Renaissance®

Life & Health Insurance Company of America

Renaissance
Group Vision Certificate

P.O. Box 1596, Indianapolis, IN 46206 | www.RenaissanceBenefits.com | 800-894-4532

V-200A-2014-TX

RENAISSANCE
GROUP VISION CERTIFICATE

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

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

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

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

IMPORTANT NOTICE

To obtain information or to make a complaint:

You 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, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512)475-1771
Web :**http://www.tdi.texas.gov**
Email :**consumerprotection@tdi.texas.gov**

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact Renaissance Life & Health Insurance Company of America 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.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de Renaissance Life & Health Insurance Company of America para informacion o para someter 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

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512)475-1771
Web : **http://www.tdi.texas.gov**
Email :**consumerprotection@tdi.texas.gov**

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con Renaissance Life & Health Insurance Company of America primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

Renaissance Life & Health Insurance Company of America
Summary of Vision Plan Benefits – Choice Plan
For MP0000356718 – ER Contrib Vision Plan 120 12-12-12

This Summary of Vision Plan Benefits 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 - January 1 through December 31

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 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 Providers, the Covered Person is reimbursed for such Benefits according to the schedule in the 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 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 $10 Copayment payable at the time materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

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

BENEFITS – IN-NETWORK AND OUT-OF-NETWORK PROVIDERS

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 each calendar year**
Complete initial vision analysis: includes appropriate examination of visual functions and prescription of corrective eyewear where indicated. *Less any applicable Copayment. **Beginning with the first date of service.			

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
LENSES			Available once each calendar year**
Single Vision	Covered in full*	Up to $30.00*	
Lined Bifocal	Covered in full*	Up to $50.00*	
Lined Trifocal	Covered in full*	Up to $65.00*	
Lenticular	Covered in full*	Up to $100.00*	

Benefits for lenses are per complete set, not per lens.

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

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
Frames	Covered up to Plan Allowance*	Up to $70.00*	Available once each calendar year**

Benefits for lenses and frames include reimbursement for the following necessary professional services:

1. Prescribing and ordering proper lenses;
2. Assisting in frame selection;
3. Verifying accuracy of finished lenses;
4. Proper fitting and adjustments of frames;
5. Subsequent adjustments to frames to maintain comfort and efficiency;
6. Progress or follow-up work as necessary.

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

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
CONTACT LENSES			
Necessary			Available once each calendar year**
Professional Fees/ Materials	Covered in full*	Up to $210.00*	
Elective	Elective Contact Lens fitting and evaluation*** services are covered in full once each calendar year**, after a maximum $60.00 Copayment.		Available once each calendar year**
	Materials Up to $120.00	**Professional Fees/ Materials** Up to $105.00	

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

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

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

COVERED SERVICE OR MATERIAL	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 $1000.00*	75% of amount up to $1000.00*	*

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

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

PATIENT OPTIONS

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

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

NOT COVERED

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

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

BENEFITS – AFFILIATE PROVIDERS

GENERAL

Affiliate Providers are providers of Covered Services and materials who are not contracted as 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 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 $10 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 each calendar year**

Comprehensive examination of visual functions and prescription of corrective eyewear.

Spectacle Lenses

Single Vision, Lined Bifocal or Lined Trifocal	Covered in full*	Available once each calendar year**
Frames	Covered up to the Plan allowance*	Available once each calendar year**

CONTACT LENSES

Elective Contact Lenses (Materials Only)	Up to $120.00	Available once each calendar year**

The Elective Contact Lens fitting and evaluation services are covered in full once each calendar year, after a maximum $60.00 Copayment.

Necessary Contact Lenses	Up to $210.00*	Available once each calendar year**

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 calendar year.

LOW VISION

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

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

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

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

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for Providers shall also apply to services rendered by Affiliate Providers.
2. Services from an Affiliate Provider are in lieu of services from a Provider or an 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 Full Time Eligible Employees of the Policyholder working at least 30 hours per week, retirees, members of an association or trust, and all individuals who are eligible for and elect Continuation Coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 or similar applicable state law. ("COBRA").

Also eligible are your Legal Spouse or Domestic Partner and your Children. Coverage for Children will terminate at the end of the calendar year of their 26th birthday.

