



Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA

**CERTIFICATE AND SUMMARY PLAN DESCRIPTION
GROUP EYE CARE INSURANCE**

The Policyholder **DINE DEVELOPMENT CORPORATION**

Policy Number **10-67112** **Insured Person**

Plan Effective Date **January 1, 2026** **Certificate Effective Date**
Refer to Exceptions on 9070

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.

President

AZ Health Care Insurer Appeals Process Information Packet

Ameritas Life Insurance Corp.

CAREFULLY READ THE INFORMATION IN THIS PACKET AND KEEP IT FOR FUTURE REFERENCE. IT HAS IMPORTANT INFORMATION ABOUT HOW TO APPEAL ADVERSE DETERMINATIONS THAT WE MAKE ABOUT YOUR HEALTH CARE.

IMPORTANT: THE STANDARD APPEAL PROCESS FOR ALL PLANS MUST INCLUDE AN INITIAL APPEAL LEVEL OF REVIEW. FOR SOME PLANS WE MAY ELECT TO OFFER A SECOND INTERNAL LEVEL OF REVIEW CALLED A VOLUNTARY INTERNAL APPEAL. THE VOLUNTARY INTERNAL APPEAL, AND ANY REFERENCE TO THE VOLUNTARY INTERNAL APPEAL IN THIS PACKET, DOES APPLY TO YOUR PLAN.

We must send you a copy of this information packet when you first receive your policy, at the request of you or your treating provider, and provide access to a copy of this health care appeals information packet on our website Ameritas.com. When your insurance coverage is renewed, we will send you a reminder that you can request another copy of this packet. Just call our customer/member services number at on the CONTACT US page in this packet to request an additional copy.

WHICH DISPUTES ARE ELIGIBLE FOR ARIZONA'S HEALTH CARE APPEALS PROCESS?

You can file an appeal when you are notified by us of an Adverse Determination, which means that a requested service or a claim for service or a denial, reduction, or termination of service, in whole or in part is:

- Not medically necessary or appropriate, including the health care setting, level of care or effectiveness of a treatment or service.
- Experimental or investigational.
- Not a covered service.

An Adverse Determination also includes a cancellation of the policy back to the effective date due to a reason other than failure to pay premiums, known as a rescission of coverage.

Examples of disputes that are not eligible for Arizona's Health Care Appeals process include:

- You disagree with our determination as to the amount we paid for a service or treatment.
- You disagree with how we are coordinating benefits when you have health insurance with more than one insurer.
- You disagree with the amount of your cost-share (Co-payments and co-insurance) or how we have applied your claims or services to your plan deductible.

If you disagree with a decision we made that is not appealable, contact us at the number on the CONTACT US page in this packet.

WHO CAN FILE A HEALTH CARE APPEAL OR REPRESENT A MEMBER?

You or your treating provider on your behalf can file an appeal. The following authorized representatives can also file an appeal on your behalf:

- A parent or legal guardian.
- A surrogate who is authorized to make health care decisions for the member through a power of attorney, a court order or the provisions of A.R.S. § 36-3231.
- An agent who is an adult and who has the authority to make health care treatment decisions for the member pursuant to a health care power of attorney.

If you are the member and want to file a health care appeal, you can work with your treating provider to help you with information you need to support your appeal. In Arizona, the majority of health care appeals are filed by treating providers.

TOOLS FOR FILING A HEALTH CARE APPEAL

In this packet, you will find forms that you can use for your appeal. The Arizona Department of Insurance and Financial Institutions (“AZ DIFI”) developed these forms to help consumers file a health care appeal. You are **not** required to use them and we **cannot** reject your appeal if you do not use them. To file an appeal, you can call us or send us a request in writing. If you need help in filing an appeal, or you have questions about the appeals process, contact us at the Phone number on your ID card or listed on the CONTACT US page in this packet.

If you have general questions about health care appeals, you can contact the AZ DIFI’s Consumer Services Section at (602) 364-2499 or visit the AZ DIFI website at www/difi.az.gov.

