Renaissance®
Life & Health Insurance Company of America

Renaissance Texas Group Dental Certificate

National Associated Buying Services Association

P.O. Box 1596 * Indianapolis, Indiana 46206 * 888-358-9484 (TTY users call 711) * www.RenaissanceDental.com

RENAISSANCE
TEXAS GROUP DENTAL CERTIFICATE

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Important Cancellation Information - Please Read Section X Entitled, "Termination of Coverage"

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the company.

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

READ YOUR GROUP DENTAL CERTIFICATE CAREFULLY

Renaissance Group Dental Certificate
Summary of Dental Plan Benefits
For Group #3623
National Associated Buying Services Association (NABSA)

This Summary of Dental Plan Benefits is part of, and should be read in conjuction with your Group Dental Certificate. Your Group Dental 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 - January 1 to December 31 **Covered Services**	**Contracting Dentist**		**Non-Contracting Dentist**		
	RLHICA Pays	**You Pay**	**RLHICA Pays**	**You Pay**	**Waiting Period**
	1st Year/ 2nd Year/ 3rd Year		1st Year/ 2nd Year/ 3rd Year		
Diagnostic and Preventive Services					
Diagnostic and Preventive Services - Used to evaluate existing conditions and/or to prevent dental abnormalities or disease (includes exams, cleanings, bitewing X-rays and fluoride treatments)	100/100/100%	0/0/0%	100/100/100%	0/0/0%	None
Brush Biopsy - Used to detect oral cancer	100/100/100%	0/0/0%	100/100/100%	0/0/0%	None
Basic Services					
Emergency Palliative Treatment - Used to temporarily relieve pain	60/70/80%	40/30/20%	60/70/80%	40/30/20%	None
Radiographs/Diagnostic Imaging/Diagnostic Casts - X-rays as required for routine care or as necessary for the diagnosis of a specific condition	20/30/50%	80/70/50%	20/30/50%	80/70/50%	None
Minor Restorative Services - Used to repair teeth damaged by disease or injury (for example, silver fillings and white fillings)	60/70/80%	40/30/20%	60/70/80%	40/30/20%	None
Simple Extractions - Simple extractions including local anesthesia, suturing, if needed, and routine post-operative care	60/70/80%	40/30/20%	60/70/80%	40/30/20%	None
Sealants - Sealants for occlusal (biting) surface of unrestored permanent molars	60/70/80%	40/30/20%	60/70/80%	40/30/20%	None
Periodontal Maintenance - Periodontal maintenance following active periodontal therapy	20/30/50%	80/70/50%	20/30/50%	80/70/50%	None
Other Basic Services - Miscellaneous Services	60/70/80%	40/30/20%	60/70/80%	40/30/20%	None
Major Services					
Oral Surgery Services - Extractions and dental surgery, including local anesthesia, suturing, if needed, and routine post-operative care, including services for the diagnosis and treatment of temporomandibular disorders	20/30/50%	80/70/50%	20/30/50%	80/70/50%	None
Endodontic Services - Used to treat teeth with diseased or damaged nerves (for example, root canals)	20/30/50%	80/70/50%	20/30/50%	80/70/50%	None
Peridontic Services - Used to treat diseases of the gums and supporting structures of the teeth	20/30/50%	80/70/50%	20/30/50%	80/70/50%	None
Major Restorative Services - Used when teeth can't be restored with another filling material (for example, crowns)	20/30/50%	80/70/50%	20/30/50%	80/70/50%	None

	Contracting Dentist		Non-Contracting Dentist		
	RLHICA Pays	You Pay	RLHICA Pays	You Pay	Waiting Period
	1st Year/ 2nd Year/ 3rd Year		1st Year/ 2nd Year/ 3rd Year		
Major Services Con't					
Prosthodontic Services - Used to replace missing natural teeth (for example, bridges, endosteal implants, partial dentures and complete dentures)	20/30/50%	80/70/50%	20/30/50%	80/70/50%	None
Relines and Repairs - Relines and repairs to fixed bridges, removable bridges, partial dentures, and complete dentures	20/30/50%	80/70/50%	20/30/50%	80/70/50%	None
Other Major Services - Occlusal guards, and limited occlusal adjustments	20/30/50%	80/70/50%	20/30/50%	80/70/50%	None
Orthodontic Services					
Orthodontic Services - Services, treatments, and procedures to correct malposed teeth (for example, braces)	0/0/0%	100/100/100%	0/0/0%	100/100/100%	None

Maximum Payment - $1,000/$2,000/$3,000 per person per Benefit Year on Diagnostic and Preventive, Basic, and Major Services collectively.

Deductible - $100 per person, per Lifetime, to an Unlimited Maximum Deductible per family per Lifetime. The Deductible does not apply to Diagnostic and Preventive Services.

Waiting Period - You (and your Eligible Dependents, if covered) will be eligible for enrollment on the next available effective date.

Method of Payment - For services rendered or items provided by an In-Network Dentist, the Allowed Amount is a pre-negotiated fee that the provider has agreed to accept as payment in full. For services rendered by Out-of-Network Dentists, RLHICA determines this amount based on the pre-negotiated fees agreed to by In-Network Dentists in your geographic area. RLHICA will base Benefits on the lesser of the Submitted Amount and the Allowed Amount. If the Submitted Amount for an Out-of-Network Dentist is more than the Allowed Amount, you are not only responsible for paying the Dentist that percentage listed in the "You Pay" column, but are also responsible for paying the Dentist the difference between the Submitted Amount and the Allowed Amount.

Out of Country Services - Having Renaissance coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of Dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our website or contact your benefits representative to get a copy of our Passport Dental information sheet.

Eligibility (You or Your Eligible Dependents) - All dues paying members in good standing are eligible to elect coverage hereunder.

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

You pay the full cost of this coverage.

PLEASE NOTE: RLHICA recommends Predetermination before any services are rendered where the total charges will exceed $200. You and your Dentist should review your Predetermination Notice before your Dentist proceeds with treatment.

I. Renaissance Group Dental Certificate

RLHICA issues this Renaissance Group Dental Certificate to you, the Certificate Holder. The Certificate is a summary of your dental benefits coverage. It reflects and is subject to the agreement between RLHICA and your 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 Dental 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 1596
Indianapolis, Indiana 46206-1596

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

II. Definitions

Adverse Benefit Determination

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

Allowed Amount

Means the maximum dollar amount upon which RLHICA will base Benefits. RLHICA determines the Allowed Amount using statistically valid claims data submitted to RLHICA and its affiliates which show the most frequently charged fees by providers in the same geographic areas for comparable services or supplies. The claims data and fees are updated periodically using the most current codes and nomenclature developed and maintained by the American Dental Association. (This definition is only applicable if the Allowed Amount method for Benefits is shown in the Summary of Dental Plan Benefits Section).

