



A STOCK COMPANY  
LINCOLN, NEBRASKA

**CERTIFICATE  
GROUP EYE CARE INSURANCE**



**The Policyholder**      **unum**

**Policy Number**      **10-350221**      **Insured Person**

**Plan Effective Date**      **January 1, 2001**      **Certificate Effective Date**  
**Refer to Exceptions on 9070.**

**Plan Change Effective Date**      **January 1, 2008**

**Class Number 1**

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

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

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

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

**NOTICE TO INSURED: THIS CERTIFICATE PROVIDES EYE CARE BENEFITS ONLY.**

President



## **GRIEVANCE PROCEDURES**

### **In Accordance with Chapter 850 of the Maine Regulations**

Please read this notice carefully. This notice contains important information about how a covered person can file grievances with us. Also, the covered person always has the right to contact the Maine Bureau of Insurance if there are questions or concerns regarding coverage under this contract. The Maine Bureau may be contacted:

In Writing:	Maine Bureau of Insurance State House Station 34 Augusta, ME 04333
Consumer Hotline:	800-300-5000

The covered person has the right to ask us to review decisions involving requests to have claims paid. The covered person also has the right to receive copies of any clinical review criteria utilized in arriving at any adverse determination. For adverse determinations, the treating provider has a right to request Reconsideration, which will be conducted within one working day of the request, between the treating provider and the reviewing provider or a peer if the reviewing provider is unavailable during the required timeframe.

#### **I. Definitions**

"Adverse Determination" means a decision denying in whole or in part payment for otherwise covered services requested by or on behalf of an insured in which the denial is based on a position that the treatment provided was not determined to be medically necessary.

"Covered Person" means the policyholder, insured or other individual entitled to benefits under this health benefit plan and/or their representative or provider acting on behalf of the covered person.

"Grievance" means a written complaint submitted by or on behalf of a covered person regarding:

1. the availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;
2. benefits or claims payment, handling, or reimbursement for health care services; or
3. matters pertaining to the contractual relationship between a covered person and us.

#### **II. Filing a Grievance**

A grievance concerning any matter may be submitted by a covered person. Written grievances should be sent to the following individual:

Name:	Quality Control
Address:	P.O. Box 82657 Lincoln, Nebraska 68501-2657
Phone:	1-877-897-4328
Fax:	402-309-2579

#### **III. Levels of Appeals Review for Grievances Concerning Adverse Determinations**

The following levels of review will be available to a covered person who requests an appeal of an adverse determination:

##### **A. Standard Appeal**

Appeals shall be evaluated by an appropriate clinical peer or peers. The clinical peer(s) shall not have been involved in the initial adverse determination, unless new information is provided that had been unavailable at the time of the original decision.

Written notification of the appeal review decision shall be made within 20 working days following the request for an appeal. Additional time is permitted where we can establish that the 20-day time frame cannot reasonably be met due to the inability to obtain all necessary information. Request for delay will be sent to the covered person and the attending provider. In such instances, decisions will be issued within 20 days of the receipt of all necessary information.

The written decision will contain the following:

1. Names, titles and qualifying credentials of the person or persons evaluating the appeal;
2. A statement of the reviewer's understanding of the reason for the covered person's request for an appeal;
3. The reviewer's decision in clear terms and the rationale in sufficient detail for the covered person to respond further, if necessary;
4. A reference to the clinical review criteria used to make the determination and instructions for requesting copies of such criteria; and
5. Notice of the right to subsequent appeal rights as well as right to request an external review.

## **B. Second Level Reviews**

In any case where the standard appeal review process does not resolve a difference of opinion between us and the covered person, a written grievance may be submitted and we will review it as a second level grievance.

A second level review panel will review the second level grievance. A majority of the panel shall be comprised of health care professionals who are clinical peers and who were not previously involved in the grievance.

The review panel shall schedule and hold a review meeting within 45 working days after receiving a request from a covered person for a second level review. The covered person shall be notified 15 working days in advance of the review date. In those situations where the covered person cannot appear in person, we shall offer the covered person the opportunity to communicate with the review panel, at our expense, by conference call, video conferencing or other available technology.

Upon the request of a covered person, we shall provide to the covered person all relevant information that is not confidential or privileged. A covered person has the right to attend the second level review, present his or her case to the review panel, submit supporting material both before and at the review meeting, ask questions of any representative and be assisted or represented by a person of his or her choice.

