



Ameritas Life Insurance Corp.

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

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**The Policyholder**            **MONTGOMERY COUNTY GOVERNMENT**

**Policy Number**            **10-46012**                            **Insured Person**

**Plan Effective Date**       **October 1, 2017**                    **Certificate Effective Date**  
**Refer to Exceptions**

**Class Number 1**

Ameritas Life Insurance Corp. certifies that you will be insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder.

Possession of this certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this certificate.

The group policy may be amended or cancelled without the consent of the insured person.

The group policy and this certificate are governed by the laws of the state in which the group policy was delivered.

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.

Your service area for this plan includes the Commonwealth of Virginia.

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](mailto: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](http://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](http://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.





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**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:

When a Participating Provider is used:

Exams - Each Benefit Period	\$10
Contact Lens Fitting and Evaluation - Each Benefit Period	\$60
Frames, Lenses, and Medically Necessary Contacts - Each Benefit Period	\$0

When a Non-Participating Provider is used:

Exams - Each Benefit Period	\$10
Frames, Lenses, and Medically Necessary Contacts - Each Benefit Period	\$0

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



## 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 unmarried and married child through the end of the year in which they turn 26 years of age, for whom the Insured, the Insured's spouse is legally responsible, including natural born children, adopted children from the date of placement for adoption, foster child(ren) and children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws. Grandchildren, spouses of Dependents and other Dependent family members under the age of 26 are not eligible for coverage under this plan.

If the child is a full-time student and such child is unable, due to a medical condition, to continue as a full-time student, coverage under the policy for such child nevertheless shall continue in force provided the child's treating physician certifies to the insurer at the time the child withdraws as a full-time student that the child's absence is medically necessary. Coverage of such child shall continue in force until the earlier of (i) the date that is 12 months from the date the child ceases to be a full-time student or (ii) the date the child no longer qualifies as a Dependent child under the terms of the group Policy. A child's status as a full-time student shall be determined in accordance with the criteria specified by the institution in which the child is enrolled.

- c. each unmarried child age 26 or older who is Totally Disabled and becomes Totally Disabled as defined below 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.

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.

**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 30 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.

Retirees are included in the Eligible Class for Insurance as defined by the Policyholder.

If both spouses are Members, and if either of them insures their dependent children, then the spouse, 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 30 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.

Retirees are included in the Eligible Class for Dependent Insurance as defined by the Policyholder.

Any spouse 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, qualification will occur on the first of the month falling on or first following the date of employment.

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. For those Dependents whose coverage terminates because they no longer meet the definition of a Dependent as a result of a limiting age (See "Definitions"), insurance will continue in force throughout the remainder of that year but will automatically terminate December 31 of the year following the attainment of that limiting age.

**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 can choose any provider at any time.

### **COVERED EXPENSES**

Covered Expenses include the lesser of:

- a. the charge for the covered procedure furnished; or
- b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Eye Care Services.

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.

### **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 PROVIDERS**

A Participating Provider is a provider who has agreed to participate in the VSP network and agrees to provide services and supplies to the Insured at a discounted fee. For questions related to providers or benefit payments, VSP's Customer Care Division is available at (800) 877-7195.

### **NON-PARTICIPATING PROVIDER**

A Non-Participating Provider is any other provider. Non-Participating providers may be referred to as Affiliate or Open Access Providers. Non-Participating Providers are not subject to our Quality Management Programs. Your out-of-pocket expenses may be greater when you visit a Non-Participating Provider. However, more cost savings or convenience may be available through VSP arrangements with Affiliate Providers. You may contact VSP's Customer Care Division for details at (800) 877-7195.

### **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 may be 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 unless arranged differently through an Affiliate or Open Access provider, or otherwise required by state regulation.

### **EXTENSION OF BENEFITS**

If your policy terminates, we will pay claims for eye care services and supplies that you received or ordered prior to your policy's termination. You will have six months following the date of service to submit your claim.

