



Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA
800-487-5553
ameritas.com

**CERTIFICATE
GROUP EYE CARE INSURANCE**

The Policyholder **LIBERTY ISD**

Policy Number **10-68576** **Insured Person**

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

Class Number 99

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.

This is not a policy of workers' compensation insurance. The employer does not become a subscriber to the workers compensation system by purchasing his policy, and if the employer is a non-subscriber, the employer loses those benefits that would otherwise accrue under the workers' compensation laws. The employer must comply with the workers' compensation law as it pertains to non-subscribers and the required notifications that must be filed and posted.

President

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Ameritas Life Insurance Corp.

To get information or file a complaint with your insurance company or HMO:

Call: Complaint Officer at 877-897-4328 (Toll Free)

Email: group@employeebenefitservice.com

Mail: P.O. Box 82657, Lincoln, NE 68501-2657

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance,
PO Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Ameritas Life Insurance Corp.

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: **Complaint Officer al 877-897-4328 (Teléfono gratuito)**

Correo electrónico: group@employeebenefitservice.com

Dirección postal: P.O. Box 82657, Lincoln, NE 68501-2657

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance,
PO Box 12030, Austin, TX 78711-2030

Notice of Complaint and Appeal Procedures - TEXAS

Please read this notice carefully. Please also review your plan documents and Explanation of Benefits you receive with a benefit decision resulting from a claim or elective request for a pre-treatment estimate of benefits. This notice contains important information about how to file complaints or appeals.

I. Definitions

“Adverse Determination” means that benefits are not available based on a utilization review determination that services provided or proposed are not medically necessary or are experimental. All adverse determinations are made by licensed dentists. Adverse determinations are made in accordance with the Utilization Review Agent's (URA) Clinical Guidelines, which are based upon Current Dental Terminology nomenclature and definitions, as well as professional clinical standards of care garnered through clinical experience and publications by organized dentistry.

“Complaint” means an oral or written expression of dissatisfaction concerning the URA's process in conducting a utilization review. The term "complaint" does not include an expression of dissatisfaction constituting an appeal or a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or by clearing up the misunderstanding to the satisfaction of the complaining party.

“Independent Review Organization” (“IRO”) means an entity authorized by the Texas Department of Insurance to provide an external review of an adverse determination.

“Prospective Review” means a benefits review prior to receiving a service. Prospective reviews are not required under this policy, but you or your provider may choose to request a pre-treatment estimate of benefits before a service is performed.

“Reasonable Opportunity” means at least one documented good faith attempt to contact the provider of record that provides an opportunity for the provider of record to discuss the services under review with us during normal business hours prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination:

- (A) no less than one working day prior to issuing a prospective utilization review adverse determination;
- (B) no less than five working days prior to issuing a retrospective utilization review adverse determination; or
- (C) prior to issuing a concurrent or post-stabilization review adverse determination.

“Retrospective Utilization Review” means a form of utilization review for health care services that have been provided to a member. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted.

II. Our Benefit Notices

If we make an adverse determination as defined above, after giving the treating provider a reasonable opportunity for discussion, you, an individual acting on your behalf, and the provider will have access to our appeals process even if the discussion does not occur. An Explanation of Benefits or Payment will also be included, that includes:

- 1. principal reason for the benefit decision, and
- 2. the clinical basis and description or source of screening criteria.

For adverse determinations, you, an individual acting on your behalf, or the provider has a right to request a review by an IRO. You can request an immediate review by an IRO in cases of life threatening conditions. Please find attached the Independent Review request forms.

III. Designated Person Responsible For Complaints and Appeals Management

Name: Bruce Mieth
Senior Vice President - Group Operations
Address: P.O. Box 82657
Lincoln, NE 68501-2657
Web: <https://www.ameritas.com>
Phone: 877-897-4328 (Toll-Free)
Fax: 402-309-2579

IV. Levels of Review Available

A. Our Internal Review

The member or someone acting on the member's behalf and the provider of record have the right to appeal an adverse determination (denial) orally or in writing. A licensed dentist who has not previously reviewed the case will make the appeal decision. The appealing party must send us the appeal no later than 30 calendar days after the date of this letter.

- **Written Appeal:** To submit a written appeal, mail or fax the written appeal to the address or fax number listed above.
- **Oral Appeal:** To file an oral appeal, call the following toll-free number: 877-897-4328.