The review panel shall issue a written decision to the covered person within 5 business days of completing the review meeting. The decision will include the covered person's right to request an external review.

## **C. Expedited Review**

Expedited Reviews are available to the covered person or provider acting on his or her behalf for any appeals involving a situation whether the time frame of the standard review procedures would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function. The appeal decision will be communicated telephonically within 72 hours of the request for the expedited appeal and written confirmation will be provided within 2 working days after the decision.

## **D. External Review - In accordance with 24-A M.R.S.A. 4312**

A covered person or his or her authorized representative has a right to request an independent external review of an adverse determination. Except as noted below for those situations which would require an expedited review, a covered person may not make a request for external review until the covered person has exhausted all levels of the internal grievance process. The request must be made within 12 months of date the covered person has received the final adverse determination from us.

Requests are made to the Maine Bureau of Insurance. There is no charge for the filing of the request for external review.

Our Quality Control Department is available to assist in the preparation of the request for the External Review. Please call 1-877-897-4328 or fax 1-402-309-2579.

The covered person may ask for or submit information related to the benefit under review, attend the external review, and ask questions of our representative at the review. If the covered person wishes to use any outside assistance for the review process, it will be at his or her own expense.

The covered person has the right to seek assistance or file a complaint with the Maine Bureau of Insurance:

In Writing:	State House Station 34 Augusta, Maine 04333
Consumer Hotline:	800-300-5000

#### **E. Expedited External Review**

A covered person is not required to exhaust all levels of the internal grievance process before filing a request for external review if:

1. We have failed to make a decision on an internal grievance within the time period required;
2. We have mutually agreed to by-pass the internal grievance process;
3. The life or health of the insured is in serious jeopardy; or
4. The insured has died.

#### **IV. Review Procedures for Grievances Concerning Matters Other than an Adverse Determination**

The following review will be available to a covered person concerning any matter except an adverse determination. For these types of grievances, refer to Item III. above.

A written grievance concerning any matter should be submitted to the address shown in Item II. above. A covered person does not have the right to attend, or to have a representative in attendance, at this review. We will notify the covered person within 3 working days of our receipt of the grievance and the name, address and telephone number of the person who is coordinating the grievance review.

Written notification of the grievance review decision shall be made within 20 working days following the request for a review. Additional time is permitted where the carrier can establish the 20-day time frame cannot reasonably be met due to the inability to obtain all necessary information. Request for delay will be sent to the covered person and the attending provider. In such instances, decisions will be issued within 20 days of the receipt of all necessary information.

The written decision will contain the following:

1. Names, titles and qualifying credentials of the person or persons conducting the review;
2. A statement of the reviewer's understanding of the reason for the covered person's grievance;
3. The reviewer's decision in clear terms and the basis for the decision;
4. A reference to the evidence or documentation used as the basis for the decision; and
5. Notice of the covered person's right to contact the Superintendent's office which will include the toll free number and address of the Maine Bureau of Insurance.



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**SCHEDULE OF BENEFITS  
OUTLINE OF COVERAGE**

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

Benefit Class

Class Description

Class 1

All Eligible Employees

**EYE CARE EXPENSE BENEFITS**

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

Deductible Amount:

Exams - Each Benefit Period	\$10
Frames and Lenses - Each Benefit Period	\$15

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



## DEFINITIONS

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

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

**INSURED** refers to a person:

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

**DOMESTIC PARTNER** means the partner of a Member who:

- a. Is an adult as is the Member;
- b. Has been legally domiciled with the Member for at least 6 months;
- c. Is not legally married to another individual; and
- d. Is jointly responsible with the Member for each other's common welfare as evidenced by joint living arrangements, joint financial arrangement or joint ownership of real or personal property.

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

**DEPENDENT** refers to:

- a. an Insured's spouse or Domestic Partner.
- b. each unmarried child less than 25 years of age, including a stepchild, an adopted child of, or a child placed for adoption with the Insured, the Insured's spouse or the Insured's Domestic Partner;
- c. each unmarried child age 25 or older, including a stepchild, an adopted child of, or a child placed for adoption with the Insured, the Insured's spouse or the Insured's Domestic Partner who:
  - i. is Totally Disabled due to mental or physical reasons; and
  - ii. becomes Totally Disabled while insured as a dependent under b above; and
  - iii. is entirely dependent on the Insured for support and maintenance.

Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

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

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

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

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

**PLAN EFFECTIVE DATE** refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

**PLAN CHANGE EFFECTIVE DATE** refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder's records or on the cover of the certificate.

## **CONDITIONS FOR INSURANCE COVERAGE**

### *ELIGIBILITY*

**ELIGIBLE CLASS FOR MEMBERS.** The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

If employment is the basis for membership, a member of the Eligible Class for Insurance is any full time active employee working at least 40 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 a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, 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 2<sup>nd</sup> birthday. The child may be added at birth or within 31 days of the 2<sup>nd</sup> 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 full time active employee working at least 40 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 husband or wife 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 new employees of Unum who become Members after January 1, 2002, qualification will occur on the first day of the full pay period following date of hire. Effective dates for new hires will always be the 1st or the 16th of the month, depending on the date of hire.

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.

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 the policy of group insurance providing like benefits at any time during the 90 days before the Effective Date of this policy; and
- b. the person is considered a Member under this policy and was a Member under a prior policy.

### ***TERMINATION DATES***

**INSUREDS.** The insurance for any Insured, will automatically terminate on the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

**DEPENDENTS.** The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

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

**CONTINUATION OF COVERAGE.** If coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. Contact your plan administrator for details.

Injury or Sickness  
For Certain Dependents

Coverage will continue for a covered Dependent student (see Definition of Dependent on 9060) if the student is unable to remain enrolled in school on a full-time basis due to a mental or physical illness or an accidental injury, provided, however, that nothing in this provision shall require coverage of a dependent student beyond the age at which coverage would otherwise terminate. We may require written documentation from a health care provider and the student's school verifying that the student is no longer enrolled full-time as a result of such mental or physical illness or accidental injury.



## EYE CARE EXPENSE BENEFITS

If an Insured under this section incurs Covered Expenses, we will pay benefits as stated below. The Insured may use a Participating Provider or a Non-Participating Provider. The Insured has the freedom to choose any provider at all times.

**AMOUNT PAYABLE.** The Amount Payable for Covered Expenses performed by a Participating Provider is the amount agreed to by the Participating Provider and the Company for the services.

The Amount Payable for Covered Expenses performed by a Non-Participating Provider is the lesser of:

- a. the Non-Participating Provider's charge, or
- b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Eye Care Services.

**DEDUCTIBLE AMOUNT.** The Deductible Amount shown in the Schedule of Benefits is an amount of Covered Expenses for which no benefits are payable. It applies separately to the Covered Expenses incurred by each Insured. Benefits will be 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 our insureds at a discounted fee. A Non-Participating Provider is any other provider.

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

**EYE CARE SUPPLIES.** Eye care supplies includes all services listed on the Schedule of Eye Care Services except for any services provided for Eye Care Examinations.

**REQUEST FOR SERVICES.** An Insured may request services from a Participating Provider by scheduling an appointment and notifying the provider's office that the Insured has coverage for services provided by that office as a Participating Provider. Should the Insured receive services from a Participating Provider without such notification, then for the purposes of those services provided to the Insured, the provider will be considered a Non-Participating Provider, and the benefits available will be limited to those for a Non-Participating Provider.

**ASSIGNMENT OF BENEFITS.** When services and supplies are performed or furnished by a Participating Provider, benefits will be paid to the Participating Provider. When services are performed by a Non-Participating Provider, benefits will be paid to the Insured.

**EXTENSION OF BENEFITS.** This section provides an extension of benefits for eye care supplies if the policy terminates. To be eligible for this extension, the supply must have been prescribed prior to the termination of the policy and must be received within six months after the policy terminates.

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

**LIMITATIONS.** Covered Expenses will not include and no benefits will be payable for expenses incurred for:

1. eye exam more than once in any 12 month period.
2. more than one pair of lenses in any 24 month period.
3. more than one set of frames in any 24 month period.
4. contact lenses more than once in any 24 month period. When chosen, contact lenses shall be in lieu of any other lenses benefit during the 24 month period and in lieu of any other frame benefit during the 24 month period. When lenses are chosen, expenses for contact lenses are not Covered Expenses during the 24 month period.
5. medically necessary contact lenses, except for the first \$210 of expense, when such lenses are purchased for any reason other than for the following conditions:
  - a. following cataract surgery.
  - b. to correct extreme visual problems that cannot be corrected with spectacle lenses.
  - c. certain conditions of anisometropia.
  - d. keratoconus.

Such payment is limited to once in any 24 month period and is in lieu of lens and frame benefits under this policy.

