



Ameritas Life Insurance Corp.

A STOCK COMPANY  
LINCOLN, NEBRASKA

**CERTIFICATE  
PREFERRED PROVIDER GROUP EYE CARE INSURANCE**

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**The Policyholder**      **ROCKDALE COUNTY BOARD OF EDUCATION**

**Policy Number**      **10-377306**      **Insured Person**

**Plan Effective Date**      **January 1, 2011**      **Certificate Effective Date**  
**Refer to Exceptions on 9070**

**Plan Change Effective Date**      **January 1, 2023**

**Class Number 3**

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.

**IMPORTANT NOTICE**

**Eye Care benefits include a Preferred Provider Option. An Insured person has the freedom of choice to receive treatment from any Provider. Reimbursement for all eye care services, including treatment for emergencies, to a Non-Preferred Provider will be equal to or greater than reimbursement to a Preferred Provider. The Insured should verify with their provider if they are a Preferred Provider. The Insured may be responsible for additional charges if services are provided by a Non-Preferred Provider.**

President

**GEORGIA  
IMPORTANT INFORMATION TO INSURED**

**We are here to serve you . . .**

You have the right to receive appropriate care in a timely and convenient manner and to be an active participant in any decision making regarding treatment, care and services provided to you or one of your family members who are covered under this plan.

In order to provide you the best possible service, it is important that you provide any necessary information to your provider that will facilitate effective care and that you cooperate with your provider(s) by keeping appointments and following recommended treatment.

Please review your certificate of coverage carefully so that you fully understand the benefits provided. If you have a question about your policy or if you need assistance with a problem, you should first contact us at the address shown below.

If you have a grievance or complaint regarding:

- (a) the availability, delivery, or quality of vision plan services;
- (b) benefits or claims payment, handling, or reimbursement for vision services

You may document your concerns in writing and forward your written documentation to the following:

Name:	Quality Control
Address:	P.O. Box 82657 Lincoln, NE 68501-2657
Phone:	877-897-4328
Fax:	402-309-2579

Please also refer to your Explanation of Benefits and your Certificate Booklet for appeals rights related to claims.

If after a careful review of your appeal, we determine that the benefit should have been denied, we will send you a written notice of that decision. You will also receive a notice of your right to appeal the decision to the Georgia Insurance Department.

If we agree that a benefit is available, we will issue a new predetermination of benefits or pay the claim in question.

**You always have the right to contact the Department of Insurance:**

**Consumer Services Division  
2 Martin Luther King, Jr. Drive  
West Tower, Suite 716  
Atlanta, Georgia 30334**

**Telephone: 404-656-2070  
Toll Free: 800-656-2298  
Between 8:00 AM and 6:00 PM**

## TABLE OF CONTENTS

<b>Name of Provision</b>	<b>Page Number</b>
Schedule of Benefits	Begins on 9040
Benefit Information, including Deductibles, Coinsurance, & Maximums	
Definitions	
Dependent	9060
Conditions for Insurance	9070
Eligibility	
Eligibility Period	
Contribution Requirement	
Effective Date	
Termination Date	
Eye Care Expense Benefits	9270
General Provisions	9310
Claim Forms	
Proof of Loss	
Payment of Benefits	
ERISA Information and Notice of Your Rights	ERISA Notice

**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.

<u>Benefit Class</u>	<u>Class Description</u>
Class 3	Eligible Employee Electing Vision

**EYE CARE EXPENSE BENEFITS**

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

When a Preferred Provider is used:

Deductible Amount:

Exams - Each Benefit Period	\$10
Frames	\$0
Lenses - Each Benefit Period	\$25

When a Non-Preferred Provider is used:

Deductible Amount \$0

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

In accordance with Georgia law, this plan does not restrict the provision of covered benefits from a Preferred Provider to a covered person solely because the covered person obtained treatment from a Non-Preferred Provider leading to a balance bill.

## 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.

**MEMBER** refers to an employee of the eligible class(es) as defined by the Policyholder.

**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.

**FULL-TIME STUDENT:** A full-time student means that the child remains a dependent of the Insured or the Insured's spouse, has been enrolled for five calendar months or more as a full-time student at a post secondary institution of higher learning or, if not so enrolled, would have been eligible to be so enrolled and was prevented from being so enrolled due to illness or injury.

**DEPENDENT** refers to:

- a. an Insured's spouse.
- b. each unmarried and married child less than 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, 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.
- 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.

**TOTAL DISABILITY** describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation 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.