DESCRIPTION OF THE APPEALS PROCESS

There are two types of appeal time frames: an expedited appeal for urgent matters, and a standard appeal. The appeals operate in a similar fashion, except that expedited appeals are processed much faster because of the patient’s condition.

Appeals are categorized as either Medical Necessity or Coverage. The designation will affect how the case is handled by us and by the AZ DIFI, as well as the rights you have once the health care appeals process has been completed.

STANDARD VS EXPEDITED TIME FRAMES: IS IT URGENT?

Generally, a standard appeal for a service not yet provided will be completed within 30 days.

If your appeal is urgent, your treating physician must certify and provide supporting documentation to us that the time frame for a standard appeal review would cause a significant negative change in your condition. There is a provider certification form at the end of this packet, but it is not required to be used. Your provider could also send a written request or create a form with similar information. Your treating provider must send the certification and documentation to us using the information on the CONTACT US page in this packet.

Adverse Determinations Eligible for Expedited Appeal Process

The following is a non-exhaustive list of Adverse Determinations that may be expedited with certification from your provider:

- A denial of a health care service as experimental or investigational.
- A denial of a health care service for which a member has received emergency services but has not been discharged.
- A denial, reduction, or termination of coverage for an admission.
- Availability of care.
- A continued stay for a course of treatment before the end of the period of time or number of treatments recommended by the treating provider.
- A prior authorization denial.

If you already received the service, or it is an issue of policy rescission, it **cannot** be expedited.

GENERAL APPEALS PROCESS INFORMATION

- Your plan may or may not offer a second internal level of review called the Voluntary Internal Appeal. The first page of this packet indicates whether the Voluntary Internal Appeal applies to your plan.
- You have two years from the date of an Adverse Determination to begin the health care appeals process.
- Requests for all health care appeal levels are to be sent directly to us using the information on the CONTACT US page in this packet.
- An appeal must first go through the Initial Appeal level and, if applicable, the Voluntary Internal Appeal level, or the internal level(s) of review must be waived or deemed exhausted, before seeking an External Independent Review, except that you can simultaneously initiate an Expedited External Independent Review at any internal level of review.
- The Initial Appeal and Voluntary Internal Appeal, if applicable, and the Expedited Medical Review and Expedited Appeal levels of review are completed by us. For the External Independent Review and Expedited External Independent Review levels, we send the appeal to the AZ DIFI.
- At any time we may waive the internal levels of review and move an appeal to the External Independent Review level.
- There is no minimum dollar amount for the value of a claim or service for it to be eligible for the health care appeals process.
- There is no fee to you or your provider for any level of appeal.
- It is important to pay attention to deadlines at each level of review.
- For group and grandfathered individual plans that elect to offer a Voluntary Internal Appeal level, there are three standard appeal levels, and for all plans, there are three expedited appeal levels:

	Expedited Appeals <u>(for urgently needed services you have not yet received)</u>	Standard Appeals <u>(for non-urgent services or denied claims)</u>
Level 1	Expedited Medical Review	Initial Appeal
Level 2	Expedited Appeal	Voluntary Internal Appeal
Level 3	Expedited External Independent Review	External Independent Review

- If the External Independent Review involves medical necessity, the AZ DIFI selects an Independent Review Organization (“IRO”) that is completely independent of us to make the determination. The IRO reviewer will be a provider that typically manages the condition that is the subject of the appeal.
- If the appeal involves whether a treatment or service is covered in your policy, the AZ DIFI is the external reviewer.

**EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES
NOT YET PROVIDED**

Level 1: Expedited Medical Review

You may obtain Expedited Medical Review of an Adverse Determination for a service that has not already been provided if your treating provider certifies in writing and provides supporting documentation that the time required for a standard appeal is likely to cause a significant negative change in your medical condition. At the end of this packet is a form that your treating provider may use, but that form is **not** required. Your provider could also provide a written request or create a form with similar information. Your treating provider must send the certification and documentation to us using the information on the CONTACT US page in this packet.