There are three types of appeals:

- **Standard Appeal:** An appeal that does not involve urgent care such as emergency care, life-threatening conditions, or continued hospitalization.
- **Expedited Appeal:** An expedited appeal is available for emergency care, life-threatening conditions, and hospitalized members. An expedited appeal is also available for denials of prescription drugs and intravenous infusions for which the member is currently receiving benefits.
- **Acquired Brain Injury Appeal (this type of appeal may not be applicable in your case):** An appeal of denied services concerning an acquired brain injury.

Appeal Acknowledgment: Within five working days of receipt of the appeal, we will send the appealing party a letter acknowledging the date that we received the appeal and a list of documents that we may need for the appeal. If the appeal is oral, we will send the appealing party a one-page appeal form. The appealing party does not have to return the appeal form but we encourage its return because the form will help us resolve the appeal.

Our deadlines to resolve the appeal and send a written decision to the member or someone acting on the member's behalf and the provider of record are:

- **Standard Appeal:** 30 calendar days of receipt of the appeal
- **Expedited Appeal:** One working day from the date we receive all information necessary to complete the appeal. We may provide the determination by telephone or electronic transmission, but will provide a written determination within three working days of the initial telephonic or electronic notification.
- **Retrospective (claim) Appeal:** 30 calendar days after receipt of appeal. However, we may extend this deadline once for a period not to exceed 15 days.
- **Acquired Brain Injury Appeal (this type of appeal may not be applicable in your case):** Not later than three business days after the date on which the individual submits the appeal. The notification of the determination must be provided through a direct telephone contact to the individual making the request. We will provide a written determination within 30 calendar days of receipt of the appeal.

Life-Threatening Conditions: If the patient has a life-threatening condition or receives a denial for prescription drugs or intravenous infusions for which they are currently receiving benefits, the patient, or someone acting on the patient's behalf, and the provider of record can request an immediate review by an independent review organization (IRO) and is not required to follow our internal appeal procedures. See below for more information about the independent review.

After our internal review of your appeal, we will send a written decision, including:

- A statement of the specific medical, dental, or contractual reasons for the resolution;

- The clinical basis for the decision
- A description of or the source of the screening criteria that were utilized in making the determination
- The professional specialty of the provider who made the determination
- Notice of the appealing party's right to seek review of the adverse determination by an IRO under 28 TAC 19.1717
- A copy of a request for a review by an IRO form;
- Procedures for filing a complaint as described in 28 TAC 19.1705 (f).

Exhaustion of Internal Appeals: We will not require exhaustion of our internal appeals process if: (a) we fail to meet our internal appeal process timelines, or (b) the claimant with an urgent care situation files an external review before exhausting our internal appeal process, or (c) we decide to waive the appeal process requirements.

B. Independent Review

If we deny the appeal (continue to deny the services or treatment described above), the member or someone acting on the member's behalf and the provider of record have the right to request a review by an IRO. The IRO does not have an affiliation with your payor (insurance company or health plan), your health care providers, or the URA. To request the independent review, fill out the enclosed form and return it to the address or fax number listed in Section III. above. The patient, parent, or the patient's legal guardian must sign the consent to release medical information to the IRO (included as part of the IRO form). We will notify the Texas Department of Insurance of the request for an Independent Review within one working day from the date the IRO request is received. The Texas Department of Insurance will randomly assign an IRO to review the matter. We will provide all required information to the IRO within three working days after the date we receive a request for IRO review. We will bear the costs of the Independent Review and will comply with their benefit decisions.

V. Complaint Procedures

The enrollee, an individual acting on behalf of the enrollee, or the provider of record may file an oral or a written complaint regarding our utilization review process or procedures by using the contact information listed above. We will respond to your complaint within 30 calendar days.

