Legal Spouse; (b) your Child(ren); and (c) any other dependents who meet the criteria for eligibility set forth in the Summary of Vision Plan Benefits Section. If dependent coverage has been selected, it will be indicated in the Summary of Vision Plan Benefits Section.

Legal Spouse

Means a person who is any of the following: (a) your spouse through a marriage legally recognized by the State in which the Policy governing this Certificate was issued; or (b) your partner through a civil union legally recognized by the State in which the Policy governing this Certificate was issued.

Limiting Age

Means the age at which a Child of yours is no longer eligible for Benefits under This Plan pursuant to the definition of Child above.

Non-Preferred Provider

Means a Provider who has not entered into a contract to be part of the vision care network to provide Covered Services to Covered Persons.

Open Enrollment Period

Means the period of time during which an eligible person as indicated in the Summary of Vision Plan Benefits Section may enroll or be enrolled to receive Benefits.

Policy

Means the insurance contract for the provision of Benefits to you and your Eligible Dependents between RLHICA and your employer or organization. Policy includes, if applicable, the application, this Certificate and any appendices, supplements, riders, successor agreements or renewals now or hereafter executed.

Policy Year

Means the 12 month period beginning on the Effective Date of the Policy and each 12 month renewal period thereafter.

Preferred Provider

Means a Provider who has entered into a contract to be part of the vision care network and to provide Covered Services to Covered Persons. A current list of Preferred Providers will be made available to Certificate Holders.

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.

RLHICA

Means Renaissance Life & Health Insurance Company of America.

Summary of Vision Plan Benefits

Means a list of the specific provisions of This Plan and is a part of this Certificate.

This Plan

Means the vision coverage as provided for you and your Eligible Dependents pursuant to this Certificate.

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.

III. General Eligibility Rules

A. You are not eligible for Benefits unless you are either currently enrolled in This Plan or currently listed as an Eligible Dependent.

B. Effective Date of Eligibility

1. **Initial Effective Date**: All Certificate Holders and Eligible Dependents on the Effective Date of the Policy are immediately eligible for Benefits.

2. **After the initial Effective Date:** For all Certificate Holders (and their Eligible Dependents) not associated with the employer or organization on the initial Effective Date of the Policy, eligibility for Benefits will begin, unless otherwise stated as follows:

   a. Newly members: Date on which RLHICA approves the enrollment of the new member, or, if applicable, that date plus the number of days specified as a waiting period in the Summary of Vision Plan Benefits Section;

   b. Spouse: Date of marriage or civil union;

   c. Newborn: Child's actual date of birth;

   d. Foster children, legal adoptions or guardianships: Date the Child is placed in the foster home or with the Certificate Holder; at which time this Child will be covered on the same basis as a natural child;

   e. Newly adopted child: Coverage begins the earlier of (1) the date the Child is placed with the Certificate Holder for adoption; (2) the date of an entry of an order granting custody of the Child for adoption; or (3) the effective date of the adoption;

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

   g. 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, you and your Eligible Dependents must enroll for coverage within 31 days from the date upon which you or your Eligible Dependents become eligible for Benefits under the terms of Section III B immediately above. You and your Eligible Dependents may properly enroll for coverage by completing all enrollment forms required by RLHICA and submitting such forms to your employer or organization. If you and your Eligible Dependents are not properly enrolled for coverage within 31 days from the date upon which you and your Eligible Dependents become eligible for Benefits, then you and/or your Eligible Dependents must wait until the next Open Enrollment Period to enroll.

C. Termination of Eligibility

Eligibility for Benefits will terminate for you and your Eligible Dependents under This Plan at the earlier of:

1. The termination of the Policy; or
2. The last day of the month for which payment has been made if the employer or organization fails to make the payments required by their Policy.

Your eligibility, and that of your Eligible Dependents, will also terminate if you cease to be a Certificate Holder as defined in the Summary of Vision Plan Benefits Section. An Eligible Dependent's eligibility also terminates upon lack of compliance with the eligibility requirements of the Policy.

IV. Benefits

COVERED SERVICES

RLHICA agrees to provide Benefits to you and your Eligible Dependents (if dependent coverage is selected) under the policies and procedures of RLHICA and under the terms and conditions of this Certificate, including, but not limited to, the categories of services, exclusions and limitations listed in the Summary of Vision Plan Benefits Section.