We have 72 hours after we receive the request to decide whether we should change our determination and authorize your requested service. Within this time frame, we must call and tell you and your treating provider about our determination. We must also send you a written determination.

If we overturn our determination, we will authorize the service and the appeal is over.

If we deny your appeal, our determination letter will explain the reasons for our determination and the information on which we based our determination. Our determination letter will also include instructions for the next steps in the appeal process.

We may decide at any time to waive the Expedited Medical Review and Expedited Appeal levels and send your appeal to the AZ DIFI for Expedited External Independent Review.

Level 2: Expedited Appeal

If we deny your Expedited Medical Review (Level 1), you may request an Expedited Appeal. After you receive our Expedited Medical Review determination, your treating provider must immediately send us a written appeal request using the information in the CONTACT US page in this packet. To help your appeal, your provider should also send us any additional information that the provider hasn't already sent to show why you need the requested service.

We have three business days after we receive the request to decide whether we should change our determination and authorize your requested service. Within this time frame, we must call and tell you and your treating provider about our determination. We must also send you a written determination.

If we overturn our determination, we will authorize the service and the appeal is over.

If we deny your appeal, our determination letter will explain the reasons for our determination and the information on which we based our determination. Our determination letter will also include instructions for the next steps in the appeal process.

We may decide at any time to waive the Expedited Appeal level and send your appeal to the AZ DIFI for Expedited External Independent Review.

Level 3: Expedited External Independent Review

Unless we waive the Expedited Medical Review (Level 1) or Expedited Appeal (Level 2) levels of review and send your appeal to the AZ DIFI for Expedited External Independent Review, you may request an Expedited External Independent Review after you have completed an Expedited Medical Review and an Expedited Appeal or simultaneously at any internal level of review. You have four months after you receive a Final Internal Adverse Determination to send to us your written request for Expedited External Independent Review. If the treatment or service is considered experimental or investigational, you can make an oral request if your treating physician certifies in writing that the requested service or treatment would be significantly less effective if not promptly initiated. Send us your request and any additional supporting information using the information in the CONTACT US page in this packet.

There are two types of Expedited External Independent Review (Level 3) depending on the issues in your case: Medical Necessity or Contract Coverage.

(A) Medical necessity

These are cases where we have decided not to authorize a benefit because we determined that the services you or your treating provider are asking for are not medically necessary to treat your condition. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization (“IRO”), which is procured by the AZ DIFI and not connected with our company. The IRO reviewer must be a provider who typically manages the condition under review. Medical necessity appeals are subject to the following time frames:

- Within one business day of receiving your request, we must:
 1. Send a written acknowledgment of the appeal request to the AZ DIFI, you, and your treating provider.
 2. Send the AZ DIFI all of the following: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our determination; a summary of the applicable issues including a statement of our determination; the criteria used and clinical reasons for our determination; the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the internal levels of review.
- Within two business days of receiving our information, the AZ DIFI must send all the submitted information to the IRO.
- Within 72 hours of receiving the information the IRO must make a determination and send their determination to the AZ DIFI.
- Within one business day of receiving the IRO’s determination, the AZ DIFI must send a notice of the determination to you, your treating provider, and us.

The determination (medical necessity): If the IRO decides that we should provide the service, we must authorize the service. If the IRO agrees with our determination to deny the service, the appeal is over. Your only further option is to pursue a claim in Superior Court.

(B) Contract coverage

These are cases where we have denied coverage because we believe the requested service is not covered under your insurance policy. For contract coverage cases, the AZ DIFI is the independent reviewer. Contract Coverage appeals are subject to the following time frames:

- Within one business day of receiving your request, we must:
 1. Mail a written acknowledgment of your request to the AZ DIFI, you, and your treating provider.
 2. Send the AZ DIFI all of the following: the request for review, your policy, evidence of coverage or similar document, all medical records and supporting documentation used to render our determination, a summary of the applicable issues including a statement of our determination, the criteria used and any clinical reasons for our determination and the relevant portions of our utilization review guidelines.
- Within two business days of receiving this information, the AZ DIFI must determine whether the service or claim is covered under your insurance policy and send a written notice of their determination to you, your treating provider and us.