### **EXPENSES INCURRED**

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

### **PROOF OF LOSS**

Written proof of loss must be given to us within 180 days after completion of the service for a claim to be covered. An exception may be made if the Insured shows it was not possible to submit the proof of loss within this period.

### **LIMITATIONS**

This plan has the following limitation:

Some brands of spectacle frames may be unavailable at all locations for purchase as Covered Expenses, or may be subject to additional out-of-pocket expenses. Insureds may obtain details regarding frame brand availability from their treating provider or by calling VSP's Customer Care Division at (800) 877-7195.

### **EXCLUSIONS**

This plan does not cover:

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits,
- Plano lenses (lenses with refractive correction of less than plus or minus .50 diopter) except as specifically allowed in the frames benefit section below,
- Services or materials that are cosmetic, including Plano contact lenses to change eye color and artistically painted Contact Lenses,
- Two pairs of glasses in lieu of Bifocals,
- Replacement of Spectacle Lenses, Frames, and/or contact lenses furnished under this plan that are lost or damaged, except at the normal intervals when services are otherwise available,
- Orthoptics or vision training and any associated supplemental testing,
- Medical or surgical treatment of the eyes,
- Contact lens modification, polishing or cleaning,
- The refitting of Contact Lenses after the initial 90-day fitting period,
- Contact Lens insurance policies or service contracts,
- Additional office visits associated with contact lens pathology,
- Local, state and/or federal taxes, except where law requires us to pay,
- Membership fees for any retail center in which an Affiliate or Open Access provider office may be located. Covered persons may be required to purchase a membership in such entities as a condition of accessing Plan Benefits.





## SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for which benefits payable under this section, You must first pay a Deductible for certain services as indicated on the Schedule of Benefits in the - Eye Care Expense Benefits section.

SERVICE	WHEN COVERED	PLAN MAXIMUM COVERED EXPENSE	
		<i>Participating Provider</i>	<i>Non-Participating Provider*</i>
<b>Vision Examination(s)</b>			
Eye Exam	Once every 12 months	Covered in Full	Up to \$ 45.00
Contact Lens Fitting & Evaluation	Once every 12 months	Covered in Full	See Elective Contact Lenses benefit below
<b>Complete Pair of Spectacles</b>			
<b>Lenses</b> (per pair, only one pair of lens type below allowed per covered period)			
Single Vision	Once every 12 months	Covered in Full	Up to \$ 30.00
Lined Bifocal	Once every 12 months	Covered in Full	Up to \$ 50.00
Lined Trifocal	Once every 12 months	Covered in Full	Up to \$ 65.00
Lenticular	Once every 12 months	Covered in Full	Up to \$100.00
<b>Frames</b>			
Single Frame	Once every 24 months	Up to \$130.00	Up to \$ 70.00
<b>Contact Lenses</b> (in lieu of Complete Pair of Spectacles) Includes allowance for Contact Lens Fitting & Evaluation			
Elective	Once every 12 months	Up to \$130.00	Up to \$105.00
Medically Necessary**	Once every 12 months	Covered in Full	Up to \$210.00

**Low Vision** (for severe visual problems not correctable with regular lenses, as determined by the treating provider)  
 Insureds can receive professional services for treatment of severe visual problems that are not correctable with regular lenses. The treating provider determines if an Insured's condition meets the criteria for coverage of this benefit. Insureds may contact VSP's Customer Care Division for details at (800-877-7195) for additional information.

\*Insureds may receive additional savings and some services may be covered in full by choosing to visit an Affiliate Non-Participating Provider.

\*\*The benefit for Medically Necessary contact lenses is in lieu of the Elective contact lenses benefit listed. The treating provider determines if an Insured meets the coverage criteria for this benefit.





## COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies if an Insured person has eye care coverage under more than one **Plan**. **Plan** is defined below. All benefits provided under this policy are subject to this section.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** do not exceed 100% of the total **Allowable expense**.

### DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or eye care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in automobile "no fault" and traditional "fault" type contracts; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

B. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as eye care benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

C. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and co-payments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

(1) If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

(2) If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

(3) If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

(4) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

## **ORDER OF BENEFIT DETERMINATION RULES**

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

A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other **Plan**.