Benefit Year

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

Benefits

Means payment for Covered Services.

Certificate

Means this document. RLHICA will provide dental Benefits as described in this Certificate. Any changes in this Certificate will be based on changes to the Policy. Changes to the Certificate will be in the Summary of Dental Plan Benefits Section.

Certificate Holder

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

Child(ren)

Means your natural children, stepchildren, adopted children (without respect to residency and including while the Certificate Holder is a party to a suit seeking to adopt the

Child, Insert Printed on 2-28-18 by name 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) or the child(ren) of your Legal Spouse if, pursuant to a court decree or medical or dental support order issued under Chapter 154 of the Texas Family Code (or enforceable by a court in the state of Texas) you or your Legal Spouse is financially responsible for the dental care of the child; or

* Your grandchild(ren) or the grandchild(ren) of your Legal Spouse who: (a) have not yet reached the end of the calendar year of his or her 26th birthday; and (b) are you or your Legal Spouse's dependent for federal income tax purposes at the time of application for coverage under this Certificate; or

* Your child(ren) 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 you for support and maintenance. 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. Such requests will not be made more frequently than annually after the second anniversary of the date the child attains the Limiting Age.

Coinsurance

Means the percentage of the Allowed Amount for Covered Services that you will have to pay toward treatment.

Completion Dates

Means the date that treatment is complete. Treatment is complete:

* for dentures and partial dentures, on the delivery date;
* for crowns and bridgework, on the permanent cementation date;

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

Copayment

Means the dollar amount you must pay toward treatment.

Covered Services

Means the unique dental services selected for coverage by your organization under This Plan. The Summary of Dental Plan Benefits Section lists your Covered Services.

Deductible

Means the amount an individual and/or a family must pay toward Covered Services before RLHICA begins paying for those services. The Summary of Dental Plan Benefits Section lists the Deductible that applies to you, if any.

Dentist

Means a person licensed to practice dentistry in the state or jurisdiction in which dental services are rendered.

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 Dental Plan Benefits Section. If dependent coverage has been selected, it will be indicated in the Summary of Dental 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 was issued; (b) your partner through a civil union legally recognized by the State in which the Policy 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.

Maximum Payment

Means the maximum dollar amount RLHICA will pay in any Benefit Year or lifetime for Covered Services. (See the Summary of Dental Plan Benefits Section.)

Open Enrollment Period

Means the period of time during which an eligible person as indicated in the Summary of Dental 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 organization.

Policy Year

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

Pre-Treatment Estimate

Means a voluntary and optional process where, at the request of you, your Eligible Dependent or Dentist, RLHICA issues a written estimate of dental benefits which may be available for a proposed dental service under the terms of your coverage.

Predetermination is provided for informational purposes only and is not required in advance of obtaining dental care or as a prerequisite or condition for approval of future dental benefits payment. The benefits estimate provided on a Predetermination notice is determined based on the benefits available for you or your Eligible Dependent on the date the notice is issued, and is not a guarantee of future dental benefits payment.

Availability of dental benefits at the time a dental service is completed depends on factors such as, but not limited to, eligibility for Benefits, annual or lifetime Maximum Payments, coordination of benefits, Policy and Dentist status, Policy limitations and other provisions. A request for a Predetermination is not a claim for Benefits or a preauthorization, precertification or other reservation of future Benefits.

RLHICA

Means Renaissance Life & Health Insurance Company of America.

Submitted Amount

Means the fee a Dentist bills to RLHICA for a specific service or item.

Summary of Dental Plan Benefits

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

Table of Allowances

Means the maximum amount allowed per procedure as determined by your organization and RLHICA. (If the Table of Allowances method for Benefits has been selected by your organization, it will be reflected in the Summary of Dental Plan Benefits Section).

This Plan

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

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.

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 organization on the initial Effective Date of the Policy, eligibility for Benefits will begin, unless otherwise stated as follows:

   a. New 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 Dental Plan Benefits Section;
   b. Spouse: Date of marriage, civil union or domestic partnership;
   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, or at the time Certificate Holder becomes party to a suit to adopt the child, at which time this Child will be covered on the same basis as a natural child;
   e. Stepchild: Date that the Child's natural parent becomes an Eligible Dependent;
   f. All others: Date that RLHICA approves in writing the enrollment or listing of those people, unless compelled by a court or administrative order to otherwise provide Benefits for a Child or Eligible Dependent.

   Once eligible, you and your Eligible Dependents must enroll for coverage within 30 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 organization. If you and your Eligible Dependents are not properly enrolled for coverage within 30 days from the date upon which you and your Eligible Dependents become eligible for Benefits,Dependents 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 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 Dental Plan Benefits Section. An Eligible Dependent's eligibility also terminates upon lack of compliance with the eligibility requirements of the Policy.

D. Conversion to an Individual Policy

A person whose eligibility is terminated or who loses coverage may be eligible to elect coverage under an individual conversion policy with RLHICA. Any request to obtain a conversion policy will be honored in accordance with applicable state law. Please contact RLHICA to obtain further information.

IV. Benefits

COVERED SERVICES

RLHICA agrees to provide Benefits to you and your Eligible Dependents under the policies and procedures of RLHICA and under the terms and conditions of This Plan, including, but not limited to, the categories of services, exclusions and limitations listed below.

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

A detailed list of the Benefits provided under This Plan is available upon request. All time limitations are measured either from the last date of service in any RLHICA plan or, at the request of your organization, from the last date of service in any dental Plan.

DIAGNOSTIC AND PREVENTIVE SERVICES

Services and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease. These services include oral evaluations (examinations), prophylaxes (cleanings), bitewing X-rays and fluoride treatments. These services are subject to the following exclusions and limitations:

(i) Topical fluoride treatments are payable twice in any Benefit Year for Children under age 19;

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

(iii) Prophylaxes, including periodontal maintenance procedures, are payable twice in any Benefit Year;

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

(v) Space maintenance services are payable once per lifetime, per area on posterior teeth, for Children under age 14;

(vi) RLHICA will not make payment for preventive control programs, including home care items, oral hygiene instructions, nutritional counseling and tobacco counseling and all charges for the same will be your responsibility;

(vii) RLHICA will not make payment for tests and laboratory examinations (including, but not limited to cytology, bacteriology or pathology) and caries susceptibility tests and all charges for the same will be your responsibility, unless otherwise indicated in the Summary of Dental Plan Benefits Section or in this Certificate.

Brush Biopsy

Oral brush biopsy procedure and laboratory analysis used to detect oral cancer, an important tool that identifies and analyzes precancerous and cancerous cells.