Referral to the IRO for contract coverage cases: The AZ DIFI may be unable to determine issues of coverage. If this occurs, the AZ DIFI will forward the case to an IRO. The IRO will have 72 hours to make a determination and send it to the AZ DIFI. The AZ DIFI will have one business day after receiving the IRO's determination to send the notice of determination to you, your treating provider and us.

The determination (contract coverage): If the AZ DIFI decides that we should provide the service or pay the claim, we must do so. If either you or we disagree with the AZ DIFI's determination on a coverage issue, you or we may request a hearing with the Arizona Office of Administrative Hearings ("AZ OAH") by sending a request to the AZ DIFI within 30 days after receiving the AZ DIFI's determination.

STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS

Level 1. Initial Appeal

You can request an Initial Appeal of an Adverse Determination if all of the following apply:

- You have coverage with us,
- We denied your request for a covered service or claim,
- You do not qualify for an expedited appeal, and
- You request an Appeal within two years after the date we make the Adverse Determination.
- You send your request to us using the information in the CONTACT US page in this packet.

At any time we may decide to waive internal review and send your appeal to the AZ DIFI for External Independent Review.

Before we make a Final Internal Adverse Determination that relies on new or additional information generated by us, we must provide you with a copy of the new information along with a reasonable opportunity to respond within the applicable time frames for us to provide a written determination.

Determination and Time Frames:

- For group plans and for grandfathered individual plans that elect to offer a Voluntary Internal appeal level, we have:
 - a. 15 days to make a determination for a service not yet provided.
 - b. 30 days to make a determination for a service already provided.

We must send you and your treating provider a written determination letter within the time frames above.

If we overturn our determination, we will authorize the service or pay the claim and the appeal is over.

If we deny your appeal, our determination letter will explain the reasons for our determination and the information on which we based our determination. Our determination letter will also include instructions for the next steps in the appeal process, subject to the following time frames:

- For individual plans, and for group plans that do not elect to offer a voluntary internal appeal level, you have 4 months to request an External Independent Review.
- For group plans and for grandfathered individual plans that elect to offer a voluntary internal appeal level, you have 60 days to request a Voluntary Internal Appeal.

Level 2. Voluntary Internal Appeal

This level of appeal applies only if you have a group plan or grandfathered individual plan, we elect to offer this level of appeal, and you previously completed an Initial Appeal.

You or your treating provider must send us a written request within 60 days of an Initial Appeal determination to tell us you want a Voluntary Internal Appeal (Level 2). To help us make a determination on your appeal, you or your provider should also send us any additional information that you have not already sent to show why we should authorize the requested service or pay the claim. Send your appeal request and information to us using the information in the CONTACT US page in this packet.

At any time we may decide to waive internal review and send your appeal to the AZ DIFI for External Independent Review.

Before we make a Final Internal Adverse Determination that relies on new or additional information generated by us, we must provide you with a copy of the new information along with a reasonable opportunity to respond within the applicable time frames for us to provide a written determination.

Determination and Time Frames:

- We have 15 days to make a determination for a service not yet provided.
- We have 30 days to make a determination for a service already provided.

If we overturn our determination, we will authorize the service or pay the claim and the appeal is over.

If we deny your appeal, our determination will explain the reasons for our determination and the information on which we based our determination. Our determination will also include instructions for the next steps in the appeal process. You have four months to appeal to the External Independent Review Level (3).

Level 3: External Independent Review

You may appeal to the External Independent Review Level 3 only after you have completed the internal level(s) of appeal. You have four months after you receive a Final Internal Adverse Determination to send us your written appeal request and any additional supporting information for External Independent Review. Send your request to us using the information in the CONTACT US page in this packet

This level of review also applies if we elect to waive the internal level(s) of review.