**PREFERRED AND NON-PREFERRED PROVIDERS.** A Preferred Provider is a Provider who has a contract with Us to provide services to Insureds at a discount. A Preferred 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 Preferred Provider’s contracted fees for covered services. A Non-Preferred 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 Preferred 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 eligible employee electing vision working at least 20 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 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 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.

**COVERAGE FOR NEWBORN AND ADOPTED CHILDREN.** A newborn child will be covered from the date of birth. An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence. A newborn adopted child will be covered from the date of birth.

Coverage for a newborn child or a child placed for adoption shall consist of coverage for covered expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, resulting from care or treatment of congenital defects, birth abnormalities, including cleft lip and cleft palate and premature birth.

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

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 eligible employee electing vision working at least 20 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 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 January 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 after an eligibility period defined by the Policyholder is satisfied. The same eligibility period will be applied to all members.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur after an eligibility period defined by the Policyholder is satisfied. The same eligibility period will be applied to all members.

**OPEN ENROLLMENT.** If a Member does not elect to participate when initially eligible, the Member may elect to participate at the Policyholder's next enrollment period. This enrollment 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 January 1.

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:

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 Insured may terminate coverage upon written notice to the Policyholder. The insurance for any Insured, will automatically terminate on 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; or
3. the date the policy is terminated.

**DEPENDENTS.** The insurance for all of an Insured's dependents will automatically terminate on 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; or
4. the date all Dependent Insurance under the policy is terminated.

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

**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.

## **EYE CARE EXPENSE BENEFITS**

If an Insured has Covered Expenses under this section, we pay benefits as described. The Insured may use a Preferred Provider or a Non-Preferred 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 Preferred and Non-Preferred 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.

### **PREFERRED AND NON-PREFERRED PROVIDERS**

A Preferred Provider agrees to provide services and supplies to the Insured at a discounted fee. A Non-Preferred 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 Preferred Provider's office that he or she has coverage under this network plan. If the Insured receives services from a Preferred Provider without this notification, the benefits are limited to those for a Non-Preferred Provider.

### **ASSIGNMENT OF BENEFITS**

We pay benefits to the Preferred Provider for services and supplies performed or furnished by them. When a Non-Preferred Provider performs services, we pay benefits to the Insured or as assigned to the Non-Preferred Provider.

### **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 more than one Eye Exam in any 12-month period.
- 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 24-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 meridian powers.
- 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	
	<i>Preferred Provider</i>	<i>Non-Preferred Provider</i>
Eye Exam	Covered in Full	Up to \$ 35.00
<i>(All lenses are per pair)</i> 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

## GENERAL PROVISIONS

**NOTICE OF CLAIM.** Written notice of a claim must be given to us within 90 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

**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 10 days after the giving 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 90 days after the incurred date of the services provided for which benefits are payable. If it is not reasonably possible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason. For Eye Care benefits that use either the EyeMed or VSP network, please refer to the limitations section on the Eye Care Expense Benefits page.

**TIME OF PAYMENT.** We will pay all benefits within 15 working days of when we receive all information necessary to pay the claim. If a claim cannot be paid within 15 working days of receipt, we will notify you within that 15-day period providing you with a list of information necessary for us to pay the claim. Upon receipt of the additional information, we will have an additional 15 working days within which to process the claim and either make payment or notify the claimant of the denial. We will pay interest at the rate of eighteen percent per year on benefits for valid claims not paid within the time periods noted above until the claim is settled.

**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.

**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.

**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.

## ERISA INFORMATION AND NOTICE OF YOUR RIGHTS

### A. **Eligibility and Benefits Provided Under the Group Policy**

Please refer to the **Conditions for Insurance** within the Group Policy and Certificate of Coverage for a detailed description of the eligibility for participation under the plan as well as the benefits provided. If this plan includes a participating provider (PPO) option, provider lists are furnished without charge, as a separate document.

### B. **Qualified Medical Child Support Order ("QMCSO")**

QMCSO Determinations. A Plan participant or beneficiary can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determinations from the Plan Administrator.

### C. **Termination Of The Group Policy**

The Group Policy which provides benefits for this plan may be terminated by the Policyholder at any time with prior written notice to Ameritas Life Insurance Corp. It will terminate automatically if the Policyholder fails to pay the required premium. Ameritas Life Insurance Corp. may terminate the Group Policy on any Premium Due Date if the number of persons insured is less than the required minimum, or if Ameritas Life Insurance Corp. believes the Policyholder has failed to perform its obligations relating to the Group Policy.