6. Orthokeratology ( a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).
7. refitting of contact lenses after the initial (90-day) fitting period.
8. plano contact lenses to change eye color cosmetically.
9. artistically-painted contact lenses.
10. contact lens insurance policies or service contracts.
11. additional office visits associated with contact lens pathology.
12. contact lens modification, polishing or cleaning.
13. orthoptics or vision training and any associated testing.
14. plano lenses.
15. two pairs of glasses in lieu of bifocals.
16. lenses and frames that are lost or broken, except at the normal intervals when services are otherwise available.
17. medical or surgical treatment of the eyes.
18. services for which a claim is filed more than 180 days after completion of the service, unless it can be shown that it was not reasonably possible to submit the proof of loss within this time period.
19. the following materials, over and above the Covered Expense for the basic material. These materials

are cosmetic and the Insured will be responsible for the cost of these materials.

- a. blended lenses
  - b. oversized lenses
  - c. photo chromatic lenses; tinted lenses except pink #1 and #2
20. progressive multi-focal lenses.
  21. the coating of the lens or lenses.
  22. the laminating of the lens or lenses.
  23. frames exceeding the maximum allowance selected by the Policyholder.
  24. Corrective vision treatment of an Experimental Nature.
  25. Corneal Refractive Therapy (CRT).
  26. costs for services and/or materials exceeding plan benefit allowances.
  27. services or materials of a cosmetic nature.
  28. any procedure not listed on the Schedule of Eye Care Services.

## SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for benefits payable under this section. No benefits are payable for a service not listed.

<i><b>SERVICE</b></i>	<i><b>MAXIMUM COVERED EXPENSE</b></i>	
	<i>Participating Provider</i>	<i>Non-Participating Provider</i>
Eye Examination	Covered in Full	Up to \$ 40.00
<i>(All lenses are per pair)</i>		
Single Vision Lenses	Covered In Full	Up to \$ 40.00
Lined Bifocal Lenses	Covered In Full	Up to \$ 60.00
Lined Trifocal Lenses	Covered In Full	Up to \$ 80.00
Lenticular Lenses	Covered In Full	Up to \$125.00
Frame	Up to \$120.00	Up to \$ 45.00
Contact Lenses (Medically Necessary)	Covered In Full	Up to \$210.00
Contact Lenses (Elective)	Up to \$105.00	Up to \$105.00

The contact lens allowance applies to the contact lens exam (fitting and evaluation) and lenses.

## GENERAL PROVISIONS

**NOTICE OF CLAIM.** Written notice of a claim must be given to us within 30 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 30 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.

**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.** All benefits will be paid to the Insured unless you authorize us in writing to make payment to the Provider providing the services or supplies.

**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 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.

**WORKER'S COMPENSATION.** The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.



## ERISA INFORMATION AND NOTICE OF YOUR RIGHTS

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

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

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

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

### C. Termination Of The Group Policy

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

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

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

### D. Claims For Benefits

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

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

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

#### i. Definitions For This Section

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

A Qualifying Event occurs when:

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

4. The Member becomes divorced or legally separated from a Spouse (hereinafter referred to as Qualifying Event 4);
5. The Member becomes entitled to receive Medicare benefits under Title XVII of the Social Security Act (hereinafter referred to as Qualifying Event 5);
6. The Child of a Member ceases to be a Dependent (hereinafter referred to as Qualifying Event 6);
7. The Employer files a petition for reorganization under Title 11 of the U.S. Bankruptcy Code, provided the Member is retired from the Employer and is insured on the date the petition is filed (hereinafter referred to as Qualifying Event 7).

**ii. Electing COBRA Continuation**

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

**iii. Notice Requirements**

1. When the Member becomes insured, the Plan Administrator must inform the Member and Spouse in writing of the right to COBRA continuation.
2. The Qualified Beneficiary must notify the Plan Administrator in writing of Qualifying Event 4 or 6 above within 60 days of the later of:
  - a. The date of the Qualifying Event; or
  - b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.
3. A Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security

Administration pursuant to Title II or XVI of the Social Security Act, must notify the Plan Administrator of the disability in writing within 60 days of the later of:

- a. The date of the disability determination;
  - b. The date of the Qualifying Event; or
  - c. The date on the Qualified Beneficiary loses coverage due to the Qualifying Event.
4. Each Qualified Beneficiary who has become entitled to COBRA continuation with a maximum duration of 18 or 29 months must notify the Plan Administrator of the occurrence of a second Qualifying Event within 60 days of the later of:
- a. The date of the Qualifying Event; or
  - b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.
5. The Employer must give the Plan Administrator written notice within 30 days of the occurrence of Qualifying Event 1, 2, 3, 5, or 7.
6. Within 14 days of receipt of the Employer's notice, the Plan Administrator must notify each Qualified Beneficiary in writing of the right to elect COBRA continuation.