B. (1) Except as provided in Paragraph B(2) below, a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

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

D. Each **Plan** determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order of benefits is determined as follows:

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

The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or

If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

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

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

The **Plan** covering the **Custodial parent**;

The **Plan** covering the spouse of the **Custodial parent**;

The **Plan** covering the **non-custodial parent**; and then

The **Plan** covering the spouse of the **non-custodial parent**.

(c) For a dependent child covered under more than one **Plan** of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

(6) If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

#### **EFFECT ON THE BENEFITS OF THIS PLAN**

A. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more **Closed panel** plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

#### **RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give the Company any facts it needs to apply those rules and determine benefits payable.

#### **FACILITY OF PAYMENT**

A Payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. The Company 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 the reasonable cash value of the benefits provided in the form of services.

#### **RIGHT OF RECOVERY**

If the amount of the payments made by the Company is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.



## 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.

**PHYSICAL EXAMINATIONS AND AUTOPSY.** At Our own expense, We have the right and opportunity to conduct a physical examination of the Insured when and as often as the insurer reasonably requires while a claim under the policy is pending and, in case of death, to require that an autopsy be conducted if not forbidden by law.

**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 be 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.



## **YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.**

### **THIS NOTICE OF PRIVACY PRACTICES (“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 applies to the Group Divisions of Ameritas Life Insurance Corp. and Ameritas Life Insurance Corp. of New York. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all personal health information maintained by us.

**Ameritas Privacy Office Contact Information:** To assert any of your rights with respect to this Notice, or to obtain an authorization form, please call 1-800-487-5553 and request the appropriate form. Please direct any questions about this Notice or requests for further information, or to file a complaint: The Privacy Office, Attn. HIPAA Privacy, P.O. Box 81889, Lincoln, NE 68501-1889, or e-mail us at [privacy@ameritas.com](mailto:privacy@ameritas.com).

## **YOUR RIGHTS**

### **YOU HAVE THE RIGHT TO:**

#### **Get a copy of your claims records**

- You can ask to see or get a copy of your claims records we maintain about you. Ask us how to do this.
- We will provide a copy or a summary of your claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

#### **Correct your claims records**

- You can ask us to correct your claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days

#### **Request confidential communication**

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

#### **Ask us to limit the information we share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect payment for your care.

#### **Get a list of those with whom we've shared your information**

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).
- We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

#### **Get a copy of this Privacy Notice**

You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

### **Choose someone to act for you**

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

### **File a complaint if you believe your privacy rights have been violated**

- You can complain if you feel we have violated your rights by contacting us using the contact information above.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/). We will not retaliate against you for filing a complaint.

### **YOUR CHOICES**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- **Answer coverage questions from your family and friends.**  
At your directions we will share information with your family, close friends, or others involved in payment for your care.
- **Share information in a disaster relief situation.**

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

**We will not share your personal information for marketing purposes or sell your personal information unless you give us your written permission to do so.**

### **OUR USES AND DISCLOSURES**

#### **How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

#### **Run our organization**

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.

*Example:* We use health information about you to develop better coverage and service offerings for our insured members, including you.

#### **Pay for your health services**

- We can use and disclose your health information as we pay for your health services.

*Example:* We share information about you with other health benefit plans that you might also be covered by to coordinate payment for your health services.

### **Administer your health plan**

We may disclose your health information to your health plan sponsor for plan administration.

*Example:* Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

### **HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?**

We are allowed or required to share your information in other ways– usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

**Help with public health and safety issues** – We can share your health information in certain situations such as to help prevent disease or to report suspected abuse, neglect or domestic violence.

**Comply with the law** – We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

**Address workers’ compensation, law enforcement, and other government requests** – We can share health information about you:

- For workers’ compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.

**Respond to lawsuits and legal actions** – We can share health information about you in response to a court or administrative order, or in response to a subpoena.

### **OUR RESPONSIBILITIES**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

This Revised Notice is effective 9/23/13.

