Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA

CERTIFICATE
GROUP EYE CARE INSURANCE

The Policyholder **NORTH RANCH BENEFITS TRUST**
INSHORE BENEFITS

Policy Number **10-350785** **Insured Person**

Plan Effective Date **January 1, 2023** **Certificate Effective Date**
Refer to Exceptions on 9070

Class Number 52

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

CALIFORNIA - IMPORTANT INFORMATION

We are here to serve you . . .

Your satisfaction is very important to us. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion. In the event you need to contact someone about this insurance coverage for any reason, including your ability to access dental services in a timely manner, please contact your agent or feel free to contact us at the following:

Quality Control Unit
P.O. Box 82657
Lincoln, NE 68501-2657
1-877-897-4328 (Toll-Free)

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 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 additional information is needed we will only request what is reasonably necessary to handle the claim. A written decision based on the facts as known by us will be provided within fifteen (15) calendar days after receipt of 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 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 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 dental practice.

If you are not satisfied . . .

Should you feel you are not being treated fairly, we want you to know you may contact the California Department of Insurance with your complaint and seek assistance from the governmental agency that regulates insurance.

To contact the Department, write or call:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
1 800 927 HELP (4357) or (213) 897-8921
TDD Number: 1-800-482-4TDD (4833)
The Hotline hours are from 8:00 a.m. - 6:00 p.m.
Mon - Fri (Except Holidays)
http://www.insurance.ca.gov

Thank you for choosing Ameritas Group for your eyecare benefit coverage. As a member you always have complete freedom of choice in choosing your eyecare provider; however, by choosing a PPO network provider you may reduce your out-of-pocket expenses due to the discounted fees on covered eyecare procedures.

Please read the following information so you will know from whom or what group of providers eyecare may be obtained.

For the most current and complete provider listing and information, please visit the ***Plan Member*** section of our website, **www.ameritas.com** and click on the ***Find a Provider*** tab. Select ***EyeMed*** to locate a provider in your area.

For questions regarding your eyecare benefit coverage, contact our customer relations department at 1-866-289-0614 Monday-Friday, 8:00am - 8:00pm Eastern Standard Time.

When scheduling your appointment, please verify the provider is an active network participant.

No Cost Language Services. You can get an interpreter and get documents read to you in your language. For help, call us at the number listed on your ID card or **877-233-3797**. For more help call the CA Dept. of Insurance at 1-800-927-4357 English

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 877-233-3797. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. Arabic

Անվճար թարգմանչական ծառայություններ: Դուք կարող եք օգտվել թարգմանչի ծառայություններից, և ձեր փաստաթղթերը ձեզ համար կընթերցեն ձեր լեզվով: Եթե օգնության կարիք ունեք, զանգահարեք մեզ՝ ձեր նույնականացման (ID) քարտի վրա նշված հեռախոսահամարով կամ 877-233-3797 հեռախոսահամարով: Եթե լրացուցիչ օգնության կարիք ունենաք, զանգահարեք Կալիֆորնիա նահանգի Ապահովագրության վարչություն՝ (Department of Insurance) 1-800-927-4357 հեռախոսահամարով: Armenian

免費語言服務。您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打877-233-3797與我們聯絡。欲取得其他協助，請致電1-800-927-4357與加州保險部聯絡。Chinese

निशुल्क भाषा सेवाएँ। आप एक अनुवादक की सेवाएँ लेकर दस्तावेजों को अपनी भाषा में पढ़वा सकते हैं। मदद के लिए हमें अपने आईडी कार्ड पर दिए नंबर या **877-233-3797** पर फोन करें। अधिक मदद के लिए CA Dept. of Insurance को 1-800-927-4357 Hindi

Cov Kev Pab Txais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 877-233-3797. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

無料の言語サービス　日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または877-233-3797までお問い合わせください。更なるお問い合わせは、カリフォニア州保険庁、1-800-927-4357までご連絡ください。Japanese

សេវាកម្មភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 877-233-3797 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 적혀 있는 안내 전화로 문의해 주시 길 바랍니다: 887-233-3797. 더 자세한 사항을 문의하실 분들은 캘리포니아 주 보험국으로 연락해주시 길 바랍니다: 1-800-927-4357. Korean

خدمات رایگان ترجمه. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، از با شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 877-233-3797 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تماس حاصل نمایید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਿਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹੇ ਜਾਣ ਲਈ ਕਹਿ ਸਕਦੇ ਹੋ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 877-233-3797 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

Бесплатные языковые услуги. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, пожалуйста, позвоните нам по номеру, указанному на вашей идентификационной карте, или наберите 877-233-3797. Если вам нужна дополнительная помощь, пожалуйста, обратитесь в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