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

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

A Domestic Partner is defined as follows:

- each party is the sole Domestic Partner of the other;
- each party is at least 18 years of age or older and competent to enter into a contract in the state in which they reside;
- both parties currently share a common legal residence and have shared said residence for at least six months prior to application for Domestic Partner coverage;
- neither party is married to anyone or related to the other by adoption or blood to a degree of closeness that would otherwise bar marriage in the state in which they legally reside;
- both parties are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship in the indefinite future;
- both parties are jointly responsible for basic living expenses (basic living expenses are defined as the cost of basic food, shelter, and any other expenses of the common household - the partners need not contribute equally or jointly to the payment of these expenses as long as they agree that both are responsible for them); and
- neither party filed a Termination of Domestic Partnership within the preceding nine months.

I. RENAISSANCE GROUP VISION PPO 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 employer or organization (the “Policyholder”).

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

RLHICA agrees to provide Benefits as described in this Certificate.

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

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

Jeffrey Kolesar
Interim President and CEO

Home Office:

Renaissance Life & Health Insurance Company of America

Attn: Renaissance Administration
P.O. Box 1596
Indianapolis, IN 46206

Administrative Direct Line: **1-800-745-7509**
Customer Service Direct Line:
1-888-791-5995 (TTY users call 711)
Claim Service Direct Line: **1-800-877-7195**

II. DEFINITIONS

Additional Benefit Rider

Means a document, attached as a rider to this Certificate (when purchased by the Policyholder) which lists selected supplemental vision care services and vision care materials which a Covered Person is entitled to receive under this Certificate.

Adverse Benefit Determination

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

Assignments of Benefits

Means a written order signed by a Covered Person, eighteen (18) years of age or older, and included with each claim, directing RLHICA's claims administrator to pay available Benefits to a named 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 Year

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

Benefits

Means payment for Covered Services.

Certificate

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

Certificate Holder

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

Children

Means your natural children, stepchildren, adopted children, foster children or children by virtue of legal guardianship during the waiting period for legal adoption or guardianship who are or meet one of the following:

- Your child(ren) who has not reached the end of the calendar year of their 25th birthday; or,
- 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
- You or your Legal Spouse's grandchild who is: (a) younger than 25 years of age; and (b) 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
- Your Child who has reached the end of the calendar year of his or her 25th 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 Covered Persons acquired by RLHICA in the course of providing the Benefits hereunder.

Copayment

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

Covered Person

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

Covered Services

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

Eligible Dependent

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

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 any of the following: (a) your spouse through a marriage legally recognized by the State in which the Policy governing this Certificate was issued; (b) your partner through a civil union legally recognized by the State in which the Policy governing this Certificate was issued; or (c) your Domestic Partner so long as the requirements listed in the Summary of Vision Plan Benefits Section are met and proof that those requirements are met is provided to RLHICA at its request.

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 employer or organization. Policy includes, if applicable, the application, this Certificate and any appendices, supplements, riders, successor agreements or renewals now or hereafter executed.

Policy Year

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

Provider

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

RLHICA

Means Renaissance Life & Health Insurance Company of America.

Summary of Vision Plan Benefits

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

This Plan

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

Urgent Condition

Means a condition with sudden onset and acute symptoms which requires the Covered Person to obtain immediate care; or an unforeseen occurrence calling for immediate action.

III. GENERAL ELIGIBILITY RULES

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

B. Effective Date of Eligibility

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

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

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

b. **Spouse:** Date of marriage, civil union or domestic partnership;

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

C. Termination of Eligibility

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

1. The termination of the Policy; or

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

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

IV. BENEFITS

COVERED SERVICES

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

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

A. General

This Certificate provides Benefits for you and your Eligible Dependents, if dependent coverage is selected by the Policyholder.

B. Copayments for Covered Services

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

C. Obtaining Covered Services from In-Network Providers

To receive Covered Services from a In-Network Provider, You should select a 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. If you or your Eligible Dependents receive Covered Services from a In-Network Provider without a Benefit Authorization, any services or materials received from

the In-Network Provider will be treated as if they were obtained from a Out-of-Network Provider. You or your Eligible Dependents may obtain information on In-Network Providers through our website: www.RenaissanceFamily.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 a 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 a In-Network Provider or a 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 (TTY users call 711) for assistance. Reimbursement and eligibility are subject to the terms and conditions of this Certificate.