BASIC SERVICES

Emergency Palliative Treatment

Emergency treatment to temporarily relieve pain is not a Covered Service when done in conjunction with any services except X-rays, tests or examinations.

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

X-rays for routine care or as necessary for the diagnosis of a specific condition, subject to the following exclusions and limitations:

(i) Full mouth X-rays (which include bitewing X-rays) or a panoramic X-ray (with or without bitewing X-rays) are payable once in any 5 year period;

(ii) A serial listing of X-rays is paid as a full mouth series if the total fee equals or exceeds the fee for a complete series;

(iii) Any supplemental films with a full mouth series are part of the complete procedure;

(iv) Cephalometric films, oral/facial images or diagnostic casts are not payable except in conjunction with Orthodontic Services and all charges for the same will be your responsibility;

(v) Posterior-anterior or lateral skull and facial bone survey, sialography, temporomandibular joint films (including arthrograms) or tomographic films are not payable and all charges for the same will be your responsibility.

Minor Restorative Services

Minor restorative services to rebuild and repair natural tooth structure when damaged by disease or injury. These services include amalgam (silver) and composite resin (white) restorations (fillings), subject to the following exclusions and limitations:

(i) Amalgam and composite resin restorations are payable once per tooth surface within a 24 month period regardless of the number or combination of restorations placed on a surface;
(ii) RLHICA will not make payment for dentistry for aesthetic reasons and all charges for the same will be your responsibility.

Simple Extractions

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

Sealants

Sealants are payable only for the occlusal surface of first permanent molars for Children under age 16 and second permanent molars for Children under age 16. The surface must be free from decay and restorations. Sealants are a Benefit payable once per tooth per 3 year period.

Periodontal Maintenance Following Therapy

Periodontal maintenance following active periodontal therapy procedures to treat diseases of the gums and supportive structures of the teeth, along with benefits for prophylaxes, including periodontal maintenance procedures, are payable twice in any Benefit Year.

Other Basic Services

After hours visits, not to exceed once per Benefit Year.

MAJOR SERVICES

Oral Surgery Services

Surgical extractions and dental surgery, including local anesthesia, suturing, if needed, and routine postoperative care are subject to the following exclusions and limitations:

(i) RLHICA will not make payment for the following services and items and all charges for the same will be your responsibility unless otherwise specified in the Summary of Dental Plan Benefits Section: appliances, restorations, X-rays or other services for the diagnosis or treatment of temporomandibular disorders ("TMD") including myofunctional therapy;
(ii) RLHICA will not make payment for the following services and items and all charges for the same will be your responsibility: charges related to hospitalization or general anesthesia and/or intravenous sedation for restorative dentistry or surgical procedure unless a specified need is shown.

Endodontic Services

The treatment of teeth with diseased or damaged nerves (for example, root canals) is subject to the following exclusions and limitations:

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

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

(iii) RLHICA will not make payment for pulp caps and all charges for the same will be your responsibility.

Maxillofacial Prosthetics

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

Periodontic Services

The treatment of diseases of the gums and supporting structures of the teeth is subject to the following exclusions and limitations:

(i) Full mouth debridement will be payable once in your or your Eligible Dependent's lifetime;

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

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

Major Restorative Services

Major restorative services, such as crowns, used when teeth cannot be restored with another filling material. These services are subject to the following exclusions and limitations:

(i) Indirect restorations including porcelain/ceramic substrate, porcelain/resin processed to metal and cast restorations (including crowns and onlays) and associated procedures such as cores and post and core substructures on the same tooth are payable once in any 5 year period;

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

(iii) Optional treatment: if you or your Eligible Dependent selects a more expensive service than is customarily provided or for which RLHICA does not determine that a valid dental need is shown, RLHICA may make an allowance based on the fee

for the customary provided services. You are responsible for the difference in cost;

(iv) Inlays, regardless of the material used: RLHICA will pay only the applicable amount that it would have paid for a resin-based composite restoration. You will be responsible for any additional charges;

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

(vi) RLHICA will not make payment for dentistry for aesthetic reasons and all charges for the same will be your responsibility;

(vii) Veneers are payable once in a 5 year period.

Prosthodontic Services

Services and appliances that replace missing natural teeth (such as fixed bridges, endosteal implants, partial dentures and complete dentures) are subject to the following exclusions and limitations:

(i) One complete upper and one complete lower denture is payable once in any 5 year period for any individual;

(ii) A partial denture, fixed bridge and any associated services are payable once in any 5 year period;

(iii) Fixed bridges, endosteal implants and cast metal partial dentures are not payable for Children under age 16 and all charges for the same will be your responsibility;

(iv) Optional treatment: if you or your Eligible Dependent selects a more expensive service than is customarily provided or for which RLHICA does not determine that a valid dental need is shown, RLHICA may make an allowance based on the fee for the customarily provided service. You are responsible for the difference in cost;

(v) Services for tissue conditioning are payable twice per denture unit in any 3 year period;

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

(vii) RLHICA will not make payment for specialized implant surgical techniques, removal of an implant, implant maintenance procedures or implant repairs and all charges for the same will be your responsibility unless otherwise specified in the Summary of Dental Plan Benefits Section;

(viii) RLHICA will not make payment for the following services and items and all charges for the same will be your responsibility: lost, missing or stolen appliances of any type; temporary, provisional or interim prosthodontic appliances; precision or semi-precision attachment copings or myofunctional therapy;

(ix) RLHICA will not make payment for procedures to replace a missing tooth or teeth that were lost prior to becoming a Certificate Holder or Eligible Dependent under the Policy and all charges for the same will be your responsibility.

Relines and Repairs

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

Other Major Services

(i) An occlusal guard is payable once in your or your Eligible Dependent's lifetime;

(ii) Limited occlusal adjustments are limited to 1 in a lifetime;

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

ORTHODONTIC SERVICES

No person will be eligible for Orthodontic Services under the Policy unless Orthodontic Services are provided for in the Summary of Dental Plan Benefits Section. Services, treatment and procedures to correct malposed teeth (for example, braces), are subject to the following exclusions and limitations:

(i) RLHICA's payment for Orthodontic Services will be limited to the lifetime Maximum Payment specified in the Summary of Dental Plan Benefits Section;

(ii) Orthodontic Services are payable until the end of the calendar year of the 19th birthday of you or your Eligible Dependent unless otherwise specified in the Summary of Dental Plan Benefits Section;

(iii) RLHICA's payment for Orthodontic Retention Services (removal of appliances, construction and placement of retainer) is included in its payment of overall Orthodontic Services. If a Dentist bills these services separately, payment will be denied.

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

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

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

Other Services

The Summary of Dental Plan Benefits Section lists any other Benefits that may have been selected.