After the first policy year, Ameritas Life Insurance Corp. may also terminate the Group Policy on any Premium Due Date for any reason by providing a 60-day advance written notice to the Policyholder.

The Group Policy may be changed in whole or in part. No change or amendment will be valid unless it is approved in writing by a Ameritas Life Insurance Corp. executive officer.

### D. **Claims For Benefits**

Claims procedures are furnished automatically, without charge, as a separate document.

### E. **Continuation of Coverage Provisions (COBRA)**

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) gives Qualified Beneficiaries the right to elect COBRA continuation after insurance ends because of a Qualifying Event. The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. The law does not, however, apply to plans sponsored by the Federal government and certain church-related organizations.

#### i. **Definitions For This Section**

Qualified Beneficiary means an Insured Person who is covered by the plan on the day before a qualifying event. Any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary.

A Qualifying Event occurs when:

1. The Member dies (hereinafter referred to as Qualifying Event 1);
2. The Member's employment terminates for reasons other than gross misconduct as determined by the Employer (hereinafter referred to as Qualifying Event 2);
3. The Member's work hours fall below the minimum number required to be a Member (hereinafter referred to as Qualifying Event 3);
4. The Member becomes divorced or legally separated from a Spouse (hereinafter referred to as Qualifying Event 4);

5. The Member becomes entitled to receive Medicare benefits under Title XVII of the Social Security Act (hereinafter referred to as Qualifying Event 5);
6. The Child of a Member ceases to be a Dependent (hereinafter referred to as Qualifying Event 6);
7. The Employer files a petition for reorganization under Title 11 of the U.S. Bankruptcy Code, provided the Member is retired from the Employer and is insured on the date the petition is filed (hereinafter referred to as Qualifying Event 7).

**ii. Electing COBRA Continuation**

- A. Each Qualified Beneficiary has the right to elect to continue coverage that was in effect on the day before the Qualifying Event. The Qualified Beneficiary must apply in writing within 60 days of the later of:
  1. The date on which Insurance would otherwise end; and
  2. The date on which the Employer or Plan Administrator gave the Qualified Beneficiary notice of the right to COBRA continuation.
- B. A Qualified Beneficiary who does not elect COBRA Continuation coverage during their original election period may be entitled to a second election period if the following requirements are satisfied:
  1. The Member's Insurance ended because of a trade related termination of their employment, which resulted in being certified eligible for trade adjustment assistance;
  2. The Member is certified eligible for trade adjustment assistance (as determined by the appropriate governmental agency) within 6 months of the date Insurance ended due to the trade related termination of their employment; and
  3. The Qualified Beneficiary must apply in writing within 60 days after the first day of the month in which they are certified eligible for trade adjustment assistance.

**iii. Notice Requirements**

1. When the Member becomes insured, the Plan Administrator must inform the Member and Spouse in writing of the right to COBRA continuation.
2. The Qualified Beneficiary must notify the Plan Administrator in writing of Qualifying Event 4 or 6 above within 60 days of the later of:
  - a. The date of the Qualifying Event; or
  - b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.

3. A Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, must notify the Plan Administrator of the disability in writing within 60 days of the later of:
  - a. The date of the disability determination;
  - b. The date of the Qualifying Event; or
  - c. The date on which the Qualified Beneficiary loses coverage due to the Qualifying Event.
4. Each Qualified Beneficiary who has become entitled to COBRA continuation with a maximum duration of 18 or 29 months must notify the Plan Administrator of the occurrence of a second Qualifying Event within 60 days of the later of:
  - a. The date of the Qualifying Event; or
  - b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.
5. The Employer must give the Plan Administrator written notice within 30 days of the occurrence of Qualifying Event 1, 2, 3, 5, or 7.
6. Within 14 days of receipt of the Employer's notice, the Plan Administrator must notify each Qualified Beneficiary in writing of the right to elect COBRA continuation.

In order to protect your rights, Members and Qualified Beneficiaries should inform the Plan Administrator in writing of any change of address.

**iv. COBRA Continuation Period**

1. 18-month COBRA Continuation

Each Qualified Beneficiary may continue Insurance for up to 18 months after the date of Qualifying Event 2 or 3.

2. 29-month COBRA Continuation

Each Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, may continue coverage for up to 29 months after the date of the Qualifying Event. All Insured Persons in the Qualified Beneficiary's family may also continue coverage for up to 29 months.

3. 36-Month COBRA Continuation

If you are a Dependent, you may continue Coverage for up to 36 months after the date of Qualifying Event 1, 4, 5, or 6. Each Qualified Beneficiary who is entitled to continue Insurance for 18 or 29 months may be eligible to continue coverage for up to 36 months after the date of their original Qualifying Event if a second Qualifying Event occurs while they are on continuation coverage.