V. ACCESSING YOUR BENEFITS

To access your Benefits, follow these steps:

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

2. Make an appointment with your 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 within 30 days of receipt of the claim, or notify you that the claim has been denied or deemed incomplete.

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

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

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

VI. QUESTIONS AND ANSWERS

May I choose any Provider?

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

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

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

How much of the vision bill do I pay?

If you choose a In-Network Provider, you are only responsible for applicable Copayments and anything not covered by the plan. For Covered Services provided by a 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:

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

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

B. DEFINITIONS

1. **"Allowable Expense"** means an expense covered under this Certificate when the item of expense is covered

at least in part by one or more Plans covering the person for whom the claim is made.

When a Plan provides payment for services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

2. **"Claim Determination Period"** means a calendar year during which Allowable Expenses are compared with total Benefits payable in the absence of COB, to determine whether overinsurance exists and how much each Plan will pay or provide. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

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

   a. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage;

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

   Each contract or other arrangement for coverage under (a) or (b) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

4. **"Primary Plan/Secondary Plan:"** The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

   When This Plan is a Primary Plan, its Benefits are determined before those of the other Plan and without considering the other Plan's benefits.

   When This Plan is a Secondary Plan, its Benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

   When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

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

C. ORDER OF BENEFIT DETERMINATION RULES

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

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

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

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

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

      (ii) Primary to the Plan covering the person as other than a dependent (*e.g.,* a retired employee), then the order of benefit

determination is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Plan is primary.

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

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

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

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

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

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

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

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

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

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

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

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

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

e. Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal

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

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

D. EFFECT ON THE BENEFITS OF THIS PLAN

1. When This Paragraph Applies. This Paragraph D. applies when, in accordance with Paragraph C. "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other Plans. In that event the Benefits of This Plan may be reduced under this Paragraph D. Such other Plan or Plans are referred to as "the other Plans" in subparagraph (D)(2) immediately below.

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

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

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

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

E. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

F. FACILITY OF PAYMENT

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

That amount will then be treated as though it were a Benefit paid under This Plan. RLHICA's claims administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

G. RIGHT OF RECOVERY

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

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

2. Insurance companies; or

3. Other organizations.

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

VIII. CLAIM DENIAL APPEALS

If you receive notice of an Adverse Benefit Determination, and if you think that RLHICA incorrectly denied all or part of your claim, you or your Provider should contact the Member Services Department and ask them to check the claim to make sure it was processed correctly. You may do this by calling the toll-free number, 1-800-877-7195 (TTY users call 711) and speaking to a representative. You may also mail your inquiry to VSP, ATTN: Appeals Department P.O. Box 1596, Indianapolis, IN 46206 .

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

Second Level Appeal

If you disagree with the response to the Initial Appeal of the denied claim, you have the right to a Second Level Appeal. A request for a Second Level Appeal must be submitted to RLHICA's claims administrator within sixty (60) calendar days after receipt of the response to the Initial Appeal. Communication of a final determination to you shall be provided within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. The communication to you shall include the specific reasons for the determination.

Other Remedies

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

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

IX. TERMINATION OF COVERAGE

RLHICA must give your employer or 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 employer or 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 employer or organization advises RLHICA to terminate your coverage;

2. On the last day of the month for which your employer or organization has failed to pay RLHICA subject to the applicable Grace Period;

3. Or for any other reason stated in the Policy.

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

X. CONTINUATION OF COVERAGE

A. Loss of Eligibility During Treatment

1. If you and/or an Eligible Dependent lose eligibility while receiving vision treatment, only those Covered Services received while you and/or your Eligible Dependent were eligible under the Policy will be payable.

2. Certain procedures begun before the loss of eligibility may be covered if the services were completed within a 90 day period measured from the date of termination. In those cases, RLHICA evaluates those services in progress to determine what portion may be paid by RLHICA. The difference between RLHICA's payment and the total fee for those procedures is your responsibility.