V. Exclusions and Limitations

Exclusions

In addition to the exclusions listed above in the Benefits Section, RLHICA will not make payment for the following services, items or supplies and all charges for the same will be your responsibility, unless otherwise specified in the Summary of Dental Plan Benefits Section:

1. Services for injuries or conditions paid pursuant to Workers' Compensation or Employer's Liability laws. Services that are received from any government agency, political subdivision, community agency, foundation or similar entity. NOTE: This provision does not apply to any programs provided under Title XIX of the Social Security Act, that is, Medicaid;

2. Services or appliances started prior to the date the person became eligible under This Plan, excluding orthodontic treatment in progress (if a Covered Service);

3. Charges for failure to keep a scheduled visit with the Dentist;

4. Charges for completion of forms or submission of claims;

5. Services, items or supplies for which no valid dental need can be demonstrated, as determined by RLHICA;

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

7. Services, items or supplies that are investigational in nature, including services, items or supplies required to treat complications from investigational procedures, as determined by RLHICA;

8. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist or other licensed provider under the scope of his or her license as permitted by applicable state law;

9. Services, items or supplies excluded by the policies and procedures of RLHICA;

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

11. Services, items or supplies for which no charge is made, for which the patient is not legally obligated to pay or for which no charge would be made in the absence of RLHICA coverage;

12. Services, items or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared;

13. Services, items or supplies that are generally covered under a hospital, surgical/medical or prescription drug program;

14. Services, items or supplies that are not within the categories of Benefits that have been selected by your organization and are not covered in This Plan;

15. Prescription drugs, non-prescription drugs, premedications, localized delivery of chemotherapeutic agents, relative analgesia, non-intravenous conscious sedation, therapeutic drug injections, hospital visits, desensitizing medicaments and techniques, behavior management, athletic mouthguards, house/extended care facility visits, mounted occlusal analysis, complete occlusal adjustments, enamel microabrasions, odontoplasty or bleaching;

16. Correction of congenital or developmental malformations (except those for a newborn child added to the Policy after the initial Effective Date), cosmetic surgery or dentistry for aesthetic reasons as determined by RLHICA;

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

Limitations

In addition to the limitations listed above in the Benefits Section, the following limitations apply under This Plan, unless otherwise specified in the Summary of Dental Plan Benefits Section:

1. RLHICA's obligation for payment of Benefits ends on the last day of the month in which coverage is terminated under This Plan;

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

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

4. The Maximum Payment will be limited to the amount specified in the Summary of Dental Plan Benefits Section;

5. If a Deductible amount is specified in the Summary of Dental Plan Benefits Section, RLHICA will not be obligated to pay, in whole or in part, for any services, items or supplies to which the Deductible applies, until the Deductible amount is met.

VI. Accessing Your Benefits

To access your Benefits, follow these steps:

1. Please read this Certificate, including the Summary of Dental Plan Benefits Section carefully to become familiar with the Benefits and provisions of This Plan;

2. Make an appointment with your Dentist and tell him or her that you have coverage with RLHICA. If the dental office needs a claim form, you may obtain one from your organization or plan administrator. If your Dentist is not familiar with This Plan or has any questions regarding This Plan, have him or her contact RLHICA by writing Attention: Customer Services Department, P.O. Box 1596, Indianapolis, Indiana 46206-1596 or by calling the toll-free number, 1-888-358-9484 (TTY users call 711);

3. After receiving your dental treatment, you or the dental office staff will file a claim form, completing the information portion with:

   a. Your full name and address;
   b. Your Social Security number;
   c. The name and date of birth of the person receiving dental care; and
   d. The group's name and number.

Upon request, RLHICA will furnish to you, 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, 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 occurence, the character and the extent of the loss for which the 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 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:

RLHICA
P.O. Box 17250
Indianapolis, IN 46217

After receiving all required claim information, RLHICA will pay all Benefits due for Covered Services as soon as received and within 15 business days. If applicable, failure to pay within that period shall entitle you to interest at the state prescribed rate per annum from the 30th day. Interest amounts less than one dollar ($1.00) will not be paid.

Payment for services rendered is sent to either (1) you, and it is your responsibility to make full payment to the Dentist; or (2) directly to the Dentist if you or your Eligible Dependent has assigned Benefits to the Dentist who rendered Covered Services under This Plan.

Upon the payment of a claim under This Plan, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

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 30 days after receipt of the claim. RLHICA may extend this period by up to 15 days if RLHICA determines that the extension is necessary due to matters out of RLHICA's control.

If RLHICA determines that an extension is necessary, it will notify you before the end of the original 30 day period of the circumstances requiring the extension and the date by which RLHICA expects to render a decision. If such an extension is necessary because you did not submit all the information necessary to decide the claim, the notice of extension will specifically describe the additional information required. You will have at least 45 days to provide the requested information. If you deliver the information within the time specified, the 15 day extension period will begin after you provide the information.

After written notice has been sent to RLHICA at its home office, benefits payable on behalf of an Eligible Dependent must be paid to the Texas Department of Human Services if:

1. The parent who is the Certificate Holder under this Policy is required to pay child support by a court order or court approved agreement and:

   a. Is a possessory conservator of the Eligible Dependent under a court order issued in the state of Texas; or
   b. Is not entitled to possession of or access to the Eligible Dependent;

2. The Texas Department of Human Services is paying benefits on behalf of the Eligible Dependent under Chapter 31 or 32 of the Texas Human Resources Code; and

3. RLHICA is notified, through an attachment to the claim for Benefits at the time the claim is first submitted to it, that the Benefits must be paid directly to the Texas Department of Human Services.

Note: RLHICA recommends Predetermination before any services are rendered where the total charges will exceed $200. You and your Dentist should review your Predetermination Notice before your Dentist proceeds with treatment.

If you have any questions about This Plan, please check with your organization or plan administrator or you may call RLHICA's Customer Services Department toll-free at 1-888- 358-9484. You may also write to RLHICA's Customer Services Department, P.O. Box 1596, Indianapolis, IN 46206- 1596. When writing to RLHICA please include your name, the group's name and number, the Certificate Holder's Social Security number, and your daytime telephone number.

VII. Questions and Answers

May I choose any Dentist?

Yes, you are free to choose any Dentist, as long as the Dentist is licensed to practice dentistry in the state or jurisdiction in which you receive care.

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

RLHICA will either send payment to you or directly to the Dentist if you have assigned Benefit payments to the Dentist who rendered Covered Services.

When does my dental coverage begin?

See Waiting Period in the Summary of Dental Plan Benefits Section. This Plan will cover only those dental services received after you become eligible.

How much of the dental bill do I pay?