Note: The total period of COBRA continuation available in 1 through 3 will not exceed 36 months.

4. COBRA Continuation For Certain Bankruptcy Proceedings

If the Qualifying Event is 7, the COBRA continuation period for a retiree or retiree's Spouse is the lifetime of the retiree. Upon the retiree's death, the COBRA continuation period for the surviving Dependents is 36 months from the date of the retiree's death.

v. **Premium Requirements**

Insurance continued under this provision will be retroactive to the date insurance would have ended because of a Qualifying Event. The Qualified Beneficiary must pay the initial required premium not later than 45 days after electing COBRA continuation, and monthly premium on or before the Premium Due Date thereafter. The monthly premium is a percentage of the total premium (both the portion paid by the employee and any portion paid by the employer) currently in effect on each Premium Due Date. The premium rate may change after you cease to be Actively at Work. The percentage is as follows:

18 month continuation - 102%

29 month continuation - 102% during the first 18 months, 150% during the next 11 months

36 month continuation - 102%

vi. When COBRA Continuation Ends

COBRA continuation ends on the earliest of:

1. The date the Group Policy terminates;
2. 31 days after the date the last period ends for which a required premium payment was made;
3. The last day of the COBRA continuation period.
4. The date the Qualified Beneficiary first becomes entitled to Medicare coverage under Title XVII of the Social Security Act;
5. The first date on which the Qualified Beneficiary is: (a) covered under another group Eye Care policy and (b) not subject to any preexisting condition limitation in that policy.

**F. Your Rights under ERISA**

As a participant in this Plan, you are entitled to certain rights and protections under the Employment Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

### **Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### **Continue Group Health Plan Coverage**

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to operate and administer this plan prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance with Your Rights**

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and

responsibilities under ERISA by calling those publications hotline of the Employee Benefits Security Administration

**CLAIMS REVIEW PROCEDURES  
AS REQUIRED UNDER  
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)**

The following provides information regarding the claims review process and your rights to request a review of any part of a claim that is denied. Please note that certain state laws may also require specified claims payment procedures as well as internal appeal procedures and/or independent external review processes. Therefore, in addition to the review procedures defined below, you may also have additional rights provided to you under state law. If your state has specific grievance procedures, an additional notice specific to your state will also be included within the group policy and your certificate.

**CLAIMS FOR BENEFITS**

Claims may be submitted by mailing the completed claim form along with any requested information to:

EyeMed Vision care  
4000 Luxottica Place  
Mason, Ohio, 45040-8114  
(866) 289-0614 phone  
(513) 765-6050 fax

**NOTICE OF DECISION OF CLAIM**

We will evaluate your claim promptly after we receive it.

We will provide you written notice regarding the payment under the claim within 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

- a. The reasons for our decision.
- b. Reference to the parts of the Group Policy on which our decision is based.
- c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
- d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Eye Care practice.
- e. A description of any additional information needed to support your claim and why such information is necessary.
- f. Information concerning your right to a review of our decision.
- g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

**APPEAL PROCEDURE**

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

- a. The reasons for our decision.
- b. Reference to the parts of the Group Policy on which our decision is based.
- c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
- d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
- e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Eye Care practice.
- f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please review your certificate for such information, call us, or contact your state insurance regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for appeal should be directed to:

Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.

**THIS NOTICE OF PRIVACY PRACTICES (“NOTICE”) DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This notice describes how the Group Divisions of Ameritas Life Insurance Corp. and Ameritas Life Insurance Corp. of New York use and disclose your protected health information, and how we guard that information. 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 a new Notice effective for all protected health information maintained by us. If we do make changes to this Notice, a copy of the new Notice will be placed on our web site at [www.ameritas.com](http://www.ameritas.com) and/or sent to you if the changes are material. If you reside in a state whose law provides stricter privacy protections than those provided by HIPAA, we will maintain the privacy of your health information as required by your stricter state law.

## how we use or disclose information

**We must** use and disclose your health information to provide that information:

- To you, or someone who has the legal right to act for you (your personal representative), in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to see that we are complying with federal privacy law and administrative simplification provisions of HIPAA.

**We have the right to** use and disclose your health information for your treatment, to pay for your health care, and to operate our business. For example, we typically use your information in the following ways:

- **For Payment.** We may use or disclose health information to collect premiums due to us, to determine your coverage, or to process claims for health care services you receive. For example, we may tell a provider whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your provider to help them provide health care services to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we may use health information for operational activities such as quality assessment and improvement.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on the use and disclosure of the information in accordance with federal law.

