Ameritas Life Insurance Corp.

A STOCK COMPANY
5900 "O" Street
Lincoln, Nebraska 68510

GROUP EYE CARE INSURANCE POLICY

The Policyholder	**CULPEPER COUNTY AND SCHOOLS**		
		Policy Number	**10-350788**
State of Delivery	**Virginia**	**Plan Effective Date**	**October 1, 2014**
Premium Due Date 1st of each month.		**Renewal Date**	**October 1**

Ameritas Life Insurance Corp. agrees to pay, with respect to each Insured Person, the group insurance benefits provided in this policy.

This policy is issued to the Policyholder in consideration of the Policyholder's application and the payment of premiums, as provided herein.

This policy is delivered in and governed by the laws of the state of delivery.

We are subject to regulations in the Commonwealth by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

AMERITAS LIFE INSURANCE CORP.

Corporate Secretary

President

VIRGINIA
IMPORTANT INFORMATION REGARDING YOUR INSURANCE

This notice contains important information about how to file complaints, grievances or appeals with us. Please read this and the Explanation of Benefits (EOB) that is sent in response to a claim or request for a pre-treatment estimate of benefits. The EOB will have information specific to that benefit determination.

WHO TO CONTACT

If you need to contact us about your insurance, please see the following address:

Complaint Officer
Quality Control
P.O. Box 82657
Lincoln, NE 68501-2657
1-877-897-4328 (Toll-Free)
402-309-2579 (FAX)

You may call us between the hours of 8:00 a.m. to 7:00 p.m. ET Monday through Friday. After hours, you may leave a message and we will return your call. Consultants are available for discussions with treating providers 40 hours per week during typical working hours.

If you have been unable to contact us or if you need additional help, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

In writing:	Life and Health Division Bureau of Insurance P.O. Box 1157 Richmond, VA 23218
Richmond area:	804-371-9741
In Virginia:	1-800-552-7945
Out-of-State:	1-877-310-6560

Since this coverage includes an option to seek services from a participating provider (PPO), both the Virginia Department of Health and the Virginia Bureau of Insurance are also available to assist you.

If you have any questions regarding an appeal, or grievance concerning the health care services that you have been provided, that have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance.

Contacting the Managed Care Ombudsman at the Bureau of Insurance:

In writing:	Office of the Managed Care Ombudsman Bureau of Insurance P.O. Box 1157 Richmond, VA 23218
Toll-free:	1-877-310-6560
In Richmond area:	804-371-9032
Email:	ombudsman@scc.Virginia.gov
Web Page:	Information regarding the ombudsman may be found by accessing the state corporation commission's web page at: www.scc.virginia.gov

Contacting The Office of Licensure and Certification (OLC)

In writing:	Virginia Department of Health 9960 Mayland Drive, Suite 401

	Richmond, VA 23233
Toll-free:	1-800-955-1819
Richmond metro area:	804-367-2106
Fax:	804-527-4503
Email:	mchip@vdh.virginia.gov
Web Page:	Information regarding The Office of Licensure and Certification may be found by accessing the Department of Health's web page at www.vdh.virginia.gov/olc.

HOW GRIEVANCES AND APPEALS ARE HANDLED

If you wish to file a complaint, grievance or appeal, please review the information below.

I. Definitions

"Adverse Decision" means a determination by Private Review Agent, Ameritas Life Insurance Corp., that a dental service is not medically necessary and reimbursement for the service is either denied or reduced.

"Covered Person" means the policyholder, claimant or representatives, provider, agent or other entity which expresses a grievance or complaint involving our activities or any persons involved in the solicitation, sale, service, execution of any transaction, or disposition of any funds of the policyholder.

"Grievance" means a complaint on behalf of an insured person submitted by a covered person including, but not limited to, a provider, authorized in writing to act on behalf of the insured person regarding:

(a) the availability, delivery, or quality of covered services;
(b) benefits or claims payment, handling, or reimbursement for covered services;
(c) matters pertaining to the contractual relationship between a covered person and the insurer.