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

**iv. COBRA Continuation Period**

1. 18-month COBRA Continuation

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

2. 29-month COBRA Continuation

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

3. 36-Month COBRA Continuation

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

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

4. **COBRA Continuation For Certain Bankruptcy Proceedings**

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

v. **Premium Requirements**

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

18 month continuation - 102%

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

36 month continuation - 102%

vi. **When COBRA Continuation Ends**

COBRA continuation ends on the earliest of:

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

**F. Your Rights under ERISA**

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

**Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts and

collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

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

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

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

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

### **Enforce Your Rights**

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

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

### **Assistance with Your Rights**

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



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

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

**CLAIMS FOR BENEFITS**

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

Vision Service Plan  
Attn: Out-of-Network Provider Claims  
P.O. Box 997105  
Sacramento, CA 95899-7105

**NOTICE OF DECISION OF CLAIM**

We will evaluate your claim promptly after we receive it.

**Utilization Review Program.** Generally, utilization review means a set of criteria designed to monitor the use of, or evaluate the medical necessity, appropriateness, or efficiency of health care services. We have established a utilization review program to ensure that any guidelines and criteria used to evaluate the medical necessity of a health care service are clearly documented and include procedures for applying such criteria based on the needs of the individual patients. The program was developed in conjunction with licensed dentists and is reviewed at least annually to ensure that criteria are applied consistently and are current with dental technology, evidence-based research and any dental trends.

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

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

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

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

- g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

## **APPEAL PROCEDURE**

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

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

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

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

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

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

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

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

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

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

Any request for appeal should be directed to:

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



## **NOTICE OF PROTECTED HEALTH INFORMATION PRIVACY PRACTICES**

We are required by law to maintain the privacy of our insured members' and their dependents' personal health information and to provide notice of our legal duties and privacy practices with respect to your personal health 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 the new Notice effective for all personal health information maintained by us. Copies of revised Notices will be provided to you directly or to your group's Plan Sponsor (usually your employer) by regular mail or e-mail with instructions to deliver a paper copy to each certificate holder.

**THIS NOTICE DESCRIBES OUR PRACTICES REGARDING YOUR PROTECTED HEALTH INFORMATION MAINTAINED BY THE GROUP EYE CARE LINE OF BUSINESS WITHIN THE UNIFI COMPANIES.**

**THIS NOTICE MORE PARTICULARLY DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

### **Contact Information**

All of the entities affiliated under the common control of the UNIFI Mutual Holding Company that pay for the cost of healthcare, including Ameritas Life Insurance Corp. and First Ameritas Life Insurance Corp. of New York, are required by federal law to maintain the privacy of your protected health information and to provide notice of the legal duties and privacy practices with respect to your protected health information. This Notice fulfills the "Notice" requirements of the Final Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you have any questions about any part of this Notice of Protected Health Information Privacy Practices or desire to have further information concerning the information practices at the UNIFI Companies, please direct your inquiries to: The Privacy Office, Attn. HIPAA Privacy, P.O. Box 81889, Lincoln, NE 68501-1889, or e-mail us at [privacy@ameritas.com](mailto:privacy@ameritas.com).

**THIS NOTICE IS PUBLISHED AND BECOMES EFFECTIVE: APRIL 14, 2003**

### **OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION**

We understand that information about you and your family is personal and we are committed to protecting your privacy and the security of your protected health information. This Notice explains the ways in which we use and disclose protected health information about you and your covered dependents and details certain obligations we have in connection with such use and disclosure. It also describes your rights with regard to your protected health information. **We are required by both law and internal policy to: make sure that protected health information that identifies you and/or your covered dependents is kept private; give you notice of our legal duties and privacy practices and your rights with respect to your protected health information; and follow the practices outlined in this Notice.**

### **WHO WILL FOLLOW THE PRIVACY PRACTICES DESCRIBED IN THIS NOTICE**

The Protected Health Information Privacy Practices described in this Notice have been adopted and implemented by all of the divisions and associates who work directly or indirectly with your protected health information within the following UNIFI Companies: Ameritas Life Insurance Corp.; and First Ameritas Life Insurance Corp. of New York. All of the associates who need access to your protected health information in order to service your products and administer your claims have received proper training about how to protect your privacy, secure your protected health information and adhere to our Privacy of Protected Health Information Policies, Practices and Procedures.

