



Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA

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

The Policyholder **CENTENNIAL PLASTICS, INC.**

Policy Number **10-36095** **Insured Person**

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

Plan Change Effective Date **January 1, 2017**

Class Number 2

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

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

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

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

President

Notice of Grievance Procedures

In accordance with Chapter 44, Article 73 - Health Carrier Grievance Procedure Act of the Nebraska Insurance Code

Quality Control
P.O. Box 82657
Lincoln, NE 68501-2657
877-897-4328

Please read this notice carefully for important information about how to file grievances with your insurer. You always have the right to contact the Nebraska Department of Insurance if you have a question or concern regarding your coverage under this policy. The Nebraska Department of Insurance may be contacted:

In Writing:	Nebraska Department of Insurance Terminal Building, Suite 400 941 "O" Street Lincoln, NE 68508
By Phone:	402-471-2201 or 877-564-7323 - Consumer Affairs Hotline

We are available to help you in filing a grievance, reviewing benefit decisions and reviewing claim payments. We will provide copies of any records or information relevant to your question including the clinical basis for any adverse determinations, such as criteria, standards, or clinical indicators. Such information will be provided to you upon request and at no charge.

I. Definitions

"Adverse Determination" means a determination by us that a benefit has been reviewed and, based upon the information provided, does not meet the plan protocols for medical necessity or appropriateness and the benefit is therefore denied or reduced.

"Covered Person" means the policyholder, provider, enrollee, claimant or a designated representative.

"Grievance" means a written complaint on behalf of an insured person submitted by a Covered Person as described above regarding:

- (a) the availability, delivery, or quality of health care services, including a complaint regarding an adverse determination;
- (b) claims payment, handling, or reimbursement for health care services;
- (c) matters pertaining to the contractual relationship between a covered person and the insurer.

II. Our Internal Review

A written grievance concerning any matter can be sent to the Quality Control address listed above. You or your representative may submit written comments, documents, or other information in support of an appeal. We will provide a written decision within 15 working days of receipt of the grievance and all information necessary for our review. The person or persons reviewing the grievance will not be the same person or persons who made the initial benefit determination or who handled the matter that is the subject of the grievance. Additionally, we will provide the name, phone number and address of the person who will be coordinating the appeal.

If a decision cannot be made within 15 working days due to circumstances beyond our control, we may

take up to an additional 15 working days. We will provide written notice to the Covered Person of the extension and the reasons for the delay on or before the fifteenth working day after receiving a grievance.

The time requirement for responding to a request for a standard review of an adverse determination is 15 working days.

A. Our Written Decision

We will include the following information in our written decision:

1. the names, titles and qualifying credentials of the persons participating in the grievance review;
2. a statement of the reviewer's understanding of the grievance;
3. the decision stated in clear terms and the contract basis or medical rationale supporting the decision, a reference to the evidence or documentation used as a basis for the decision;
4. notice of the Covered Person's right to contact the Nebraska Department of Insurance.

B. Urgent Matters

Our policies have no requirements for pre-authorization of benefits. However, we offer a Pre-Treatment Review of benefits if a Covered Person would like to get an idea of the benefits to be paid prior to seeking treatment. If a Covered Person has a grievance about a pre-treatment estimate decision, and the matter is considered urgent by the treating provider, an Expedited Review will be provided. We will respond within 72 hours. In the rare event a grievance review of a pre-treatment benefit estimate is requested for an emergency situation, we will respond to a telephone request within 30 minutes.

Notice of Availability for Second Level Grievance Review

In accordance with Chapter 44, Article 73 - Health Carrier Grievance Procedure Act of the Nebraska Insurance Code

Correspondence concerning this claim determination should be mailed to:

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

Please read this notice carefully. This notice contains important information about how to file a second level grievance with your insurer following the first level review just completed.

You always have the right to contact the Nebraska Department of Insurance if you have a question or concern regarding your coverage under this contract. The Nebraska Department of Insurance may be contacted:

In Writing:	Nebraska Department of Insurance Terminal Building, Suite 400 941 "O" Street Lincoln, NE 68508
By Phone:	402-471-2201 877-564-7323 – Consumer Affairs Hotline

Definitions

“Adverse determination” means a determination by a health carrier that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the health carrier’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested health care service is therefore denied, reduced or terminated.

“Covered Person” means the policyholder, enrollee, claimant or their representatives, provider, agent or other entity which expresses a grievance or complaint involving the activities of the company or any persons involved in the solicitation, sale, service, execution of any transaction, or disposition of any funds of the policyholder.

“Grievance” means a written complaint on behalf of an insured person submitted by an insured person or a person, including, but not limited to, a provider, authorized in writing to act on behalf of the insured person regarding any aspect of the managed care plan involving:

- (a) the availability, delivery, or quality of health care services, including a complaint regarding an adverse determination;
- (b) claims payment, handling, or reimbursement for health care services;
- (c) matters pertaining to the contractual relationship between a covered person and the insurer.

Availability of Second Level Grievance Review

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

A second level grievance review panel shall be established to give those covered persons who are dissatisfied with the first level grievance review decision the option to request a second level review. A majority of the panel shall be comprised of persons who were not previously involved in the grievance. A health carrier shall provide that

the majority of the persons reviewing a grievance involving an adverse determination are health care professionals who have appropriate expertise.

Upon the request of a covered person, an insurer 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 schedule and hold a review meeting within forty-five working days after receiving a request from a covered person for a second level review. In those situations where the covered person cannot appear in person, the insurer shall offer the covered person the opportunity to communicate with the review panel by conference call or other available technology.