II. Grievance and Appeal Procedures

A. Requesting an Appeal or Filing a Grievance

At any time, you may file a grievance about the matters defined in the section above. You cannot be disenrolled or penalized in any way because a grievance or complaint was filed.

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting us, or any of the regulatory agencies, use the contact information above and include your identification and/or policy number.

B. Internal Reviews

For situations or issues other than an adverse decision, the grievance will be reviewed by all appropriate internal parties. We will respond to a grievance within 30 days and will provide a written letter of our final decision no later than 60 days from the date of receipt of the grievance.

For those situations which meet the definition of an adverse decision and we receive a request for reconsideration of this decision, we will notify you and the provider within 10 working days following the request for reconsideration. If the decision is upheld and you request a formal appeal, we will provide a written letter of our final decision no later than 60 working days after receiving the required documentation.

For a formal appeal of an adverse decision, the case will be reviewed by a peer of the treating provider who was primarily responsible for the care under review. The licensed provider who renders the final decision on an appeal will not have participated in the adverse decision or any prior reconsideration

and will not be employed by or a director of the company.

You have the right to participate via a teleconference call or in person during the review process in order to present additional information regarding an appeal of an adverse decision.

C. Expedited Reviews

Requests for reconsideration or appeal of prospective pre-treatment estimates related to urgent care will be reviewed within 1 business day of the request and receipt of all information necessary to make the determination. We will provide our decision by telephone or e-mail and send written confirmation within 24 hours of the decision.

PPO Participant Rights and Responsibilities

Your Rights

- You have the right to receive considerate and respectful care, with recognition of your personal dignity regardless of race, color, religion, sex, age, physical or mental handicap or national origin.
- You have the right to participate with your network provider in decision-making regarding your eye care.
- You have the right to know your costs in advance for routine and emergency care.
- You have the right to tell us when something goes wrong.
- Start with your provider. He/she is your primary contact.
- If you have a problem that cannot be resolved with your provider, call our claims department for assistance at 1-877-897-4328.
- You have the right to know about your PPO plan, covered services, network providers, and your rights and responsibilities. This includes:
- The right to schedule an appointment with your network provider office within a reasonable time.
- The right to see a provider within 24 hours for emergency care.
- The right to information from your network provider regarding appropriate or necessary treatment options without regard to cost or benefit coverage.
- The right to obtain information on types of payment arrangements used to compensate providers.
- The right to request information regarding the PPO plan's quality goals.
- The right to request information regarding the PPO plan’s annual performance.
- You have the right to privacy and confidential treatment of information and medical records, as provided by law.

Your Responsibilities

- Read the details of your Certificate.
- Provide information to your provider that he/she needs to know to provide appropriate care.
- Feel free to call us to address any concerns you may have.
- Let your provider know whether you understand the treatment plan he/she recommends and follow the treatment plan and instructions for care.
- Pay any coinsurance due as soon as possible for the care received so your provider can continue to serve you.
- Be considerate of the rights of other patients and the provider office personnel.
- Keep appointments or cancel in time for another patient to be seen in your place.

NOTICE OF
PROTECTION PROVIDED BY
VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or health insurance company licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
  - o $300,000 in death benefits
  - o $100,000 in cash surrender or withdrawal values
- Health Insurance
  - o $500,000 in hospital, medical and surgical insurance benefits
  - o $300,000 in disability [income] insurance benefits
  - o $300,000 in long-term care insurance benefits
  - o $100,000 in other types of health insurance benefits
- Annuities
  - o $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000, except for hospital, medical and surgical insurance benefits, for which the limit is increased to $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association's website at www.valifega.org or contact:

VIRGINA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.
8001 Franklin Farms Drive, Suite 235
Henrico, VA 23229
804-282-2240

STATE CORPORATION COMMISSION
Bureau of Insurance
P. O. Box 1157
Richmond, VA 23218
804-371-9741
Toll Free Virginia only: 1-800-552-7945
http://www.scc.virginia.gov/division/boi/index.htm

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia law, then Virginia law will control.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

Benefit Class	Class Description
Class 1	All Eligible Employees

EYE CARE EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount	$0

Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.