Unless otherwise specified in the Summary of Vision Plan Benefits Section, Covered Services will be subject to the following terms and conditions:

A. General

This Certificate provides Benefits for you and your 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 you and your Eligible Dependents who are receiving Benefits. Copayments are to be paid at the time services are rendered or materials ordered. Amounts which exceed the Certificate allowances, annual maximum benefits or any other stated limitations are not considered Copayments, but are also the responsibility of you and your Eligible Dependents.

C. Obtaining Covered Services from Preferred Providers

To receive Covered Services from a Preferred Provider, You should select a Preferred Provider, schedule an appointment and inform the Provider's office that you are a Covered Person under this Certificate. The Preferred 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 Preferred Provider. Each Benefit Authorization will contain an expiration date and must be used by you or your Eligible Dependents 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 past service utilization of you or your Eligible Dependents, if any. Any Benefit Authorization so issued shall constitute a certification to the Preferred Provider that payment will be made to the Preferred Provider, irrespective of a later loss of eligibility of you or your Eligible Dependents, as long as the services are rendered or materials provided prior to the Benefit Authorization expiration date. If you or your Eligible Dependents receive Covered Services from a Preferred Provider without a Benefit Authorization, any services or materials received from the Preferred Provider will be treated as if they were obtained from a Non-Preferred Provider. You or your Eligible Dependents may obtain information on Preferred Providers through our website: www.RenaissanceDental.com, the Member Service's toll-free number 1-800-877-7195 (TTY users call 711) or by written request.

D. Obtaining Covered Services from Non-Preferred Providers

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

E. Urgent Vision Care

When vision care is necessary for Urgent Conditions, you or your Eligible Dependents may obtain such care by contacting a Preferred Provider or a Non-Preferred Provider (if Non-Preferred benefits are available). Services for conditions of a medical nature are covered by RLHICA only under supplemental eyecare 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 you or your Eligible Dependents are not covered by RLHICA for such care and should contact a physician under your medical insurance plan for care. For situations of a non-medical nature, such as lost, broken or stolen glasses, you may call the Member Service's toll-free number 1-800-877-7195 (TTY users call 711) for assistance. Reimbursement and eligibility are subject to the terms and conditions of this Certificate.

V. Accessing Your Benefits

To access your Benefits, follow these steps:

1. Please read this Certificate, including the Summary of Vision Plan Benefits Section carefully to become familiar with the Benefits and provisions of This Plan;
2. Make an appointment with your Preferred Provider and tell him or her that you have coverage with RLHICA and provide your ID number. If your Provider is not familiar with This Plan or has any questions regarding This Plan, have him or her contact us by calling the toll-free number, 1-800-877-7195 (TTY users call 711);
3. After receiving your treatment, your Provider's office staff will file the claim.

If you receive services from a Non-Preferred Provider, upon request, you will be furnished with such forms as are usually furnished for filing proofs of loss. If such forms are not furnished within 10 days after such request, you will be deemed to have complied with the requirements of This Plan as to proof of loss upon submitting, within the time frame for filing proofs of loss as described below, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Written proof of loss must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, RLHICA's claims administrator shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one (1) year from the time specified unless the claimant was legally incapacitated.

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

VSP
P.O. Box 385018
Birmingham, AL 35238-5018

After receiving all required claim information, RLHICA's claims administrator will pay all Benefits due for Covered Services within 30 days of receipt of the claim, or notify you that the claim has been denied or deemed incomplete. If applicable, failure to pay within that period shall entitle you to interest at 18 percent per annum from the 15th day. Interest amounts less than one dollar ($1.00) will not be paid.

Payment for services rendered is sent to either (1) you, and it is your responsibility to make full payment to the Provider; or (2) directly to the Provider if you or your Eligible Dependent have executed an Assignment of Benefits in favor of the Provider who rendered Covered Services under This Plan.

If you file a claim for a Benefit that relates to a service that has already been rendered, and you receive notice of an Adverse Benefit Determination, RLHICA will notify you or your authorized representative of the Adverse Benefit Determination within a reasonable period of time, but not later than 15 days after receipt of the claim.