There are two types of External Independent Review (Level 3), depending on the issues in your case: Medical Necessity or Contract Coverage.

(A) Medical necessity

These are cases where we have decided not to authorize a service because we determined that the service you or your treating provider are asking for is not medically necessary to treat your condition. For medical necessity cases, the independent reviewer is a provider retained by an IRO, which is procured by the AZ DIFI and not connected with our company. The IRO reviewer must be a provider who typically manages the condition under review. Medical necessity appeals are subject to the following time frames:

- Within five business days of receiving your request, we must:
 1. Mail a written acknowledgment of the request to the AZ DIFI, you, and your treating provider. This acknowledgment must include notice that you have five business days after receiving the notice to submit any additional written evidence to the AZ DIFI for consideration by the external reviewer. The AZ DIFI will forward it to the IRO. If you provide additional information after five business days the IRO may or may not consider it.
 2. Send the AZ DIFI all of the following:
 - a. The request for review.
 - b. Your policy, evidence of coverage or similar document.
 - c. All medical records and supporting documentation used to render our determination(s).
 - d. A summary of the applicable issues including a statement of our determination.
 - e. The criteria used and clinical reasons for our determination.
 - f. The relevant portions of our utilization review guidelines.
 - g. The name and credentials of the health care provider who reviewed and upheld the determination(s) at the earlier appeal levels.
- Within five days of receiving our information, the AZ DIFI must send all the submitted information to an IRO.
- Within 21 days of receiving the appeal the IRO must make a written determination and send the determination to the AZ DIFI.

- Within five business days of receiving the IRO's determination, the AZ DIFI must send a written notice of the determination to you, your treating provider, and us.

The determination (medical necessity): If the IRO decides that we should provide the service or pay the claim, we must authorize the service or pay the claim. If the IRO agrees with our determination to deny the service or payment, the appeal is over and your only further option is to pursue a claim in Superior Court.

(B) Contract Coverage

These are cases where we have denied coverage because we determined that the requested service is not covered under your insurance policy. For contract coverage cases, the AZ DIFI is the independent reviewer. Contract coverage appeals are subject to the following time frames:

- Within 5 business days of receiving your request, we must:
 1. Send a written acknowledgment of your request to the AZ DIFI, you, and your treating provider.
 2. Send the AZ DIFI: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our determination; a summary of the applicable issues including a statement of our determination; the criteria used and any clinical reasons for our determination; and the relevant portions of our utilization review guidelines; the name and credentials of the health care provider who reviewed and upheld the determination(s) at the initial appeal, and if applicable, the voluntary internal appeal level.
- Within 15 business days of receiving this information, the AZ DIFI must determine whether the service or claim is covered and send a written notice of their determination to you, your treating provider, and us.

Referral to the IRO for Contract Coverage Appeals: The AZ DIFI may be unable to determine issues of coverage. If this occurs, the AZ DIFI will forward your case to an IRO. The IRO will have 21 days to make a determination and send it to the AZ DIFI. The AZ DIFI will have five business days after receiving the IRO's determination to send the notice of determination to you, your treating provider, and us.

The determination (contract coverage): If the Director decides that we should provide the service or pay the claim, we must do so. If either you or we disagree with the AZ DIFI's determination on a coverage issue, you or we may request a hearing with the AZ OAH by sending a request to the AZ DIFI within 30 days after receiving the AZ DIFI's determination.

NOTES ON INDEPENDENT REVIEW ORGANIZATIONS (IROs)

- The AZ DIFI contracts directly with multiple IROs. They each maintain large rosters of many types of specialties of physicians and other licensed health care professionals.
- There is no cost to a member or provider for any part of the appeal process. If the services of an IRO are used, the AZ DIFI selects and pays the IRO, then bills the insurer for reimbursement after the appeal is completed.
- The IRO will check that their reviewer does not have a conflict of interest with the insurer, member, or treating provider, and was not involved in the original denial determination or any previous appeal for the same member.