PREMIUMS

TABLE OF MONTHLY PREMIUM RATES

Eye Care Insurance	$6.08 per Insured Person
	$6.00 Spouse Only
	$4.64 Child(ren) Only
	$10.64 Spouse & Child(ren)

PAYMENT OF PREMIUMS. The first premium will be due on the Policy Effective Date to cover the period from that date to the first Premium Due Date. Other premiums will be due on or before each Premium Due Date. Premiums are payable at our Home Office or at some other location to which we and the Policyholder agree.

PREMIUM DUE DATE. The Premium Due Date will be the first day of the month that falls on or after the Policy Effective Date. If we agree with the Policyholder to the payment of premiums on a basis other than monthly, the Premium Due Date will be fixed to match the correct basis. If there is a change in the method of payment or Premium Due Date, a pro-rata charge in the premium due will be made.

PREMIUM STATEMENTS. The premium due as of any Premium Due Date is the number of units in force on such date for each type of insurance multiplied by the rate shown in the Table of Premium Rates. A premium statement will be made as of the Premium Due Date showing the premium payable. If premiums are payable on other than a monthly basis, each statement will show any pro-rata premium charges and credits in the last premium period due to changes in the number of Insureds and in the amount of insurance for which people are insured. This is subject to the rules below.

SIMPLIFIED ACCOUNTING. The premium will start on the Premium Due Date falling on or after the date the insurance or the increase in the insurance is effective for: a) a person becoming insured; or b) an increase in the amount of insurance on any person. The premium will stop on the Premium Due Date falling on or after the date of termination of insurance or through the date of service of the last paid claim. There will be no pro-rata charges or credits for a partial month. If premiums are payable other than monthly, charges and credits will be figured as though the Premium Due Date is monthly.

We will be liable for the return of unearned premiums (premium for the period which claims were not paid) to the Policyholder only for the 3 months before the date we receive evidence that a return is due.

ADJUSTMENTS IN PREMIUM RATES. We may change the rates shown in the Table of Premium Rates by giving the Policyholder at least 60 days advance written notice. We may change the rates at any time the Schedule of Benefits, or any other terms and conditions of the policy, are changed. We will not change the rates until the Renewal Date shown on the policy cover or more than once in any 12 month period thereafter, unless there is a change in the Schedule of Benefits or a change in any other terms and conditions in the policy.

Notwithstanding the above, We the Company reserves the right to change any one or more of the rates prior to the Renewal Date or more than once in any 12 month period thereafter upon the occurrence of any one or more of the following:

1. We determine that the average number of dependent children for each Insured with Dependent coverage exceeds 4.0; and/or

2. We determine that the number of Insureds is less than 80% of those Insureds initially enrolled under the Policy as of either (i) the Plan Effective Date, if during the period of time between the Plan Effective Date and the Renewal Date, or (ii) the most recent 12 month anniversary of the Renewal Date: and/or

3. We are required by either the federal government or by any state or local government or by any agency thereof to pay a new or increased tax, assessment, or monetary charge of any kind (other than a new or any increase to the amount of tax we pay based upon our net operating income). Such taxes, assessments or fees would include those that are charged or assessed in connection with the operation of a health care exchange authorized by federal or state law.

Should any of the above occur and should we elect to change rates as a result, we agree to notify the Policyholder of the corresponding rate changes at least 60 days in advance of the Premium Due Date for which the rate change shall be effective. The right to change rates as well as the timing of such changes in the above two limited situations shall at all times be subject to applicable state laws and regulations.

RENEWAL DATE Renewal Date refers to the date each calendar year that the coverage issued under the group policy is considered for renewal. The Renewal Date(s) are shown on the policy cover.

DEFINITIONS

COMPANY refers to Ameritas Life Insurance Corp. The words "we", "us" and "our" refer to Company. Our Home Office address is 5900 "O" Street, Lincoln, Nebraska 68510.

POLICYHOLDER refers to the Policyholder stated on the face page of the policy.