In order to keep costs of your coverage down and provide you with the best customer service, we may contract with outside carriers and/or vendors, known as "business associates," to assist us with the administration of your policy. For example, we may contract with third party administrators who process claims and collect premium payments; or paper-shredding companies who destroy records when they are no longer needed. Because these business associates need access to your protected health information in order to fulfill their obligations to us, we **require** them to agree in writing to keep **your protected health information confidential** in the same manner that we do as described in this Notice.

## **TYPES OF PROTECTED HEALTH INFORMATION WE MAY HAVE AND HOW WE OBTAIN IT**

**Protected Health Information is: Any information that identifies you that we obtain from you or others that relates to your past, present or future healthcare including the payment for such healthcare.**

In the regular course of business we receive protected health information about you in order to provide you with our products and services. Some of this protected health information comes directly from you. For example, when you purchase one of our health insurance products for you and your family, you provide us with information about you and your covered dependents such as name, address, phone number, social security number, etc. Some of the protected health information we obtain about you comes from your provider. For example, as you and your covered dependents utilize your coverage, your healthcare provider sends us information about services and treatments performed so that we can process and pay your claims. All of this information we receive about you and your covered dependents is necessary in order for us to provide you and your covered dependents with quality health insurance products and to comply with legal requirements.

## **HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION**

The following categories describe different ways we may use and disclose your protected health information without your authorization. For each category of uses and disclosures, we will explain what we mean and give an example. Not every use or disclosure in a category will be listed. All of the ways we are permitted to use and disclose information will fall within one of the identified categories.

**For Payment: We may use and disclose protected health information about you and your covered dependents in order to verify your coverage to your provider, process payment for claims filed under your policy or coordinate benefits with another carrier.** For example, we may need to disclose your protected health information to a provider whom you have seen or are planning to see in order to pre-approve that a particular treatment you are seeking is covered under your plan. It is also necessary for us to use the information received from your medical provider concerning the services rendered to you so the health plan can pay the provider or reimburse you for the cost of the treatment under the terms of your plan. Finally, when you have more than one insurance policy that covers some of the same procedures as your plan with us, it may be necessary for us to exchange payment information with the carrier of your other insurance plan in order to coordinate the payment of your claim with that other carrier.

**For Health Care Operations: We may use and disclose protected health information about you and your covered dependents as necessary to operate your health insurance plan and promote quality service.** For example, we may use or disclose your personal health information for quality assessment and quality improvement, credentialing health care providers, conducting or arranging for medical review or compliance. We may also disclose your personal health information to another health plan, health care facility or health care provider for activities such as quality assurance or case management.

**Business Associates: We may disclose protected health information to other persons or organizations, known as business associates, who provide services on our behalf under contract.** However, in order to assure the protection of your private information, we require our business associates to adhere to our Privacy Policies concerning the use and disclosure of your protected health information and appropriately safeguard the information we disclose to them. We prohibit our business associates from using and disclosing any of your protected health information in any manner except for the purpose intended by the contract. Business associates are expressly prohibited from using your protected health information to create any marketing target lists.

**Plan Sponsors:** We may disclose your protected health information to your plan sponsor (usually your employer). It is our policy not to disclose your protected health information to your Plan's sponsor. There may be exceptional occasions that your Plan Sponsor requests protected health information. We will only disclose your protected health information to your Plan Sponsor if we have your authorization to do so, or if the plan sponsor certifies that the information will be maintained in a confidential manner and will not be utilized or disclosed for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.

**Public policy uses and disclosures of your protected health information**

**We may use and disclose your protected health information for public policy purposes. For example:**

**As Required By Law:** We will disclose protected health information about you or your covered dependent when required to do so by federal, state or local law. For example, we may be required by law to disclose certain protected health information about you pursuant to a court order or subpoena served upon us.

**About Victims of Abuse, Neglect or Domestic Violence:** For example, if we believe that you have been a victim of abuse, neglect or domestic violence, we may disclose your protected health information to the governmental entity or agency authorized to receive such information. In this case the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Workers' Compensation:** We may release your protected health information for workers' compensation or similar programs that provide benefits to you for work-related injuries or illness but only in a manner consistent with applicable laws.