- There will be no communication with the IRO by you or us. The IRO will complete their review using the documentation in your appeal.
- The IRO reviewer will be a provider who typically manages the condition under review.
- The IRO's determination is binding on all parties. Any further challenges must proceed through Superior Court.
- Even if determined to be medically necessary, neither the IRO, the AZ DIFI, or the AZ OAH can order an insurer to provide or pay for a treatment or service that is excluded in a policy.

OBTAINING MEDICAL RECORDS

Arizona law (A.R.S. §12-2293) permits you to ask for a copy of your medical records. Your request must be in writing and must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

Designated Decision-Maker: If you have a designated health care decision-maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision-maker or a person designated in writing by your health care decision-maker unless you limit access to your medical records only to yourself or your health care decision-maker.

Confidentiality: Medical records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the appeal process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other people.

DOCUMENTATION FOR AN APPEAL

If you file an appeal, you must include any material justification or documentation. If you gather new information during the course of your appeal, you should give it to us as soon as you get it. You must also give us the address and phone number where you can be contacted.

If your appeal goes to external review, the AZ DIFI may contact you by email from a generic email address (hca@difi.az.gov). If the appeal is already at the External Independent Review level, you will be notified in writing that you have five business days to send any additional information to the AZ DIFI. If you submit anything after the five business days, it does not have to be considered in your appeal.

THE ROLE OF THE ARIZONA DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS (AZ DIFI)

Arizona law requires “any member who files a complaint with the [AZ DIFI] relating to an Adverse Determination to pursue the review process prescribed” by law (A.R.S. §20-2533(F)). This means, that you must pursue the health care appeals process for all appealable adverse determinations before the AZ DIFI can investigate a complaint you may have against our company based on the determination at issue in the appeal.

The appeal process requires the AZ DIFI to:

1. Oversee the appeals process.
2. Maintain copies of each utilization review plan submitted by insurers.
3. Receive, process, and act on requests from an insurer for External, Independent Review.
4. Enforce the determinations of insurers.
5. Review determinations of insurers.
6. Send, when necessary, a record of the proceedings of an appeal to Superior Court or to the AZ OAH.

7. Issue a final administrative determination on coverage issues, including the notice of the right to request a hearing at AZ OAH.

RECEIPT OF DOCUMENTS

Any written document that is sent by mail is deemed received by the person to whom the document is properly addressed on the fifth business day after mailing. “Properly addressed” means your last known mailing address. Any document may alternatively be sent electronically where a member has elected electronic delivery.

You always have the right to contact the Department of Insurance

Arizona Department of Insurance and Financial Institutions
100 N 15th Avenue, Suite 261
Phoenix, AZ 85007-2630
(602) 364-2499 or
(800) 325-2548 (In Arizona but outside the Phoenix area)

CONTACT US

AMERITAS LIFE INSURANCE CORP

Ameritas Life Insurance Corp.
800-487-5553

Quality Control 877-897-4328 (Toll-Free)

Ameritas.com

SEND YOUR HEALTH CARE APPEAL TO:

Ameritas Life Insurance Corp.
KRISTI DENISON, MANAGER, QUALITY MANAGEMENT
QUALITY CONTROL
P.O. BOX 82657
LINCOLN, NE 68501-2657
FAX 402-309-2579

SEND YOUR INITIAL APPEAL AND, IF APPLICABLE, VOLUNTARY APPEAL TO:

Standard appeal:

Initial Appeal, or Voluntary Internal, or External Review Send to:

QUALITY CONTROL
P.O. BOX 82657
LINCOLN, NE 68501-2657
FAX 402-309-2579

EXPEDITED appeal:

Initial, or Voluntary Internal, or External Review Send to:

QUALITY CONTROL
P.O. BOX 82657
LINCOLN, NE 68501-2657
FAX 402-309-2579

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

HEALTH CARE APPEAL REQUEST FORM

You may use this form to tell your insurer you want to appeal a denial determination.