INSURED refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for insurance by completing the eligibility period, if any; and

c. for whom the insurance has become effective.

CHILD. Child refers to the child of the Insured or a child of the Insured's spouse, if they otherwise meet the definition of Dependent.

DEPENDENT refers to:

a. an Insured's spouse.

b. each child less than 26 years of age, for whom the Insured or the Insured's spouse is legally responsible, or is eligible under the federal laws identified below, including:

   i. natural born children;

   ii. adopted children, eligible from the date of placement for adoption;

   iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

Spouses of Dependents and children of Dependents may not be enrolled under this policy. Additionally, if the Policyholder's separate medical plans are considered to have "grandfathered status" as defined in the federal Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, Dependents may not be eligible Dependents under such medical plans if they are eligible to enroll in an eligible employer-sponsored health plan other than a group health plan of a parent for plan years beginning before January 1, 2014. Dependents that are ineligible under the Policyholder's separate medical plans will be ineligible under this Policy as well.

c. each child age 26 or older who:

   i. is Totally Disabled as defined below; and

   ii. becomes Totally Disabled while insured as a dependent under b. above.

   Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of intellectual disability or physical handicap; and

2. Chiefly dependent upon the Insured for support and maintenance.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider is a Provider who has a contract with Us to provide services to Insureds at a discount. A Participating Provider is also referred to as a "Network Provider." The terms and conditions of the agreement with our network providers are available upon request. Members are required to pay the difference between the plan payment and the Participating Provider's contracted fees for covered services. A Non-Participating Provider is any other provider and may also be referred to as an "Out-of-Network Provider." Members are required to pay the difference between the plan payment and the provider's actual fee for covered services. Therefore, the out-of-pocket expenses may be lower if services are provided by a Participating Provider.

Notice: The MCHIP is subject to regulation in the Commonwealth by both the State Corporation Commission Bureau of Insurance pursuant to Title 382. and the Virginia Department of Health pursuant to Title 32.1.

PLAN EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

PLAN CHANGE EFFECTIVE DATE refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder's records or on the cover of the certificate.

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

If employment is the basis for membership, a member of the Eligible Class for Insurance is any full time active employee working at least 25 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

If a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent from the moment of birth. Notification of birth of a newly born child and payment of the required premium shall be furnished to the insurer issuing the policy within thirty-one days after the date of birth in order to have coverage continue beyond the thirty-one day period.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any full time active employee working at least 25 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

SECTION 125. This policy is provided as part of the Employer's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this policy.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on October 1.

Members may change their election option only during an Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the date of employment.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the first of the month falling on or first following:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

TERMINATION DATES

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums (subject to the Grace Period); or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums (subject to the Grace Period); or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

NOTICE REQUIREMENTS. We will provide the Policyholder written notice of the termination of coverage. Any employer who assumes part or all of the cost of providing coverage under this Policy shall give written notice to Insureds in the event of termination or upon the receipt of notice of termination of such Policy not later than 15 days after receipt of the notice of termination from us.

If coverage is terminated as a result of non-payment of premium, the notice will include a specific date, not less than 15 days from the date of such notice, by which coverage will terminate if overdue premium is not paid. Coverage shall not be permitted to terminate for at least 15 days after such notice is mailed. Reimbursement will be made for all valid claims for services incurred prior to the date coverage is terminated.

CONTINUATION OF COVERAGE. If coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. Contact your plan administrator for details.

Termination of Eligibility Under the Policy
90-Day Continuation Provision
For Insureds and Dependents

1. **Eligibility**

   Whenever any person's eligibility under the policy is terminated and the person becomes ineligible for continued participation in this plan for any reason except for when the insured person is insurable under other replacement group coverage or health care plan without waiting periods or preexisting condition limitations under the group policy or plan the benefits of this plan shall be available at the same premium for the individual and the dependents covered by the plan.

2. **Benefits**

   This continuation applies to all benefits payable under this policy.