It depends on whether your organization selected the Allowed Amount or the Table of Allowances payment method. If the "Allowed Amount" payment method has been selected, RLHICA will pay a certain percentage of the amount for each Covered Service, depending on the type of service rendered. Those Allowed Amounts are listed in the Summary of Dental Plan Benefits Section. If the Submitted Amount is more than the Allowed Amount for a specific Covered Service, then you are responsible for paying the Dentist that percentage listed in the "You Pay" column, as well as for paying the Dentist the difference between the Submitted Amount and the Allowed Amout. On the other hand, if your organization selected the Table of Allowances payment method, RLHICA will only pay up to the specific dollar amount that is listed for each Covered Services in the Table of Allowances, which is listed in the Summary of Dental Plan Benefits Section.

In either case, 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 dental services?

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

What if my spouse is covered by another plan?

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

VIII. 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. 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, or because of, medical or dental care or treatment:

   a. Plan Includes: group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts, limited benefit coverage that is not issued to supplement individual or group in- force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

   b. Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

   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 reduce the Benefits it pays so that all plan Benefits equal 100% of the total Allowable Expense.

5. "**This Plan**" means the dental coverage provided for you and your Eligible Dependents pursuant to this Certificate.

C. ORDER OF BENEFIT DETERMINATION RULES

1. When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

   a. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan;
   b. Except as provided in (c), a Plan that does not contain a COB provision that is consistent with this Policy is always primary unless the provisions of both Plans state that the complying Plan is primary;
   c. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

d. A Plan may consider the benefits paid or provided by another Plan is calculating payment of its benefits only when it is secondary to that other Plan;

e. If the Primary Plan is a Closed Panel Plan and the Secondary Plan is not, the Secondary Plan must pay or provide benefits as if it were the Primary Plan when a Covered Person uses a non- contracted health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the Primary Plan;

f. When multiple contracts providing coordinated coverage are treated as a single Plan under this subchapter, this section applies only to the Plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the Plan, the carrier designated as primary within the Plan must be responsible for the Plan's compliance with this subchapter; and

g. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this subchapter decide the order in which Seconday Plans' benefits are determind in relationship to each other. Each Secondary Plan must take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan that, under the rules of this Policy, has its benefits determined before those of that Secondary 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, subscriber or retiree (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 covered under more than one Plan. Unless there is a court order stating otherwise, Plans covering a dependent Child must determine the order of benefits using the following rules that apply:

(i) For a dependent Child whose parents are married or are living together, whether or not they have ever been married;

I. the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

II. if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

(ii) For a dependent Child whose parents are divorced or are not living together, whether or not they have ever been married:

I. if a court order states that one of the parents is responsible for the dependent's Child health care expenses or health care coverage, and the Plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent Child's health care expenses, and that parent's spouse does, then the spouse's plan is the Primary Plan. This clause must not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court order provision.

II. if a court order states that both parents are responsible for the dependent Child's health care expenses or health care coverage, the provision of subparagraph (i) of this paragraph must determine the order of benefits.

III. if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent Child the provisions of subparagraph (i) of this paragraph must determine the order of benefits.

IV. if there is no court order allocating responsibility for the Child's health care expenses or health care coverage, the order of benefits for the Child is as follows:

(iii) For a dependent Child covered under more than on Plan of individuals who are not the parents of the Child, the order of Benefits must be determined,

as applicable, under subparagraph (i) and (ii) of this paragraph as if the individuals were parents of the Child.

(iv) For a dependent Child who has coverage under either or both parents' Plan and has his or her own coverage under a spouse's Plan, subsection e of this section applies.

(v) In the event a dependent Child's coverage under the spouse's Plan began on the same date as the dependent Child's coverage under either or both parent's Plans, the order of benefits must be determined by applying the birthday rule in subparagraph (i) of this paragraph to the dependent Child's parent(s) and the dependent's spouse.

c. 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 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

d. 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.

e. 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.

f. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

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 equal 100% of the total 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 has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person subject in all events, to all provisions of applicable law. RLHICA need not tell, or get the consent of, any person to do this. Each person claiming Benefits under This Plan must give RLHICA any facts it needs to pay the claim.

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 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 will not have to

payment that amount again. The term payment 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.

IX. Disputed Claims Procedure

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 Dentist should contact RLHICA's Customer Services Department and ask them to check the claim to make sure it was processed correctly. You may do this by calling the toll-free number, 1-888-358-9484 (TTY users call 711) and speaking to a telephone advisor. You may also mail your inquiry to the Customer Services Department at P.O. Box 1596, Indianapolis, IN 46206-1596.

A complaint filed concerning dissatisfaction or disagreement with an Adverse Benefit Determination constitutes an appeal of that Adverse Benefit Determination. When writing, please enclose a copy of your explanation of benefits and describe the problem. Be sure to include your name, telephone number, the date, and any information you would like considered about your claim. This inquiry is not required and should not be considered a formal request for review of a denied claim. RLHICA provides this opportunity for you to describe problems and submit explanatory information that might indicate your claim was improperly denied and allow RLHICA to correct any errors quickly and without delay.

Whether or not you have asked RLHICA informally to recheck its initial determination, you can submit your claim to a formal review through the Disputed Claims Appeal Procedure described below.

If you receive notice of an Adverse Benefit Determination, you, or your authorized representative, should seek a review as soon as possible, but **you must file your request for review within 180 days** of the date on which you receive your notice of the Adverse Benefit Determination which you are asking RLHICA to review.

To request a formal review of your claim, send your request in writing to: DENCERT.RLHI.SDSA.15.1801

Dental Director
Renaissance Dental - RLHICA
P.O. Box 1596
Indianapolis, IN 46206-1596

Please include your name and address, the Certificate Holder's Social Security number, the reason why you believe your claim was wrongly denied, and any other information you believe supports your claim. You also have the right to review This Plan and any documents related to it. The Dental Director, or any other person(s) reviewing your claim, will not be the same as, nor will they be subordinate to, the person(s), who initially decided your claim. The reviewer will grant no deference to the prior decision about your claim, but rather will assess the information, including any additional information that you have provided, as if he/she were deciding the claim for the first time. The reviewer's decision will take into account all comments, documents, records and other information relating to your claim even if the information was not available when your claim was initially decided.

If the decision is based, in whole or in part, on a dental or medical judgment (including determinations with respect to whether a particular treatment, drug, or other item is experimental, investigational or not medically necessary or appropriate), the reviewer will, as necessary, consult a dental health care professional with appropriate training and experience. The dental health care professional will not be the same individual, or that person's subordinate, consulted during the initial determination.