If you have any questions about This Plan, please check with your employer, organization, or plan administrator or you may call the Member Services Department toll-free at 1-800-877-7195 (TTY users call 711).

VI. Questions and Answers

May I choose any Provider?

Yes, you are free to choose any Provider, as long as he or she is appropriately licensed to practice and provide vision services and supplies in the state or jurisdiction in which you receive care.

Will RLHICA send payment to the Provider or will I receive payment?

RLHICA's claims administrator will either send payment to you or directly to the Provider if you have executed an Assignment of Benefits for the Provider who rendered Covered Services.

How much of the vision bill do I pay?

If you choose a Preferred Provider, you are only responsible for applicable Copayments and anything not covered by the plan. For Covered Services provided by a Non-Preferred Provider, you will pay for the services in full and will be reimbursed up to the Non-Preferred plan allowances. Those Allowed Amounts are listed in the Summary of Vision Plan Benefits Section.

You are responsible for the Copayment shown on your explanation of benefits plus any charges for optional treatment or specific exclusions / limitations of This Plan.

Am I covered for all vision services?

No, the Summary of Vision Plan Benefits Section describes the vision services that are covered by This Plan. Please read them carefully. The exclusions and limitations govern these covered vision services.

What if my spouse is covered by another plan?

If you are covered by more than one vision Plan, your out-of-pocket costs may be reduced or eliminated. Please see Section VII Coordination of Benefits. It is important to tell your Provider about any other vision coverage so that claims are submitted properly.

VII. Coordination of Benefits

COORDINATION OF THE GROUP CONTRACT'S BENEFITS WITH OTHER BENEFITS

All of the Benefits under this Certificate, 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 you or your 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 D. "Effect on the Benefits of This Plan."

B. DEFINITIONS

1. **"Allowable Expense"** means an expense covered under this Certificate 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 during which Allowable Expenses are compared with total Benefits payable in the absence of COB, to determine whether overinsurance exists and how much each Plan will pay or provide. 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 (a) or (b) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

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 provided for you and your Eligible Dependents pursuant to this Certificate.

C. ORDER OF BENEFIT DETERMINATION RULES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

      However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the

Child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This subparagraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

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

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

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

f. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered 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 D. applies when, in accordance with Paragraph C. "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other Plans. In that event the Benefits of This Plan may be reduced under this Paragraph D. Such other Plan or Plans are referred to as "the other Plans" in subparagraph (D)(2) immediately below.

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

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

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

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

E. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. 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 paid 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.

VIII. Claim Denial Appeals

If you receive notice of an Adverse Benefit Determination, and if you think that RLHICA incorrectly denied all or part of your claim, you or your Provider should contact the Member Services Department and ask them to check the claim to make sure it was processed correctly. You may do this by calling the toll-free number, 1-800-877-7195 (TTY users call 711) and speaking to a representative. You may also mail your inquiry to VSP, ATTN: Appeals Department P.O. Box 2350, Rancho Cordova, CA 95741.

Initial Appeal: All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. You may review, during normal business hours, any documents held by RLHICA's claims administrator pertinent to the denial. You may also submit written comments or supporting documentation concerning the claim to assist in the review. Our response to the initial appeal, including specific reasons for the decision, shall be communicated to you within sixty (60) calendar days after receipt of the request for the appeal. Incomplete appeal information will suspend the 60 day response timeframe, until receipt of any additional necessary information.

The notice of a Claims Denial Appeals Procedure will meet the requirements described below under the heading "Manner and Content of Notice."

Manner and Content of Notice

Your notice of an Adverse Benefit Determination will inform you of the specific reasons(s) for the denial, the pertinent Policy provisions(s) on which the denial is based, the applicable review procedures for vision claims, including applicable time limits, and that you are entitled to access, free of charge, upon request, all documents, records and other information relevant to your claim. The notice will also contain a description of any additional materials necessary to complete your claim, an explanation of why such materials are necessary, and a statement that you have a right to bring a civil action in court if you receive an Adverse Benefit Determination after your claim has been completely reviewed according to this Claims Denial Appeals Procedure. The notice will also reference any internal rule, guideline, protocol, or similar document or criteria relied on in making the Adverse Benefit Determination, and will include a statement that a copy of such rule, guideline or protocol may be obtained upon request at no charge.