3. **Continuation Period**

The continuation period is up to ninety days immediately following the date of the termination of the person's eligibility, without evidence of insurability, subject to the following requirements:

a. The application for the extended coverage is made to the group policyholder and the total premium for the ninety-day period is paid to the group policyholder prior to the termination.

b. The premium for continuing the group coverage shall be at the insurer's current rate applicable to the group policy; and

c. Continuation shall only be available to an employee or member who has been continuously insured under the group policy during the entire three months' period immediately preceding termination of eligibility.

EYE CARE EXPENSE BENEFITS

If an Insured has Covered Expenses under this section, we pay benefits as described. The Insured may use a Participating Provider or a Non-Participating Provider. The Insured has the freedom to choose any provider.

AMOUNT PAYABLE
The Amount Payable for Covered Expenses is the lesser of:

A. the provider's charge, or

B. the Maximum Covered Expense for such services or supplies. This is shown in the Schedule of Eye Care Services for Participating and Non-Participating Providers.

DEDUCTIBLE AMOUNT
The Deductible Amount is on the Schedule of Benefits. It is an amount of Covered Expenses for which no benefits are payable. It applies separately to each Insured. Benefits are paid only for those Covered Expenses that are over the Deductible Amount.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS
A Participating Provider agrees to provide services and supplies to the Insured at a discounted fee. A Non-Participating Provider is any other provider.

COVERED EXPENSES
Covered expenses are the eye care expenses incurred by an Insured for services or supplies. We pay up to the Maximum Covered Expense shown in the Schedule of Eye Care Services.

EYE CARE SUPPLIES
Eye care supplies are all services listed on the Schedule of Eye Care Services. They exclude services related to Eye Care Exams.

REQUEST FOR SERVICES
When requesting services, the Insured must advise the Participating Provider's office that he or she has coverage under this network plan. If the Insured receives services from a Participating Provider without this notification, the benefits are limited to those for a Non-Participating Provider.

ACCESS TO PARTICIPATING PROVIDERS
If you are unable to schedule a visit with a Participating Provider within a reasonable period of time or driving distance and are not otherwise in need of emergency services, please contact us at the toll-free number shown on your ID card and we will attempt to locate a Participating Provider for you to visit. However, if we are unable to locate a Provider for you or you are in need of emergency services and are unable to obtain such services from a Participating Provider, we will review and pay the eligible claims submitted as if you had visited a Participating Provider.

ASSIGNMENT OF BENEFITS
We pay benefits to the Participating Provider for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, we pay benefits to the Insured.

EXTENSION OF BENEFITS
We will extend benefits for eye care supplies if this policy terminates. To be eligible for an extension, the supply must be prescribed prior to the termination of the policy and must be received within six months after the policy terminates.

EXPENSES INCURRED. An expense is incurred at the time a service is rendered or a supply item furnished.

LIMITATIONS
This plan has the following limitations.

1) This plan does not cover eye examinations.

2) This plan does not cover more than one pair of ophthalmic Lenses in any 12-month period.

3) This plan does not cover more than one set of Frames in any 12-month period.

4) This plan does not cover Elective Contact Lenses more than once in any 12-month period. Contact Lenses and associated expenses are in lieu of any other Lens benefit.

5) This plan does not cover Medically Necessary Contact Lenses more than once in any 12-month period. The treating provider determines if an Insured meets the coverage criteria for this benefit as listed below. This benefit is in lieu of Elective Contact Lenses.

    a. For Keratoconus where the patient is not correctable to 20/30 in either or both eyes using standard spectacle lenses.
    b. Patients whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best standard spectacle lens correction.
    c. Anisometropia of 3D or more.
    d. High Ametropia exceeding -10D or +10D in spherical equivalent.

6) This plan does not cover Orthoptics or vision training and any associated testing.

7) This plan does not cover Plano Lenses.

8) This plan does not cover non-prescribed Lenses or sunglasses.

9) This plan does not cover two pairs of glasses in lieu of Bifocals.

10) This plan does not cover replacement of Lenses and Frames that are lost or broken outside of the normal coverage intervals.