Servicios de idiomas sin costo. Puede obtener un intérprete y que le lean los documentos en español. Para recibir ayuda, llámenos al número que figura en su tarjeta de identificación o al **877-233-3797**. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

Walang Gastos na mga Serbisyo sa Wika. Maaari kayong kumuha ng isang interpreter o tagapagsalin at inyong ipabasa sa Tagalog ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa inyong ID card o sa **877-233-3797**. Para sa higit pang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Tagalog

บริการทางภาษาแบบไม่มีค่าใช้จ่าย คุณสามารถได้รับบริการจากล่ามและช่วยอ่านเอกสารในภาษาของคุณได้ หากต้องการความช่วยเหลือสามารถติดต่อได้ที่หมายเลขบนบัตรประจำตัวของคุณ หรือ **877-233-3797** สำหรับความช่วยเหลือเพิ่มเติมสามารถติดต่อได้ที่กรมการประกันภัยแห่งแคลิฟอร์เนีย (CA Dept. of Insurance) หมายเลข 1-800-927-4357 Thai

Các Dịch vụ Trợ giúp Ngôn ngữ Miễn phí. Quý vị có thể nhờ một thông dịch viên đọc các tài liệu cho quý vị nghe bằng ngôn ngữ của quý vị. Để được giúp đỡ, hãy gọi cho chúng tôi theo số điện thoại được ghi trên thẻ hội viên của quý vị hoặc gọi số **877-233-3797**. Để được trợ giúp thêm, xin gọi cho Sở Bảo hiểm Tiểu bang California theo số 1-800-927-4357. Vietnamese

California

Language Assistance/Non-Discrimination/Services for the Hearing Impaired/How to File a Complaint

Language Assistance
Ameritas Life Insurance Corp. ("Ameritas") language assistance program is designed to help Limited English Proficient (LEP) members with their language needs. It includes, but is not limited to, accessing an interpreter. A qualified interpreter will be provided at no cost to you by calling 877-233-3797. Information on how to access an interpreter is available in the top 15 languages spoken by Limited-English-Proficient individuals in California as determined by the State Department of Health Care Services.

Services for the Hearing Impaired
If you have a disability and require use of a Telecommunications Device for the Deaf (TDD), please dial 7-1-1 to use this free service. If you require additional service, contact Ameritas between 7:00 a.m. – 12:00 a.m. (CST) Monday through Thursday, and 7:00 a.m. - 6:30 p.m. (CST) Friday by calling the number on your ID card or 800-487-5553.

Non-Discrimination Policy
Ameritas complies with applicable Federal and State civil rights laws. Ameritas does not unlawfully discriminate, exclude people or treat them differently on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation in connection with the group dental and vision care insurance benefits provided to customers.

How to file a complaint

If you believe that Ameritas has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation, you may file a grievance with Ameritas at:

Ameritas Life Insurance Corp.
Quality Control Unit
P.O. Box 82657
Lincoln, NE 68501-2657
1- 877-897-4328 (Toll-Free)

You may contact the California Department of Insurance with your complaint and seek assistance from the governmental agency that regulates insurance. To contact the Department, write or call:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
1-800-927-HELP (4357) or (213) 897-8921
TDD Number: 1-800-482-4TDD (4833)
The Hotline hours are from 8:00 a.m. - 6:00 p.m.
Mon - Fri (Except Holidays)
http://www.insurance.ca.gov

You may also file a discrimination complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. You can file electronically through the Office for Civil Rights Complaint Portal (https://ocrportal.hhs.gov/ocr/portal/lobby.jsf) or you can file by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019, (800) 537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

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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 52	Eligible Associate Electing The $130 12/12/24 Vision 75% Participation

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.

When a Participating Provider is used:	
Deductible Amount:	
Exams - Each Benefit Period	$10
Frames	$0
Lenses - Each Benefit Period	$25
When a Non-Participating Provider is used:	
Deductible Amount	$0

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

DEFINITIONS

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

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

INSURED refers to a person:

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

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

c. for whom the insurance has become effective.

REGISTERED DOMESTIC PARTNER means a partner of the Insured as long as the partnership meets the requirements for such relationship as defined in Section 297 of the California Family Code or the functional equivalent registration of any other state or local jurisdiction.

Pursuant to Sections 381.5 and 10121.7 of the California Insurance Code, coverage shall be provided to Registered Domestic Partners that is equal to, and subject to the same terms and conditions as, the coverage provided to a spouse.

UN-REGISTERED 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. This partnership has not been registered with the California Secretary of State as prescribed under Section 297 of the California Family Code or any other state or local jurisdiction.

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

DEPENDENT refers to:

a. an Insured's spouse or an Insured's Registered Domestic Partner or an Un-Registered 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 Registered Domestic Partner or the Insured's Un-Registered 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.