**Public Health:** We may have an occasion to disclose protected health information about you or your covered dependent for public health activities to a public health authority that is permitted by law to collect or receive the information. A public health activity would be, for example, an activity conducted by a public health authority in the furtherance of preventing or controlling disease, injury or disability; reporting births, deaths or reactions to medications; or notifying people of recalls of products they may be using.

## **AUTHORIZED USES AND DISCLOSURES**

**From time to time you may request that we disclose your protected health information to other individuals or entities.** For example, you may request that we disclose your claims history to an attorney that you have hired to assist you in a civil matter. **Likewise, we may ask your permission to use or disclose your protected health information.** Any disclosures, such as these that do not fit into one of the categories in the previous section require us to obtain your written authorization prior to making such disclosure. In the event that you do provide us with written authorization to use or disclose your information, you may revoke such authorization at any time by writing to the Privacy Officer at the address indicated in the "Contact" section of this Notice below.

## **YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION**

You have the following rights regarding protected health information that we maintain about you. All requests must be made in writing.

**Your Right to a Paper Copy of This Notice:** You have the right to a paper copy of this Notice. You have a right to receive this Notice because you are insured by a health plan offered by Ameritas Life Insurance Corp. or First Ameritas Life Insurance Corp. of New York. You may ask us to give you a copy of this Notice at any time and we will comply. Even if you have agreed to receive this Notice electronically, you are entitled to a paper copy of this Notice if you so request.

**Your Right to an Accounting of Disclosures:** You have the right to request a listing of any disclosures of your protected health information that we have made that are required by law. This listing would exclude disclosures we made to you, or pursuant to your authorization or request, or for payment of your claims as described above, or for health care operations as described above. Your request must state a time period that may not be longer than six years and may not include dates prior to April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically, fax etc.). The first accounting of disclosures you request within a 12-month period will be free. We may charge for the costs of providing additional lists during that same 12-month period. In the event that you may incur a charge, we will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

**Your Right to Request an Amendment:** You have the right to request an amendment to the protected health information that we maintain about you if you believe that our information is incorrect or incomplete. You maintain the right to request an amendment for as long as the information is kept by or for the UNIFI Companies. You must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend information that: 1) was not created by us; 2) is not part of the medical information kept by or for a UNIFI Company; 3) is not part of the information which you would be permitted to inspect and copy under the law; or 4) is accurate and complete.

**Your Right to Request a Restriction:** You have the right to request a restriction or limitation on the protected health information we use or disclose about you for, payment or health plan operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for care, like a family member or friend. We are not required to agree to your request. If we do agree to a requested restriction, we will comply with your request unless the information is needed to facilitate emergency treatment. To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

**Your Right to Request Confidential Communications:** You have the right to request that we communicate with you about payment for your medical matters in an alternative means (such as by fax) or at an alternative location (such as to your office). To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Your Rights to Inspect and Copy:** You have the right to inspect and copy protected health information that we maintain about you that may be used to make decisions about payment for your care. To inspect this protected health information you may contact the Privacy Officer. To obtain copies of such protected health information, you must submit your request in writing as indicated below. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your protected health information, in most situations you may request that the denial be reviewed by a licensed health care professional who did not take part in the decision to deny access. We will comply with the outcome of the review.

**Your Right to Make Complaints:** If you believe that your privacy rights have been violated you may make a complaint to the UNIFI Companies Privacy Office or to the Secretary of Health and Human Resources as follows:

UNIFI Privacy Office  
Attn. HIPAA Privacy  
P.O. Box 81889  
Lincoln, NE 68510

Secretary, Health and Human Services, Office of Civil Rights  
United States Department of Health and Human Services  
200 Independence Avenue, SW Room 509F  
HHH Building  
Washington D.C. 20201

Any complaint you file will not cause you to suffer retaliation from our company. We will promptly investigate your complaint as soon as we receive it. When we have completed our investigation, we will notify you of our findings. If the investigation reveals that your privacy rights have indeed been violated, we will immediately take the appropriate measures to correct the violation pursuant to our Privacy Practices and Procedures.

### **Individual Rights Contact**

To assert any of your rights with respect to this Notice, or to obtain an authorization form, please call 1-800-487-5553 and request the appropriate form.

### **Effective Date**

This Notice will become effective as of April 14, 2003.