11) This plan does not cover medical or surgical treatment of the eyes or supporting structures.

12) This plan does not cover services for claims filed more than one year after completion of the service. An exception is if the Insured shows it was not possible to submit the proof of loss within this period.

13) This plan does not cover any procedure not listed on the Schedule of Eye Care Services

SCHEDULE OF EYE CARE SERVICES

This page lists the benefits payable for eye care services. No benefits are payable for a service not listed.

SERVICE	***PLAN MAXIMUM COVERED EXPENSE***	
	Participating Provider	*Non-Participating Provider*
(All lenses are per pair)		
Single Vision Lenses	Covered in Full	Up to $ 25.00
Lined Bifocal Lenses	Covered in Full	Up to $ 40.00
Lined Trifocal Lenses	Covered in Full	Up to $ 55.00
Frame	Up to $130.00	Up to $ 65.00
Contact Lenses*		
Elective	Up to $130.00	Up to $104.00
Medically Necessary	Covered in Full	Up to $200.00

*The contact lenses allowance applies to the contact lens exam and lenses.

GENERAL PROVISIONS

NOTICE OF CLAIM. We will provide You the forms needed for filing proof of loss. If the forms are not provided before the 16th day after the date of the notice, the claimant shall be considered to have complied with the requirements of this policy as to proof of loss on submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which the claim is made.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after receipt of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 180 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 180 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

TIME OF PAYMENT. We will pay all benefits immediately when we receive due proof or in accordance with Virginia Code, whichever is more favorable to the Insured. Virginia Code requires that clean claims shall be paid or denied within forty (40) days from receipt of the claim. If a claim cannot be processed as a result of not receiving all of the necessary information, then we will notify the claimant within thirty (30) days from receipt of the claim providing them with the information necessary to process the claim. Payment will be made within forty (40) days from receipt of all necessary information.

PAYMENT OF BENEFITS. Participating Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Participating Provider directly. If an insured visits a non-participating provider, the insured is responsible for applying any plan payment to the non-participating provider.

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed $5,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than five years after proof of loss is required.

INCONTESTABILITY. All statements made by the policy owner or by the persons insured shall be deemed representations and not warranties. No written statement made by any person insured shall be used in any contest unless a copy of the statement is furnished to the person or to his beneficiary or personal representative. In any case where a rate or benefit varies by age, and the age of an insured has been misstated, an equitable adjustment of premiums benefits, or both will be made. Such adjustment will be made based on anticipated claims projections and/or actual past claims.

The validity of the Policy will not contested after it has been in force for two years from its date of issue, except for nonpayment of premiums. Any statement made by any person insured under the policy relating to his insurability or the insurability of his insured dependents shall not be used in contesting the validity of the insurance with respect to which such statement was made:

1. After the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made; and

2. Unless the statement is contained in a written instrument signed by him.

WORKER'S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.

ENTIRE CONTRACT. The policy and any application of the Policyholder, and any individual applications of the persons insured shall constitute the entire contract between the parties. A copy of the Policyholder's application is attached to the policy when issued. All statements made by the Policyholder or an Insured will be considered representations and not warranties. No written statement made by any person insured shall be used in any contest unless a copy of the statement is furnished to the person or to his beneficiary or personal representative.

No change in this policy will be valid unless approved in writing by one of our officers and given to the Policyholder for attachment to the policy. No agent has the authority to change this policy or waive any of its provisions. Any change in this policy will be valid even though an Insured may not have agreed to it.

GENERAL PROVISIONS (CONTINUED)

CONFORMITY WITH LAW. Any policy provision that conflicts with the laws of the state in which the policy is issued, when the policy is issued, is automatically changed to meet the minimum requirements of those laws.

ENTIRE CONTRACT. The policy and the application of the Policyholder, and any individual applications of the persons insured shall constitute the entire contract between the parties. A copy of the Policyholder's application is attached to the policy when issued. All statements made by the Policyholder or an Insured will be considered representations and not warranties. No written statement made by any person insured shall be used in any contest unless a copy of the statement is furnished to the person or to his beneficiary or personal representative.