The reviewer will, within 5 business days of receiving the appeal, mail or transmit to you a letter of acknowledging receipt of the appeal and listing all information necessary to complete review. If a reviewer received an oral appeal of a Benefit Determination, the reviewer shall send a one page appeal form to the appealing party. The reviewer will make a determination and provide written notice to you and your provider within a reasonable period, but not later than 30 days after the date of which the appeal is received. An expedited appeal based on dental immediacy of a condition will not exceed one working day from the date all information necessary to complete the appeal is received. If your claim is denied on review (in whole or in part), you will be notified in writing. The notice of Adverse Benefit Determination during the Disputed Claims Appeal Procedure will meet the requirements described below under the heading "Manner and Content of Notice" and as otherwise required by Texas Insurance Code, Chapter 4201.

Manner and Content of Notice

Your notice of an Adverse Benefit Determination will inform you of the specific reasons(s) for the denial, the pertinent Policy provisions(s) on which the denial is based, the applicable review procedures for dental claims, including applicable time limits, and that you are entitled to access, free of charge, upon request, all documents, records and other information relevant to your claim. 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 appeal the decision to an independent review organization or bring a civil action in court if you receive an Adverse Benefit Determination after your claim has been completely reviewed according to this Disputed Claims Appeal Procedure. The notice will also reference any internal rule, guideline, protocol, or similar document or criteria relied on in making the Adverse Benefit Determination, and will include a statement that a copy of such rule, guideline or protocol may be obtained upon request at no charge. If the Adverse Benefit Determination is based on a matter of medical judgment or medical necessity, the notice will also contain an explanation of the scientific or clinical basis on which the determination was based.

If not later than the 10th working day after the date an appeal is denied, your provider states in writing good cause for having a particular type of specialty provider review the utilization review decision, then a provider who is the same or a similar specialty provider shall review the decision denying the appeal. The specialty review must be completed within 15 working days of the date the provider's request for specialty review is received.

If you (a) need the assistance of a government agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer, you may also contact the Consumer Protection Division of the Texas Insurance Department, P.O. Box 149104, Austin, Texas, 78714-9104.

X. Termination of Coverage

RLHICA must give your organization at least 45 days advance notice of cancellation, expiration, nonrenewal, or change in rates. In the event RLHICA chooses to terminate the Policy due to nonpayment of premium, RLHICA will give your organization notice of the termination within 45 days after the premium due date. 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 organization advises RLHICA to terminate your coverage;

2. On the last day of the month for which your organization has failed to pay RLHICA;

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.

XI. Continuation of Coverage

A. Loss of Eligibility During Treatment

1. If you and/or an Eligible Dependent lose eligibility while receiving dental 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 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 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 member 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 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 - Deceased 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 (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.

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 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.

XII. General Conditions

Change of Status

You must notify RLHICA through your 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 Dentist 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.

Subrogation

If RLHICA pays a claim for which another person or company is liable, RLHICA has the right to recover its payment from the other person or company.

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 dental records.

Dentist-Patient Relationship

You and your Eligible Dependents have the freedom to choose any Dentist. Each Dentixt maintians the dentist-patient relationship with the patient and is solely responsible to the patient for dental advice and treatment and any resulting liability.

Late Claims Submission

Except as otherwise provided in this Certificate, 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 one year from the date the proof of loss is otherwise required.

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 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 the applicable statute of limitations from 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.

Representations

In the absence of fraud, all statements made by your 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 application.

POLICY CONTRACTING DENTIST BENEFIT RIDER

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

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

If a Certificate Holder, or an Eligible Dependent, receives Covered Services from a Contracting Dentist, RLHICA will pay the applicable Copayment in excess of the applicable Deductible for Covered Services.

If a Certificate Holder or an Eligible Dependent receives Covered Services from a Non-Contracting Dentist, Benefits may be less than the amount that would have otherwise been payable with a Contracting Dentist. The same level of Benefits is paid for both Contracting and Non-Contracting Dentists. However, Contracting Dentists have agreed to accept pre-negotiated fees as payment in full for Covered Services, while the Certificate Holder will be responsible for any amount in excess of the Allowed Amount billed by a Non-Contracting Dentist.

Payment of Dental Bills With a Contracting Dentist

If a Certificate Holder or an Eligible Dependent receives Covered Services from a Contracting Dentist, the fee for services has already been agreed to between the Dentist and RLHICA. Contracting Dentists accept these pre-negotiated fees as payment in full for the dental care provided. The Certificate Holder will be responsible for paying the Dentist that percentage of the Allowed Amount listed in the "You Pay" column of the Summary of Dental Plan Benefits Section for the categories of services rendered.

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

Payment of Dental Bills With a Non-Contracting Dentist

If a Certificate Holder or an Eligible Dependent receives Covered Services from a Non-Contracting Dentist, payment will be based upon the percentage of the Allowed Amount that is set forth in the Summary of Dental Plan Benefits Section. The Certificate Holder will be responsible for paying the Dentist that percentage of the Allowed Amount listed in the 'You Pay' column of the Summary of Dental Plan Benefits Section for the categories of services rendered. In addition, if the Submitted Amount for a Non-Contracting Dentist is more than the Allowed Amount, the Certificate Holder will also be responsible for paying the Dentist the difference between the Submitted Amount and the Allowed Amount.

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

Termination of a Contracting Dentist's Participation under the Policy

In the event a Contracting Dentist terminates his or her participation under the Policy, RLHICA will provide reasonable advance notice of the impending termination, with a notice of the availability of a current listing of Contracting Dentists.

Definitions (As used in this rider):

Allowed Amount - is revised to mean the maximum dollar amount upon which RLHICA will base Benefits. For services rendered or items provided by a Contracting Dentist, the Allowed Amount is a pre-negotiated fee that the provider has agreed to accept as payment in full. For services rendered or items provided by a Non-Contracting Dentist, RLHICA determines the Allowed Amount using statistically valid claims data submitted to RLHICA and its affiliates which show the most frequently charged fees by providers in the same geographic areas for comparable services or supplies. The claims data and fees are updated periodically using the most current codes and nomenclature developed and maintained by the American Dental Association. (This definition is only applicable if the Allowed Amount method for Benefits is shown in the Declarations Section).

Contracting Dentist - means a Dentist who has entered into a contract to provide Covered Services for pre-negotiated fees that the Dentist has agreed to accept as payment in full. A current list of Contracting Dentists will be provided to each Certificate Holder.

Non-Contracting Dentist - means a Dentist who has not entered into a contract to provide Covered Services for pre-negotiated fees.