You always have the right to file a complaint with the Texas Department of Insurance

P.O. Box 12030
Austin, TX 78711-2030
Web: <http://www.tdi.texas.gov>
Toll Free: 1-800- 252-3439
Fax: 512- 490-1007

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
 - Up to \$500,000 for health benefit plans, with some exceptions.
 - Up to \$300,000 for disability income benefits.
 - Up to \$300,000 for long-term care insurance benefits.
 - Up to \$200,000 for all other types of health insurance.
- **Life insurance:**
 - Up to \$100,000 in net cash surrender or withdrawal value.
 - Up to \$300,000 in death benefits.
- **Individual annuities:** Up to \$250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to \$300,000 per person, regardless of the number of policies or contracts. A limit of \$500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact: Texas Life and Health Insurance Guaranty Association 1717 West 6th Street, Suite 230 Austin, TX 78703-4776 1-800-982-6362 or www.txlifega.org	For questions about insurance, contact: Texas Department of Insurance P.O. Box 12030 Austin, TX 78711 1-800-252-3439 or www.tdi.texas.gov
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Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

TABLE OF CONTENTS

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

**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 99

COBRA Member Electing Vision

EYE CARE EXPENSE BENEFITS

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

Deductible Amount:

When a Contracting Provider is used:

Exams - Each Benefit Period	\$10
Contact Lens Fitting and Evaluation - Each Benefit Period	\$60
Frames, Lenses, and Medically Necessary Contacts - Each Benefit Period	\$25

When a Non-Contracting Provider is used:

Exams - Each Benefit Period	\$10
Frames, Lenses, and Medically Necessary Contacts - Each Benefit Period	\$25

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

DEFINITIONS

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

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

INSURED refers to a person:

- a. who is a Member of the eligible class; and
- b. who has qualified for insurance by completing the eligibility period, if any; and
- c. for whom the insurance has become effective.

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

DEPENDENT refers to:

- a. an Insured's spouse.
- b. each unmarried and married child less than 26 years of age, for whom the Insured or the Insured's spouse is legally responsible, including natural born children, adopted children from the date of placement for adoption, or from the date that the insured is a party to a suit to adopt the child, whichever is earlier, grandchildren, if such children are dependents of the Insured for federal income tax purposes at the time application of coverage of the child is made, children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws and any child if the parent is required by a court order or administrative order to provide health insurance coverage for the child. 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 incapable of self-sustaining employment because of mental retardation or physical disability, and chiefly dependent on the insured or group member for support and maintenance. To obtain coverage for a child as described by Subsection (c), You must provide US proof of the child's incapacity and dependency, not later than the 31st day after the date the child attains the limiting age, and subsequently We require, except that we may not require proof more frequently than annually after the second anniversary of the date the child attains limiting age, and each unmarried grandchild less than 25 years of age, if such children are dependents of the Insured for federal income tax purposes at the time application for coverage of the child is made.
- d. 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 child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and
2. Chiefly dependent upon the Insured for support and maintenance.

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

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

CONTRACTING AND NON-CONTRACTING PROVIDERS. A Contracting Provider is a Provider who has a contract with Us to provide services to Insureds at a discount. A Contracting 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 Contracting Provider's contracted fees for covered services. A Non-Contracting 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 Contracting 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."

A member of the Eligible Class for Insurance is any COBRA member electing vision working a minimum number of hours per week as required by the Policyholder.

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

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. An adopted child will be covered from the date an insured enters in suit seeking adoption of a child. A foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence.

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

Initial coverage for a newborn child will be covered for a period of 31 days. For coverage to continue beyond this initial 31-day period, the Insured must give us notice and we will charge the applicable additional premium from the date of birth.

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

A member of the Eligible Class for Dependent Insurance is any COBRA member electing vision working a minimum number of hours per week as required by the Policyholder and has eligible dependents.

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 September 1.

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

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

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

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 September 1.

An Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

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

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

EXCEPTIONS. 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.

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. 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.

Strike or Lockout

For Employees Only

This continuation only applies when the Employer is required by a collective bargaining agreement to pay all or part of the Insured's premium.

1. The Insured may continue coverage if it would stop because the Insured's work is stopped due to:
 - a. a strike; or
 - b. a lockout;

provided premiums are paid by the Insured.

The Insured may also continue to insure his or her dependents.

2. Benefits
This continuation applies to all benefits payable under the policy.

3. Termination
Such insurance will stop on the earlier 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 Insured becomes eligible under another group health plan;
 - d. the date coverage has been continued for six months;
 - e. the date seventy-five percent (75%) of the covered employees continue coverage;
 - f. the date the policy terminates.

4. Premiums

We may charge the full premium, i.e. the employee 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.

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.