No change in this policy will be valid unless approved in writing by one of our officers and given to the Policyholder for attachment to the policy. No agent has the authority to change this policy or waive any of its provisions. Any change in this policy will be valid even though an Insured may not have agreed to it.

INSURANCE DATA. The Policyholder will furnish, at our request, data necessary to administer this policy. The data will include, but not be limited to data:

i. necessary to calculate premiums;

ii. necessary to determine a person's effective date or termination date of insurance;

iii. necessary to determine the proper coverage level of insurance.

We shall have the right to inspect any of the Policyholder's records we find necessary to properly administer this policy. Any inspections will be at a time and place convenient to the Policyholder.

We will not refuse to insure a person who is eligible to be insured just because the Policyholder fails or errs in giving us the data necessary to include that person for coverage. An Insured's insurance will not stay in force nor an amount of insurance be continued after the termination date, according to the Conditions for Insurance, because the Policyholder fails or errors in giving us the necessary data concerning an Insured's termination.

CERTIFICATES. We will issue certificates to the Policyholder showing the coverage under the policy. The Policyholder will distribute a certificate to each insured Member. If the terms of the certificate differ from the policy, the terms stated in the policy will govern.

PARTICIPATION REQUIREMENTS. There are two requirements that must be met in order for the policy to be placed in force, and to remain in force:

a. a certain percentage of all Members qualified for insurance must be insured at all times; and

b. a certain number of Insureds must be insured at all times.

The Participation Requirements are as follows:

Percentage of Members-	60%
Number of Members-	128

TERMINATION OF THE POLICY. The Policyholder may terminate this policy as of any Premium Due Date by giving us written notice before that date.

We may terminate this policy on the earlier of:

1. any Premium Due Date if the participation of Insureds and/or Dependents does not meet the requirements in "Conditions For Insurance." Written notice of termination of insurance must be given to the Policyholder at least 45 days before the date of termination.

2. any Premium Due Date on or after the first policy year, for reasons other than lack of participation. Written notice of termination of insurance must be given to the Policyholder at least 60 days before the date of termination.

If any premium is not paid when due, this policy will automatically be terminated as of the Premium Due Date, except as stated below.

GRACE PERIOD. This policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, the policy will stay in force. If the Policyholder has not sent us a written request to terminate the policy and a premium is not paid by the end of the grace period, the policy will terminate at the end of the grace period. If the Policyholder gives us written notice of termination before the Premium Due Date, the policy will be terminated as of the date requested. The Policyholder will be liable for any unpaid premium for the time this policy was in force, including the grace period.

CONSIDERATION. This policy is issued to the Policyholder in consideration of the application and the payment of premiums specified in this policy.

TERMS AND CONDITIONS. Payment of any benefit under this policy is subject to the definitions and all other terms of this policy pertinent to the benefit.

REQUEST FOR CLAIMS EXPERIENCE. Upon request, we will provide the policyholder with a complete record of the policyholder's claim experience incurred under this policy. This record shall include all claims incurred for the lessor of:

1. the period of time since the policy was issued or issued for delivery, or
2. the period of time since the policy was last renewed, reissued or extended, if already issued.

This record shall be made available promptly to the Policyholder upon request made not less than sixty days prior to the date upon which the premiums or contractual terms of the policy may be amended.

Application is Hereby Made to

AMERITAS LIFE INSURANCE CORP.

by: CULPEPER COUNTY AND SCHOOLS

whose main office address is: 450 RADIO LN
CULPEPER, VA 22701-1521

for Group Policy No. 10-350788

This group policy is hereby approved. Its terms are hereby accepted.

This Acceptance Application is made in duplicate. One is attached to the policy. The other part has been returned to the Company.

It is agreed that this application supersedes any previous application for the group policy.

CULPEPER COUNTY AND SCHOOLS

(Full or Corporate Name of Applicant)

Dated at_____By_____
(Signature and Title)

On_____, 20__ Witness_____
(To be signed by Resident Agent where required by law)

This copy is to Remain Attached to the Policy