**We may** use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information about you if state or federal laws require it.
- **To Persons Involved With Your Care.** We may use or disclose your health information a person involved in your care or who helps you pay for your care, such as a family member or close personal friend, when you are incapacitated, emergency situations, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests.
- **To Law Enforcement.** We may disclose your health information to a law enforcement official to provide limited information to locate a missing person or report a crime.
- **To Correctional Institutions or Law Enforcement Officials.** We may disclose your health information if you are an inmate of a correctional institution or under the custody of law enforcement, but only if necessary for the institution to provide you with health care; to protect your health and safety, or the health and safety of others; or for the safety and security of the correctional institution.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public. For example, we may disclose information to a public health agency or law enforcement in the event of a natural disaster.
- **For Public Health Activities** such as reporting disease outbreaks to a valid public health authority.
- **For Reporting Victims of Abuse, Neglect, or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social services or protective service agencies.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits, and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** to respond to a court order, search warrant, or subpoena.
- **For Specialized Government Functions** such as national security and intelligence activities, the protective services for the President and others, or if you are a member of the military, as required by the armed forces.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than allowed by the contract and federal law.
- **For Workers’ Compensation** as authorized by, or to the extent necessary to comply with, state workers’ compensation laws that govern job-related injuries or illness.

- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Cadaveric Organ, Eye, or Tissue Donation.** We may disclose information to entities that handle procurement, banking, or transplantation of organs, eyes, or tissue to facilitate donation and transplantation.

Except for uses and disclosures described and limited as explained in this notice, we will use and disclose your health information only with written permission from you. We will not share your personal information for marketing purposes or sell your personal information unless you give us written permission to do so.

## 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 in this Notice, 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 at the contact information below if you change your mind.

## your rights

- **Right to Inspect and Copy.** You have the right to inspect and copy certain protected health information that may be used to make decisions about your plan benefits. Your request must be in writing and submitted to the Ameritas Privacy Office at the contact information below. We will usually provide access to your protected health information within 30 days of receiving the request. We reserve the right to charge a fee for the costs of copying, mailing, or other supplies associated with your request. You may also ask your providers for access to your records. We may deny your request in very limited circumstances. If we deny your request to inspect or obtain a copy of your protected health information, we will inform you in writing of the reason(s) within 30 days.
- **Right to Amend.** You have the right to request that we amend, correct, or delete your protected health information in our records if you believe that it is inaccurate or incomplete. Your request must be in writing and sent to the Ameritas Privacy Office at the contact information below. In addition, you must provide a reason that supports your request. We will respond to your request in writing within 30 days. We may deny your request for an amendment if it is not in writing, or does not include a reason to support the request. If we deny your request, we will communicate the reason(s) for denial. If we deny your request, you have the right to file a written statement of disagreement and any future disclosures of the disputed information will include your statement.

- **Right to 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. Your request must be in writing and submitted to the Ameritas Privacy Office at the contact information below. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- **Right to an Accounting of Disclosures of Your Protected Health Information.** You have the right to receive a list of the times we've shared your health information for up to six years prior to the date you ask, who we share it with, and why. Your request must be in writing and submitted to the Ameritas Privacy Office at the contact information below. We will include all the disclosures, except those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Know the Reasons for an Unfavorable Underwriting Decision.** You have the right to know the reason(s) for an unfavorable underwriting decision. Your request must be in writing, and must be asked for within 90 days from when the adverse underwriting decision is sent. We will respond within 21 days. Previous unfavorable underwriting decisions may not be used as a basis for future underwriting decisions unless we make an independent evaluation of basic facts. Your genetic information cannot be used for underwriting purposes.
- **Ask Us to Limit the Information We Share.** You can send us a written request at the contact information below to not use or share certain health information for treatment, payment, or health care operations. We are not required to agree to these requests.
- **Get a Copy of this Privacy Notice.** You can ask us 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.

## exercising your rights

- **Submitting a Written Request.** If you have any questions about this Notice, want more information about exercising your rights, or want to obtain an authorization form please contact us at: The Privacy Office, Attn. HIPAA Privacy, P.O. Box 82520, Lincoln, NE 68501-2520, e-mail us at [privacy@ameritas.com](mailto:privacy@ameritas.com), or call 1-800-487-5553
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the contact information listed above. You may also 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.

This revised notice is effective 9/30/17.