Second Level Appeal

If you disagree with the response to the Initial Appeal of the denied claim, you have the right to a Second Level Appeal. A request for a Second Level Appeal must be submitted to RLHICA's claims administrator within sixty (60) calendar days after receipt of the response to the Initial Appeal. Communication of a final determination to you 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 you shall include the specific reasons for the determination.

Other Remedies

When you have 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 your state of residency. Additionally, under the provisions of ERISA (Section 502(a)(1)(B) 29 U.S.C. 1132(a)(1)(B), you have 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 Certificate and you disagree with the outcome of such appeals.

If you (a) need the assistance of a governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer, you may also contact the Consumer Services Division of the Georgia Department of Insurance, 2 Martin Luther King Jr. Dr., Room 716W, Atlanta, GA 30334. The Division's phone number is (404) 656-2070.

IX. Termination of Coverage

RLHICA must give your employer or organization at least 60 days' written notice of cancellation, expiration, nonrenewal, or change in rates. In the event RLHICA chooses to terminate the Policy due to nonpayment of premium by your employer or organization by the end of the Grace Period defined in the Policy, RLHICA will give you notice of the termination within 14 days after the expiration of the Grace Period, accompanied by a statement of your continuation or conversion rights under Georgia Code Sections 33-24-21.1 or 33-24-21.2 or any other applicable code section. If the Policy is terminated due to intentional nonpayment of premium by your employer or organization, then your employer or organization shall have the duty to notify you no later than 14 days after expiration of the Grace Period. The effective date of such termination shall be the first day of the period for which the premium is due.

Your RLHICA coverage may be automatically terminated:

1. When your employer or organization advises RLHICA to terminate your coverage;
2. On the last day of the month for which your employer or organization has failed to pay RLHICA subject to the applicable Grace Period;
3. Or for any other reason stated in the Policy.

A person whose eligibility is terminated may be eligible to transfer to an individual direct payment contract with RLHICA. Please contact RLHICA to obtain further information.

X. Continuation of Coverage

A. Loss of Eligibility During Treatment

1. If you and/or an Eligible Dependent lose eligibility while receiving vision treatment, only those Covered Services received while you and/or your Eligible Dependent were eligible under the Policy will be payable.
2. Certain procedures begun before the loss of eligibility may be covered if the services were completed within a 30 day period measured from the date of termination. In those cases, RLHICA evaluates those services in progress to determine what portion may be paid by RLHICA. The difference between RLHICA's payment and the total fee for those procedures is your responsibility.

B. Continuation Coverage - COBRA

If your employer or organization is required to comply with provisions under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and your coverage would otherwise end, you and/or your covered Eligible Dependents may have the right under certain circumstances to continue coverage in the group health plans sponsored by your employer or organization, at your expense, beyond the time coverage would normally end.

COBRA continuation coverage may be available if your coverage or a covered Eligible Dependent's coverage would otherwise end because of one of the following COBRA qualifying events:

1. Voluntary or involuntary termination of employment for any reason other than your gross misconduct;
2. Reduction in the number of hours worked so that you are no longer an eligible employee under the terms of the group health plan;
3. Divorce or legal separation;
4. Death;
5. Loss of dependent status under the terms of the group health plan; or
6. You become entitled to Medicare (if applicable).

If you are called to active duty in the armed forces of the United States, you and your covered Eligible Dependents may also have continuation coverage rights under the Uniformed Services Employment and Reemployment Rights Act ("USERRA").

If you believe you are entitled to continuation coverage either under COBRA or USERRA, you should contact your employer or organization to receive additional information about your rights and to learn more about the applicable procedures for applying for such continuation coverage.

C. Continuation Coverage – Death of Certificate Holder

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

D. Continuation Coverage – Eligible Dependents

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

E. Continuation Coverage – Total Disability

In the event the Policy is terminated for any reason, the Benefits paid pursuant to the 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.