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

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

Renaissance Life & Health Insurance Company of America

Robert P. Mulligan, President and Chief Executive Officer

To obtain information or make a complaint:

Your may call Renaissance Life & Health Insurance Company of America's toll-free telephone number for information or to make a complaint at:

1-888-791-5995

You may also write to Renaissance Life & Health Insurance Company of America at:

Renaissance Life & Health Insurance
Company of America
P.O. Box 1596
Indianapolis, Indiana 46206-1596

You may contact the Texas Department of Insurance to obtain information on companies, coverage, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512)490-1007
Web: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIMS DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

Para obtener informaci¢n o para presentar una queja: Usted puede llamar al n£mero de telefono gratuito de Renaissance Life & Health Insurance Company of America para obtener informacion o para presentar una queja al:

1-888-791-5995

Usted tambien puede escribir a Renaissance Life & Health Insurance Company of America:

Renaissance Life & Health Insurance
Company of America
P.O. Box 1596
Indianapolis, Indiana 46206-1596

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener informaci¢n sobre companias, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Sitio web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES: Si tiene una disputa relacionada con su prima de seguro o con una reclamaci¢n, usted debe comunicarse con la compa¤¡a primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU POLIZA: Este aviso es solamente para prop¢sitos informativos y no se convierte en parte o en condici¢n del documento adjunto.

NOTICE OF PRIVACY PRACTICES

Date of this notice: December 20, 2017

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS 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 Electornic Services, LLC, Tesia Clearinghous, LLC (collectively, 'we' or 'us' or the 'Plan'). These entities have designated themselves as a single affiliated coverered entity for the purposes of the privacy rules under the Health Insurance Portability and Accountability Act of 1996 ('HIPAA'), and each has to agree to abide by the terms of this Notice and may share protected health information with each other as necessary for treatment 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 related to retention and destuction 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 subpeona, discovery request, or other lawful process by someone 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 persons;
* 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 identify, 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 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/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
PO Box 30416
Lansing, MI 48909-7916
517-347-5451 (TTY users call 711)

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 share your personal information	**Does Renaissance Life & Health Insurance Company of America share?**	**Can you limit this sharing?**
For our everday 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 espanol, llame al numero de servicio al cliente (customer service) que se incluyeo en el reverso de su tarjeta de indentificacion.

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

Renaissance
Life & Health Insurance Company of America

Renaissance
Group Vision Certificate

National Associated Buying Services Association

P.O. Box 1596 * Indianapolis, Indiana 46206 * 888-358-9484 (TTY users call 711) * www.RenaissanceDental.com

RENAISSANCE
GROUP VISION CERTIFICATE

Table of Contents

Important Cancellation Information - Please read Section IX Entitled, "Termination of Coverage"

NOTE: This Group Vision Certificate should be read in conjucntion 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").

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the company.

READ YOUR GROUP VISION CERTIFICATE CAREFULLY

Renaissance Life & Health Insurance Company of America

Summary of Vision Plan Benefits - Choice Plan

For Group# 90137

National Associated Buying Services Association (NABSA)

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 - 12 months from Date of Service

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 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 Summary forms a part of the Certificate 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 Certificate, may have a separate Copayment. Please refer to COVERED SERVICES AND MATERIALS, below.

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK 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	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
LENSES			Available once every 24 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	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
FRAMES	Covered up to Plan Allowance*	Up to $70.00*	Available once every 24 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	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK 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 24 months, after a maximum $60.00 Copayment		Available ovce every 24 Months**
	Material 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 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 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 24 months.

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK 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 $1,000.00*	75% of amount up to $1,000.00*	*

*Maximum benefit for all Low Vision services and materials is $1,000.00 every two (2) years.

Low Vision benefits secured from Out-of-Network Providers 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.

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.
* Replacement of lost or damaged contact lenses, except at the normal intervals when services are otherwise available.

GENERAL

Affiliate Providers are providers of Covered Services and materials who are not contracted as In-Network 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 24 Months**
Frames	Covered up to the Plan allowance*	Available once every 24 Months**

CONTACT LENSES

Elective Contact Lenses (Materials Only)	Up to $105.00	Available once every 24 Months**

The Elective Contact Lens fitting and evaluation services are covered in full once every 24 Months, after a maximum $60.00 Copayment.

Necessary Contact Lenses	Up to $210.00*	Available once every 24 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.

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 $1,000.00*

*Maximum benefit for all Low Vision services and materials is $1,000.00 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 In-Network Providers shall also apply to services rendered by Affiliate Providers.

2. Services from an Affiliate Provider are in lieu of services from an In-Network Provider or an Out-of-Network 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 to elect coverage hereunder.

All eligible are your Legal Spouse and any individuals who meet the definition of Child(ren) as set forth in your 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 Certificate

RLHICA issues this Renaissance Group Vision 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 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 1596
Indianapolis, IN 46206-1596

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.

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 Out-of-Network 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 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.

Benefit Year

Means the calendar year, unless your 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 organization certifies to RLHICA that you are eligible to receive Benefits under This Plan.

Child

Child means your natural child, stepchild, adopted child (without respect to residency and including while the Certificate Holder is a party to a suit seeking to adopt the child), grandchild, foster child, including a child by virtue of legal guardianship during the waiting period for legal adoption or a child under legal guardianship if that child is unmarried and meets one of the following:

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

2.You or your Legal Spouse's Child if, pursuant to a court decree or medical support order issued under Chapter 154 of the Texas Family Code (or enforceable by a court in the state of Texas), you or your Legal Spouse is financially responsible for the vision care of the Child; or

3.You or your Legal Spouse's grandchild who (a) has not yet reached the end of the calendar year of his or her 26th birthday and (b) is dependent on you or your Legal Spouse for federal income tax purposes at the time of application for coverage under this Policy (coverage cannot be terminated solely because the grandchild is no longer dependent on You or Your Legal Spouse for federal income tax purposes); or

4.Your Child 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 retardation or physical disability and (b) chiefly dependent upon you for support and maintenance. In order to obtain coverage, you must notify RLHICA within 31 days of the date the Child reaches the Limiting Age. In the event that RLHICA denies a claim under this Policy for the reason that the child has attained the Limiting Age for dependent children, you have the burden of establishing that the Child continues to meet the two criteria specified above. If requested by RLHICA, you shall submit medical reports confirming that the Child meets the two criteria specified above. Such requests will not be made more frequently than annually.

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 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 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.

In-Network 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 In- Network providers will be made available to Certificate Holders.

Legal Spouse

Means a person who is your spouse through a marriage legally recognized by the State in which the Policy 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.

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.

Out-of-Network 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.

Policy

Means the insurance contract for the provision of Benefits to you and your Eligible Dependents between RLHICA and your 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.

Provider

Means an optometrist, therapeutic 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 organization on the initial Effective Date of the Policy, eligibility for Benefits will begin, unless otherwise stated as follows:

   a. New 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.