CONTRACTING PROVIDERS

A Contracting 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-CONTRACTING PROVIDER

A Non-Contracting Provider is any other provider. Non-Contracting providers may be referred to as Affiliate or Open Access Providers. Non-Contracting Providers are not subject to our Quality Management Programs. Your out-of-pocket expenses may be greater when you visit a Non-Contracting 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. The reimbursement of claims for Non-Contracting Providers may be less than the billed charge for the service, and you may be liable to the Non-Contracting Provider for any amounts not paid by Us.

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

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 from a Contracting Provider's office, the Insured must advise the Contracting Provider's office if he or she has coverage under this network plan. No notification is required if requesting services from a Non-Contracting Provider.

ASSIGNMENT OF BENEFITS

Unless we receive a written Assignment of Benefits to the contrary, we pay benefits to the Contracting Provider for services and supplies performed or furnished by them. When a Non-Contracting 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. If it was not reasonably possible to submit a claim within the period stated above, we will not reduce or deny the claim for this reason if the claim is submitted as soon as is reasonably possible.

EXPENSES INCURRED

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

COORDINATION OF BENEFITS

Unless otherwise agreed to by Client and VSP, the following rules governing coordination of benefits shall apply. When VSP is the primary insurer, it will pay benefits according to the terms of this Policy, subject to any applicable state or federal codes, statutes or regulations. When VSP is the secondary insurer, it will coordinate those vision care services and materials that were considered by the primary insurer as allowable expenses. VSP will pay the lesser of: a) The normal Plan Benefit, in the absence of other coverage, or b) The remaining balance up to Covered Person's Plan Benefits, not to exceed the billed amount.

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 reasonably 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	
		Contracting Provider	Non-Contracting Provider*
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 \$150.00	Up to \$ 70.00
Contact Lenses (in lieu of Complete Pair of Spectacles)			
Elective	Once every 12 months	Up to \$150.00	Up to \$120.00
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-Contracting 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.

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, and unless the claimant does not have the legal capacity to provide proof of loss, proof of loss is provided not later than the first anniversary of the date proof of loss is otherwise required. 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 no later than the 60th day after the date the Proof of Loss is received. Any balance remaining unpaid at the end of any period for which we are liable will be paid at that time.

PAYMENT OF BENEFITS. Contracting Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Contracting Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Contracting Provider directly.

Direct Payment of the Texas Department of Human Services

Other provisions of the policy notwithstanding, whenever we are notified that the Texas Department of Human Services has incurred expenses in connection with dental treatment for a person who is insured under this policy, benefits which would otherwise be payable to the Insured, if any, will be paid to the Texas Department of Human Services, but only to the extent of the actual costs incurred by such Department.

Benefit Payment to Parent of a Dependent Child

Regardless of any policy provision to the contrary, if:

1. a minor child is a dependent under this policy; and
2. such dependent child incurs expenses;

we will pay benefits to the parent of the dependent child who is not a Member of the group. Such parent must be legally designated the managing conservator of the child. We must receive evidence of this before we will pay benefits.

We will not pay benefits to the managing conservator in the following situations:

1. If the parent who is a Member of the group has legally assigned benefits to a provider, we will pay benefits to the provider.

2. If the parent who is a Member of the group has paid any portion of the expenses and those expenses are covered under the terms of the policy, we will pay benefits to the Member.

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 pay the benefit in an amount not to exceed \$5,000 to the insured or the insured's assignee.

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 three 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.

MISSTATEMENT OF AGE. If the age of an Insured has been misstated, the amounts payable under this policy are the amounts the premium paid would have purchased at the correct age.

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.

Our Commitment to Your Privacy

We value your trust. That is why we are committed to protecting your personal information. This notice explains the way we use and protect your personal information. You do not need to take any action, but you do have certain rights that are described in this notice.

Important Notice of Privacy of Information Practices

This Privacy Notice is provided on behalf of the group and individual dental, vision, and hearing care businesses of: Ameritas Life Insurance Corp. and Ameritas Life Insurance Corp. of New York. In addition to those companies listed above, Ameritas consists of the following affiliated companies, all of which offer their own Notice of Privacy Practices: Ameritas Investment Company, LLC, Ameritas Advisory Services, LLC, Variable Contract Agency, LLC, Ameritas Investment Partners, Inc.