B. Continuation Coverage – COBRA

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

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

1. Voluntary or involuntary termination of employment for any reason other than your gross misconduct;

2. Reduction in the number of hours worked so that you are no longer an eligible employee under the terms of the group health plan;

3. Divorce or legal separation;

4. Death;

5. Loss of dependent status under the terms of the group health plan; or

6. You become entitled to Medicare (if applicable).

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

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

C. Continuation Coverage – Death of Certificate Holder

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

D. Continuation Coverage – Eligible Dependents

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

E. Continuation Coverage – Total Disability

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

XI. GENERAL CONDITIONS

Change of Status

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

Assignment

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

Right of Recovery

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

Obtaining and Releasing Information

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

Provider-Patient Relationship

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

Late Claims Submission

Except as otherwise provided in this Certificate, RLHICA's claims administrator will not honor and no payment will be made for services, items or supplies if a claim for those services, items or supplies has not been received by RLHICA's claims administrator within one year from the date that the services, items or supplies were provided.

Change of Certificate or Policy

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

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

Legal Actions

No legal action may be brought to recover on this Policy within 60 days after written proof of loss has been given as required by this Policy, unless otherwise provided by applicable state law. No such action may be brought after the expiration of three years after the time written proof of loss is required to be given. This provision does not preclude the Policyholder or Certificate Holder from seeking a decision from a jury trial once all administrative appeals have been exhausted.

Representations

In the absence of fraud, all statements made by your employer or organization or by you or your Eligible Dependents, shall be deemed to be representations and not warranties. No such statement shall be used in defense to a claim under the Policy, unless it is contained in a written application.

ADDITIONAL BENEFIT RIDER

SUPPLEMENTAL PRIMARY EYECARE PLAN

GENERAL

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

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

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

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

SYMPTOMS

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

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

CONDITIONS

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

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

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

ELIGIBILITY

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

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

COPAYMENT

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

PLAN BENEFITS

SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT*
Eye Examination	Covered in full, less Copayment	Up to current Out-of-Network Schedule of Allowances
Consultation	Covered in full, less Copayment	Up to current Out-of-Network Schedule of Allowances
Urgent/Emergency Care	Covered in full, less Copayment	Up to current Out-of-Network Schedule of Allowances
Special Ophthalmological Services	Covered in full, less Copayment	Up to current Out-of-Network Schedule of Allowances
Eye and Ocular Adnexa Services	Covered in full, less Copayment	Up to current Out-of-Network Schedule of Allowances

***Services from an Out-of-Network provider are in lieu of services from an In-Network Provider. There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full. RLHICA's claims administrator is unable to require Out-of-Network Providers to adhere to its quality standards.**

IN-NETWORK PROVIDER REFERRALS

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

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

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

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

DEFINITIONS

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

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE
TEXAS LIFE, ACCIDENT, HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION
(For insurers declared insolvent or impaired on or after September 1, 2005)

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect Texas policyholders if their life or health insurance company fails. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not cover your policy in full or in part due to statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas at that time **(irrespective of the policyholder's residency at policy issue)**
- Residents of other states, ONLY if the following conditions are met:
    1. The policyholder has a policy with a company domiciled in Texas;
    2. The policyholder's state of residence has a similar guaranty association; and
    3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, and $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on any one life; or
- Death benefits up to a total of $300,000 under one or more policies on any one life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $100,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $100,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage.

Texas Life, Accident, Health and Hospital
Service Insurance Guaranty Association
6504 Bridge Point Parkway, Suite 450
Austin, Texas 78730
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.state.tx.us

NOTICE OF PRIVACY PRACTICES

Date of This Notice: July 20, 2021

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

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

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

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

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

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

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

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

REQUIRED DISCLOSURES

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

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

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

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

WRITTEN AUTHORIZATION

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

ADDITIONAL INFORMATION REGARDING USES OR DISCLOSURES OF YOUR PHI

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

YOUR RIGHTS REGARDING PHI THAT WE MAINTAIN

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

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

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

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

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

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

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

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

Your Right to a Paper Copy of This Notice

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

Your Right to Appoint a Personal Representative

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

CHANGES TO THIS NOTICE

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

COMPLAINTS

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

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

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

SEND ALL WRITTEN REQUESTS REGARDING THIS PRIVACY NOTICE TO:

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

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

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

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

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

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

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