Injury or Sickness for Certain Dependents
Coverage will continue for a covered Dependent student if the student is unable to remain enrolled in school and must take a medically necessary leave of absence. Coverage will continue for a period not to exceed 24 months or

the date on which coverage would otherwise terminate in accordance with the terms and provisions of the group policy, whichever comes first. We may require documentation and certification by the student's treating physician of the medical necessity of a leave of absence.

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and

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

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

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

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, and may also be subject to higher deductibles and out-of-pocket maximums. 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.

TELEHEALTH SERVICE refers to a health care service delivered by a dentist, or a health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or health professional's license or certification to a patient at a different physical location than the dentist or health professional using telecommunications or information technology.

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 associate electing the $130 12/12/24 vision 75% participation 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 associate electing the $130 12/12/24 vision 75% participation 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.

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.

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.

But any person who is not in active service or is totally disabled will be insured on the Effective Date if:

a. the person was insured under a policy of group insurance providing like benefits which ended on the day immediately before the Effective Date of the policy providing this coverage; and

b. the person is considered a Member or an eligible Dependent under the policy providing this coverage, and had the prior policy contained the same definition of eligibility, would have been a Member or Dependent under the prior policy.

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. in the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums, subject to the Grace Period; or
3. the date of 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.

Labor Dispute
For Employees Only

If membership is because of employment and the Insured's active service stops because of a labor dispute, the insurance may be continued subject to the following rules:

1. This provision only applies when the Policyholder is required by a collective bargaining agreement to pay all or part of the Insured's premiums.

2. The premium due for each Insured subject to this provision and the Insured's dependents, if applicable, will be that shown in the policy.

3. Payment of the premium by the Insured must be to the Policyholder, union, or other collection entity and forwarded to us on a monthly basis.

The insurance continued during such labor dispute will stop on the earliest of the following dates:

1. the date six months from the date cessation of work due to the labor dispute started.
2. the date that 75% of the Insureds subject to the labor dispute are continuing the coverage.
3. for any individual Insured:

    i. the date he or she takes full-time employment with another employer.
    ii. the last day of the period for which the Insured has made a premium payment.

Neither the Policyholder or us may cancel or alter the terms of the policy during the labor dispute, except that we can adjust premiums the same as we could if there were no labor dispute.

Any continuation of an Insured's benefits under this provision is applicable to the Insured's dependents, provided they were insured under the policy when the labor dispute started.

EYE CARE EXPENSE BENEFITS

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

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

A. the provider's charge, or

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

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

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

TIMELY ACCESS TO CARE
Contracted providers will maintain reasonable business hours, and ensure members can receive eye care services within 2 weeks of their request. Urgent care services will be performed the same day and contracted providers will offer after-hours support via mobile phone, pager or an answering system to members seeking emergency eye care.

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

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

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

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

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

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

LANGUAGE INTERPRETER SERVICES
Interpreter services are available by calling 888-581-3648 during normal business hours: 7:30 a.m. to 11 p.m. ET Monday through Saturday, and 11 a.m. to 8 p.m. ET on Sunday.

LIMITATIONS
This plan has the following limitations.

1) This plan does not cover more than one Eye Exam in any 12-month period.

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

3) This plan does not cover more than one set of Frames in any 24-month period.

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

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

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

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

7) This plan does not cover Plano Lenses.

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

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

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

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

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

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

SCHEDULE OF EYE CARE SERVICES

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

SERVICE	**PLAN MAXIMUM COVERED EXPENSE**	
	Participating Provider	*Non-Participating Provider*
Eye Exam	Covered in Full	Up to $ 35.00
(All lenses are per pair) Single Vision Lenses	Covered in Full	Up to $ 25.00
Lined Bifocal Lenses	Covered in Full	Up to $ 40.00
Lined Trifocal Lenses	Covered in Full	Up to $ 55.00
Frame	Up to $130.00	Up to $ 65.00
Contact Lenses		
Elective	Up to $130.00	Up to $104.00
Medically Necessary	Covered in Full	Up to $200.00

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 by a Participating Provider and within 180 days after the incurred date of the services provided by a Non-Participating Provider. If it is impossible to give written proof within the required time 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.

NOTICE REQUIREMENTS. If an Insured's coverage under this policy is terminated, premiums are increased, benefits are reduced or eliminated or eligibility for such coverage is restricted in any way, then such action will not be effective unless written notice of the action is delivered by mail to the last known address of the appropriate insurance producer and the administrator, if any, at least 45 days prior to the effective date of the action and to the last known address of the Employer Unit and the certificate holder at least 30 days prior to the effective date of the action.

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.

TELEHEALTH SERVICES
All services under this plan are covered when appropriately delivered through telehealth services and are subject to the same deductible and annual or lifetime dollar maximum (if applicable) as for equivalent services that are not provided through telehealth.

Your Information. Your Rights. Our Responsibilities.

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.