XI. General Conditions

Change of Status

You must notify RLHICA through your employer or organization, of any event causing a change in the status of an Eligible Dependent. Events that can affect the status of an Eligible Dependent include, but are not limited to, marriage, birth, death, divorce, and entrance into military service.

Assignment

Benefits to you or your Eligible Dependent are for the personal benefit of you or your Eligible Dependent and cannot be transferred or assigned. You or your Eligible Dependent, however, may assign Benefits to the Provider who rendered Covered Services under This Plan. Benefits paid pursuant to such assignment shall discharge the obligation of RLHICA with respect to the amount of the Benefits so paid.

Right of Recovery

If you or your Eligible Dependent has a claim for damages or a right to recover damages from a third party or parties for any illness or injury for which Benefits are payable under this Certificate, RLHICA may have a right of recovery. Our right of recovery shall be limited to the recovery of any Benefits paid for identical covered medical expenses under this Certificate, but shall not include non-medical items. Money received for future medical care or pain and suffering may not be recovered. Our right of recovery may include compromise settlements. You or your attorney must inform RLHI CA of any legal action or settlement agreement at least ten days prior to settlement or trial. RLHICA will then notify you of the amount it seeks to recover for Benefits paid. Our recovery may be reduced by the pro-rata share of your attorney's fees and expenses of litigation.

Obtaining and Releasing Information

While you are covered by RLHICA, you agree to provide RLHICA with any information it needs to process your claims and administer your Benefits. This includes allowing RLHICA to have access to your vision records.

Provider-Patient Relationship

You and your Eligible Dependents have the freedom to choose any Provider. Each Provider maintains the Provider-patient relationship with the patient and is solely responsible to the patient for vision advice and treatment and any resulting liability.

Late Claims Submission

Except as otherwise provided in this Certificate, RLHICA's claims administrator 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's claims administrator within one year from the date that the services, items or supplies were provided.

Change of Certificate or Policy

No agent has the authority to change any provisions in this Certificate or the provisions of the Policy on which it is based. No changes to this Certificate or the underlying Policy are valid unless approved in writing by an officer of RLHICA.

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

Legal Actions

No legal action may be brought to recover on this Policy within 60 days after written proof of loss has been given as required by this Policy, unless otherwise provided by applicable state law. No such action may be brought after the expiration of three years after the time written proof of loss is required to be given. 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.

Representations

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the terms of the Policy, all statements made by your employer or organization or by you or your Eligible Dependents, shall be deemed to be representations and not warranties. No such statement shall be used in defense to a claim under the Policy, unless it is contained in a written instrument, signed by your employer or organization, and a copy thereof provided to the same.

NOTICE OF PRIVACY PRACTICES

Date of this notice: February 12, 2016

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 Health Insurance Company of New York, and Renaissance Systems & Services, LLC (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.

For more information concerning this notice please see: www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.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/hipaa/for-individuals/guidance-materials-for-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 email). 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,
- www.renaissancedental.com, or
- www.rss-llc.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 health care.

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., SW, Washington, D.C. 20201, 877-696-6775. You also may visit OCR's website at www.hhs.gov/hipaa/filing-a-complaint/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:
Jonathan S. Groat
Chief Privacy Officer
PO Box 30416
Lansing, MI 48909-7916
517-347-5451 (TTY users call 711)

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

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

Rev. 8/2015

FACTS

WHAT DOES RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF AMERICA 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 Life & Health Insurance Company of America chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Renaissance Life & Health Insurance Company of America 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**

Questions? Call 517-347-5451 or go to www.renaissancedental.com (TTY users call 711)

Para asistencia en español, llame al número de servicio al cliente (customerservice) que se incluye o en el reverso de su tarjeta de identificación.

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

What we do	
How does Renaissance Life & Health Insurance Company of America 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 Life & Health Insurance Company of America collect my personal information?	We collect your personal information, for example, when you ■ Apply for insurance or Pay insurance claims ■ File an insurance claim or Use your credit or debit card ■ Give us your contact information
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 Health Insurance Company of New York; and others such as Renaissance Systems & Services, LLC.*
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. ■ *Renaissance Life & Health Insurance Company of America does not share your personal information with non-affiliates 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 Life & Health Insurance Company of America does not jointly market with non-affiliated 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/Legal Department, 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.