Information we collect

We collect information about you for the purpose of conducting routine business functions, such as paying your dental, vision and hearing care claims. Following are examples of the types of customer information we may collect about you:

Personal identification and contact information, such as your:

- Name and address
- Date of birth
- Social Security number

Group enrollment information (as applicable):

- Employment status
- Date of hire

Health information, such as:

- the claims information you or your dental, vision or hearing care provider submit to us so we can process your claims and assess your benefits

How we gather your personal information

Most of the information we collect about you comes directly from you. You give us personal information when you purchase an individual policy or when you enroll in your employer's dental, vision and/or hearing care plan. We also may receive information from:

- Your dental, vision and/or hearing care provider
- Governmental agencies
- Independent reporting agencies

Information collected by us from insurance support organizations, such as independent reporting agencies, is maintained by that insurance support organization and may be disclosed to other persons.

How we use and share your personal information

We do not sell or share your information with outside marketers. However, we may share your information outside of Ameritas for the following reasons:

Service providers.

We may share information about you with service providers. Service providers are unrelated companies who perform business transactions for us. We require service providers to keep your information confidential. They are contractually bound to use your information only to perform those services. They are required to have safeguards in place to protect it, and are not permitted to sell, use or disclose your information for their own marketing purposes. Disclosures to service providers are part of our business operations. You may not opt out of these disclosures.

Required by law.

Sometimes the law requires us to share customer information, such as in response to a valid summons, court order, search warrant or subpoena. We must comply with the law and therefore you may not opt out of these disclosures.

Agents and brokers.

We may share your information with your agent or broker so he or she may provide you with efficient and superior service. Our agents and brokers understand the importance of your privacy and they are required by law to maintain your privacy and safeguard your information. We require our agents and brokers to follow our policies in order to keep your personal information private and secure. You may not opt out of these disclosures.



Health or medical information

We will not release your medical or health information to anyone unless we are permitted or required by law to do so. When we are not permitted or required by law to disclose your health or medical information, we will not do so without your written authorization.

Examples:

Permitted by law.

The law permits us to exchange information with your health care provider in order to process your claims and facilitate payment.

Required by law.

The law requires us to disclose your information under a valid court order.

Your rights

This notice is also available on our website. You may request an additional copy by writing, e-mailing or calling the Ameritas Privacy Office as indicated at the end of this notice.

You have the right to review the information we have about you. You must make this request in writing and include your full name, address and policy or account number. We may charge you a reasonable fee for the copies you request.

You have the right to request that we make corrections to the information we maintain about you if you believe our records are incorrect. All requests must be in writing.

We safeguard your personal information

We maintain physical and electronic safeguards for the protection of your personal information. We restrict access of your information to our employees and agents who need it to perform their jobs. Our employees and agents understand the importance of these safeguards. We have trained them in the proper handling of your personal information.

Former customers' personal information

The policies and practices described in this notice apply equally to current and former customers. When you are no longer a customer, we will maintain your information for the period of time required by law and then it is destroyed. As a former customer, however, you will not receive our annual Privacy Notice.

Our privacy policies

This Privacy Notice summarizes the Official Privacy Policy of Ameritas identified on the first page of this notice, which became effective on January 1, 2006. This notice complies with all applicable laws and regulations. If your state's privacy law requires more restrictive practices than those described in this notice, we will apply the more restrictive practices to your information. We may make changes to our privacy policies from time to time. However, if we make a change that impacts the accuracy of the sharing practices that are explained in this notice, we will provide you with a revised Privacy Notice within 30 days.

Special note to our group and individual dental, vision and hearing care plan sponsors and participants:

Our group and individual dental, vision and hearing care plans must also comply with the privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH). Our Notice of Protected Health Information Practices more specifically describes our privacy policies with regard to your information. You may contact our Privacy Office to request an additional copy.

You may contact us at:

Ameritas Privacy Office
P.O. Box 81889
Lincoln, NE 68501-1889
1-888-284-7844
privacy@ameritas.com

Nevada residents: This notice is being provided pursuant to state law. If you prefer not to receive marketing calls, contact your agent or broker directly. For more information about this law, contact the Office of the Nevada Attorney General, Bureau of Consumer Protection, 100 N. Carson Street, Carson City, NV 89703. Phone number: 702-486-3132; email: www.aginfo@ag.nv.gov.