Insured Member's Name _____ Member ID # _____
Name of representative pursuing appeal, if different from above _____
Mailing Address _____ Phone # _____
City _____ State _____ Zip Code _____

Type of Denial: Denied Claim Denied Benefit for Service Not Yet Received

Name of Insurer that denied the claim/service: _____

If you are appealing your insurer's determination to deny a benefit for a service you have not yet received, will a 30 to 60 day delay in receiving the service likely cause a significant negative change in your health? If your answer is "Yes," you may be entitled to an expedited appeal. Your treating provider must sign and send a certification and documentation supporting the need for an expedited appeal.

What determination are you appealing?

(Explain what you want your insurer to pay for).

Explain why you believe the claim or service should be covered:

(Attach additional sheets of paper, if needed).

If you have questions about the appeals process or need help to prepare your appeal, you may call the Department of Insurance Consumer Assistance number (602) 364-2499 or 1-(800) 325-2548 (outside Metro Phoenix area), or Quality Control at 1-877-897-4328 (Toll-Free).

Make sure to attach everything that shows why you believe your insurer should cover your claim or authorize a service, including: Medical records Supporting documentation (letter from your doctor, brochures, notes, receipts, etc.) ** Also attach the certification from your treating provider if you are seeking expedited review

Signature of insured or authorized representative

Date

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

**PROVIDER CERTIFICATION FORM
FOR EXPEDITED MEDICAL REVIEWS**

(You and your provider may use this form when requesting an expedited appeal.)

A patient who is denied authorization for a covered service is entitled to an expedited appeal if the treating provider certifies and provides supporting documentation that the time period for the standard appeal process (about 60 days) "is likely to cause a significant negative change in the [patient's] medical condition at issue."

PROVIDER INFORMATION

Treating Physician/Provider _____		
Phone # _____	Fax # _____	
Address _____		
City _____	State _____	Zip Code _____

PATIENT INFORMATION

Patient's Name _____		Member ID # _____
Phone # _____		
Address _____		
City _____	State _____	Zip Code _____

INSURER INFORMATION

Insurer Name _____		
Phone # _____	Fax # _____	
Address _____		
City _____	State _____	Zip Code _____

- Is the appeal for a service that the patient has already received? Yes No
If "Yes" the patient must pursue the standard appeals process and cannot use the expedited appeals process.
If "No", continue with this form.
- What service denial is the patient appealing? _____
- Explain why you believe the patient needs the requested service and why the time for the standard appeal process will harm the patient. _____

Attach additional sheets if needed, and include: Medical records Supporting documentation

If you have questions about the appeals process or need help to prepare your appeal, you may call the Department of Insurance Consumer Assistance number (602) 364-2499 or 1-(800) 325-2548 (outside Metro Phoenix area), or Quality Control at 1-877-897-4328 (Toll-Free).
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I certify, as the patient's treating provider, that delaying the patient's care for the time period needed for the Initial Appeal and Voluntary Internal appeal processes (about 60 days) is likely to cause a significant negative change in the patient's medical condition at issue.

Provider's Signature _____ Date _____

Non-Insurance Products/Services

From time to time we may arrange, at no additional cost to you or your group, for third-party service providers to provide you access to discounted goods and/or services, such as purchase of eye wear or prescription drugs. These discounted goods or services are not insurance. While we have arranged these discounts, we are not responsible for delivery, failure or negligence issues associated with these goods and services. The third-party service providers would be liable.

To access details about non-insurance discounts and third-party service providers, you may contact our customer connections team or your plan administrator.

These non-insurance goods and services will discontinue upon termination of your insurance or the termination of our arrangements with the providers, whichever comes first.

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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 3

Eligible Employee Electing VSP

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	\$20
Contact Lens Fitting and Evaluation - Each Benefit Period	\$60
Frames, Lenses, and Medically Necessary Contacts - Each Benefit Period	\$20

When a Non-Participating Provider is used:

Exams - Each Benefit Period	\$20
Frames, Lenses, and Medically Necessary Contacts - Each Benefit Period	\$20

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.