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

   d. Child subject to a medical support order or court decree: Date of Policyholder's receipt (or notice of) the medical support order or court decree;

   e. Foster children or guardianships: Date the Child is placed in the foster home or with the Certificate Holder, or at the time Certificate Holder becomes party to a suit to adopt the child, at which time this Child will be covered on the same basis as a natural child;

   f. Adopted Children: Date of birth, adoption, placement for adoption, or filing of the suit to seek adoption;

   g. Grandchild: Date the Child becomes dependent on you or your Legal Spouse for federal income tax purposes;

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

   i. 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 30 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

Dependents are not properly enrolled for coverage within 30 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. With respect to Newborn Children, you must notify RLHICA of the birth of the Newborn Child within 31 days from the date of birth, and pay any additional premium required to continue the automatic coverage in force. With respect to Children covered pursuant to a court decree or medical support order issued under Chapter 154 of the Texas Family Code (or enforceable by a court in the state of Texas), application for coverage must be made within 31 days after receipt (or notice) of a medical support order, along with any additional premium required to continue the automatic coverage in force.

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 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 In-Network Providers

To receive Covered Services from an In-Network Provider, You should select an In-Network Provider, schedule an appointment and inform the Provider's office that you are a Covered Person under this Certificate. The In-Network 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 In-Network 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 In- Network Provider that payment will be made to the In-Network 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. You or your Eligible Dependents may obtain information on In-Network 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 Out-of-Network Providers

If required by state law, or if purchased by the Policyholder, this Policy will provide Benefits for services and materials received from Out-of-Network Providers, based on the Out-of-Network Provider fee schedule. The Out-of-Network 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 an Out-of-Network Provider, you or your Eligible Dependents remain liable for the Out-of-Network Provider's full fee. You or your Out-of-Network Providers may submit requests for reimbursement. RLHICA's claims administrator will pay available Benefits to you or your Eligible Dependents, or directly to Out-of-Network 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 an In-Network Provider or an Out-of-Network Provider (if Out-of-Network 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 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 In-Network 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 an Out-of-Network 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 15 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 as soon as received and within 15 days. If applicable, failure to pay within that period shall entitle you to interest at the state prescribed rate per annum from the 30th day. Interest amounts less than one dollar ($1.00) will not be paid.

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 a Benefit Determination, RLHICA will notify you or your

Authorized representative of the beneficiary determination within a reasonable period of time, but not later than 30 days after receipt of the claim. RLHICA's claims administrator may extend this period by up to 15 days if it determines that the extension is necessary due to matters out of its control.

After written notice has been sent to RLHICA at its home office, benefits payable on behalf of an Eligible Dependent must be paid to the Texas Department of Human Services if:

1. The parent who is the Certificate Holder under this Policy is required to pay child support by a court order or court approved agreement and:

   a. Is a possessory conservator of the Eligible Dependent under a court order issued in the state of Texas; or

   b. Is not entitled to possession of or access to the Eligible Dependent;

2. The Texas Department of Human Services is paying benefits on behalf of the Eligible Dependent under Chapter 31 or 32 of the Texas Human Resources Code; and

3. RLHICA is notified, through an attachment to the claim for Benefits at the time the claim is first submitted to it, that the Benefits must be paid directly to the Texas Department of Human Services.

If you have any questions about This Plan, please check with your 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 an In-Network Provider, you are only responsible for applicable Copayments and anything not covered by the plan. For Covered Services provided by an Out-of-Network Provider, you will pay for the services in full and will be reimbursed up to the Out-of-Network 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:

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. 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.

Dependent Child/Parents Separated or Divorced. Except as stated in subparagraph (C)(2)(c) below, when This Plan and another Plan cover the same Child as a dependent of different persons, called "parents:"

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

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

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

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

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

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

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

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

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

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the Child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This subparagraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the enitiy 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.

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 a 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 thirty (30) calendar days after receipt of the request for the appeal. Incomplete appeal information will suspend the 30 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 a 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

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 a 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 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 Protection Division of the Texas Insurance Department, P.O. Box 149104, Austin, Texas, 78714-9104.

IX. Termination of Coverage

RLHICA must give your organization at least 45 days' advance notice of cancellation, expiration, nonrenewal, or change in rates. In the event RLHICA chooses to terminate the Policy due to nonpayment of premium, RLHICA will give your organization notice of the termination within 45 days after the premium due date. 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 organization advises RLHICA to terminate your coverage;

2. On the last day of the month for which your organization has failed to pay RLHICA;

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 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 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 member 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 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 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 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.

Subrogation

If RLHICA pays a claim for which another person or company is liable, RLHICA has the right to recover its payment from the other person or company.

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

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 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, all statements made by your 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 application.

To obtain information or make a complaint:

Your may call Renaissance Life & Health Insurance Company of America's toll-free telephone number for information or to make a complaint at:

1-888-791-5995

You may also write to Renaissance Life & Health Insurance Company of America at:

Renaissance Life & Health Insurance
Company of America
P.O. Box 1596
Indianapolis, Indiana 46206-1596

You may contact the Texas Department of Insurance to obtain information on companies, coverage, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512)490-1007
Web: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIMS DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

Para obtener informaci¢n o para presentar una queja: Usted puede llamar al n£mero de telefono gratuito de Renaissance Life & Health Insurance Company of America para obtener informacion o para presentar una queja al:

1-888-791-5995

Usted tambien puede escribir a Renaissance Life & Health Insurance Company of America:

Renaissance Life & Health Insurance
Company of America
P.O. Box 1596
Indianapolis, Indiana 46206-1596

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener informaci¢n sobre companias, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Sitio web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES: Si tiene una disputa relacionada con su prima de seguro o con una reclamaci¢n, usted debe comunicarse con la compa¤¡a primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU POLIZA: Este aviso es solamente para prop¢sitos informativos y no se convierte en parte o en condici¢n del documento adjunto.

NOTICE OF PRIVACY PRACTICES

Date of this notice: December 20, 2017

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS 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 Electornic Services, LLC, Tesia Clearinghous, LLC (collectively, 'we' or 'us' or the 'Plan'). These entities have designated themselves as a single affiliated coverered entity for the purposes of the privacy rules under the Health Insurance Portability and Accountability Act of 1996 ('HIPAA'), and each has to agree to abide by the terms of this Notice and may share protected health information with each other as necessary for treatment 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 related to retention and destuction 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 subpeona, discovery request, or other lawful process by someone 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 persons;
* 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 identify, 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 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/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
PO Box 30416
Lansing, MI 48909-7916
517-347-5451 (TTY users call 711)

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 share your personal information	**Does Renaissance Life & Health Insurance Company of America share?**	**Can you limit this sharing?**
For our everday 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 espanol, llame al numero de servicio al cliente (customer service) que se incluyeo en el reverso de su tarjeta de indentificacion.

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 Life & 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 informtion 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.