DOMESTIC PARTNER: Refers to two unrelated individuals who share the necessities of life, live together, and have an emotional and financial commitment to one another, similar to that of a spouse.

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

DEPENDENT refers to:

- a. an Insured's spouse or Domestic Partner.
- b. each unmarried and married child less than 26 years of age, for whom the Insured, the Insured's spouse, or the Insured's Domestic Partner 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 or physical disability; 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 eligible employee electing VSP 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.

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. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

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 VSP 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.

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 plan 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 plan.

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 plan at that time will have their coverage 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, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

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 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; 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; or
4. the date all Dependent Insurance under the policy is terminated.

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

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.

Death or Divorce For Dependents Only

1. The Insured's spouse may continue coverage for themselves and any dependent children if coverage would terminate as a result of:
 - a. the death of the Insured; or
 - b. the dissolution of a marriage (divorce) with the Insured.

provided any required premium is paid.

2. Benefits

This continuation applies to all benefits payable under the policy.

3. Premiums

We may charge the full premium, i.e. the employee's and employer's portion during the continuation period.

We may change the premium rate at any time the Insured's group plan premium rate is changed.

4. How to Apply

Within 31 days of death of the Insured or the date of the divorce, the spouse must notify the employer and us in writing if he or she is electing to continue coverage.

5. Termination

Such insurance will stop on the earliest of:

- a. the last day of the period for which the premium is paid;
- b. the date coverage would normally stop under the terms of the policy;
- c. the date the spouse becomes insured under another group health plan;
- d. the date the spouse remarries and becomes insured under another group health plan;
- e. the date the spouse or any dependent child is eligible for coverage under Medicare, Title XVIII of the Federal Social Security Act;
- f. the date the policy terminates.

If the Policyholder is subject to COBRA, then the termination of coverage will be controlled by COBRA or by paragraph 5. above, whichever would provide a greater length of coverage.

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 PROVIDERS

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.

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 are 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>
Vision Examination(s)			
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
Complete Pair of Spectacles			
Lenses (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
Frames			
Single Frame	Once every 12 months	Up to \$130.00	Up to \$ 70.00
Contact Lenses (in lieu of Complete Pair of Spectacles)			
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; medical benefits under group or individual automobile contracts; 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. 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 15 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 impossible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible. 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 immediately when we receive due proof. Any balance remaining unpaid at the end of any period for which we are liable will be paid at that time.

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.

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

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

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

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

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and
2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.

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. General Plan Information

Name of Plan: Eye Care Insurance

Name, Address of Plan Sponsor: DINE DEVELOPMENT CORPORATION
8840 E CHAPARRAL RD STE 145
SCOTTSDALE, AZ 85250

Plan Sponsor Tax Id Number: 77-0651649

Plan Number: 501

Type of Plan: Group Insurance Plan

Name, Address, Phone Number
of Plan Administrator: KAREN HOLBROOK
DINE DEVELOPMENT CORPORATION
8840 E CHAPARRAL RD STE 145
SCOTTSDALE, AZ 85250

937-812-2568

Name, Address of Registered Agent
for Service of Legal Process: Plan Sponsor

If Legal Process Involves Claims
For Benefits Under The Group
Policy, Additional Notification of
Legal Process Must Be Sent To: Ameritas Life Insurance Corp.
P.O. Box 82595
Lincoln, NE 68501

Sources of Contributions: Employer/Member

Funding Method: Ameritas Life Insurance Corp.--Fully Insured

Plan Fiscal Year End: December 31

Type of Administration:
General Administration Plan Sponsor
Contract & Claim Administration Ameritas Life Insurance Corp.

B. Notice of Legal Process

Service of legal process may be made upon the plan administrator at the address listed above.

C. 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.

D. 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.

E. 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.

F. Claims For Benefits

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

G. 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.

H. 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:

Vision Service Plan
Attn: Claims Services
P.O. Box 385018
Birmingham, AL 35238-5018

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 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, 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/. We will not retaliate against you for filing a complaint.

This revised notice is effective 9/30/17.