If you and/or your representative plan to participate in person or by phone, please contact us:

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

Review Panel meetings will be held at 475 Fallbrook Blvd., Lincoln, NE 68521.

The review panel shall issue a written decision to the covered person within 5 business days of completing the review meeting.

Written Decision

When a decision is issued from any level of review, the following information will be included in the written decision:

- Names, titles and qualifying credentials of person(s) acting as the reviewer or reviewers participating in the grievance review process;
- A statement of the reviewer's understanding of the covered person's grievance;
- The reviewers' decision in clear terms explaining the contract basis and/or coding in sufficient detail for the covered person to respond further to Ameritas' position, a reference to the evidence or documentation used as the basis for the decision;
- In cases involving an adverse determination, the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; and,
- Notice of the covered person's right to contact the Nebraska Department of Insurance.

Nebraska - IMPORTANT INFORMATION

The following provides summary information regarding your rights as well as summary descriptions of the practices of Ameritas Life Insurance Corp. with regard to your eyecare coverage provided to you under a Ameritas Life Insurance Corp. certificate of coverage.

Your Rights

- You have the right to receive considerate and respectful care, with recognition of your personal dignity regardless of race, color, religion, sex, age, physical or mental handicap or national origin.
- You have the right to participate with your network provider in decision-making regarding your eye care.
- You have the right to know your costs in advance for routine and emergency care.
- You have the right to tell us when something goes wrong.
- Start with your provider. He/she is your primary contact.
- If you have a problem that cannot be resolved with your provider, call our eyecare claims department for assistance at 800-877-7195.
- You have the right to know about your PPO plan, covered services, network providers and your rights and responsibilities. This includes:

A right to schedule an appointment with your network provider within a reasonable time.

A right to see a provider within 24 hours for emergency care.

A right to information from your network provider regarding appropriate or necessary treatment options without regard to cost or benefit coverage.

A right to obtain information on types of payment arrangements used to compensate providers.

A right to request information regarding the PPO network's quality goals.

A right to request information regarding the PPO network's annual performance.

A right to privacy and confidential treatment of information and medical records, as provided by law.

Your Responsibilities

- Read the details of your Certificate.
- Provide information to your provider that he/she needs to know to provide appropriate care.
- Feel free to call us to address any concerns you may have.
- Let your provider know whether you understand the treatment plan he/she recommends and follow the treatment plan and instructions for care.

- Pay any coinsurance due as soon as possible for the care received so your provider can continue to serve you.
- Be considerate of the rights of other patients and the provider office personnel.
- Keep appointments or cancel in time for another patient to be seen in your place.

OUR PRACTICES

- ü **Ensuring Quality.** Depending upon the benefit plan the policyholder has selected, you may have the option to seek services from a participating provider. Please refer to your certificate of coverage for benefit plan information.

Whether your plan provides for a participating provider option (“PPO”) or not, you have the freedom of choice to seek services from any provider and benefits will be paid for all services which are considered covered expenses as defined within your certificate.

For any PPO network benefit provided under your coverage, please be assured that the network has established a Quality Management Program to state specific policies and procedures to ensure that minimum standards are met and that proper evaluations are conducted in order to provide insureds with quality care.

The Quality Management Program addresses the following:

- Provider and Member Services
- Provider Credentialing
- Utilization Review Program
- Member and Provider Satisfaction Surveys
- Office Evaluation
 - Sterilization and Infection Control
 - Medical Emergency Preparedness
 - Environmental and Radiology Safety
 - Accessibility

The Quality Management Program has been developed in conjunction with individual practitioners who participate actively within the program to ensure the program's overall effectiveness. A copy of the company's certified quality management program materials will be made available upon request.

Eye care coverage is not subject to medical necessity or Utilization Review.

For any questions you have regarding how a claim was paid, please feel free to contact us at the following:

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

Non-Insurance Products/Services

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

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

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

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**SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE**

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

Benefit Class

Class Description

Class 2

Employee Electing The High Vision Plan

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, 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 child less than 19 years of age, for whom the Insured, the Insured's spouse is legally responsible, including natural born children, adopted children from the date of placement for adoption, and children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.
- c. each unmarried child age 19 but less than 24 who is a full-time student at an accredited school or college and is primarily dependent on the Insured, the Insured's spouse for support and maintenance.
- d. each unmarried child age 19 or older who is Totally Disabled and becomes Totally Disabled as defined below while insured as a dependent under b. or c. above. Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

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 disability or physical handicap; and
2. Chiefly dependent upon the Insured for support and maintenance.

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

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider is a Provider who has a contract with Us to provide services to Insureds at a discount. A Participating Provider is also referred to as

a “Network Provider.” The terms and conditions of the agreement with our network providers are available upon request. Members are required to pay the difference between the plan payment and the Participating Provider’s contracted fees for covered services. A Non-Participating Provider is any other provider and may also be referred to as an “Out-of-Network Provider.” Members are required to pay the difference between the plan payment and the provider’s actual fee for covered services. Therefore, the out-of-pocket expenses may be lower if services are provided by a Participating Provider.

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

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

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

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

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

If employment is the basis for membership, a member of the Eligible Class for Insurance is any employee electing the high vision plan working at least 30 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

If both spouses are Members and if either of them insures their dependent children, then the spouse, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the 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. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

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

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any employee electing the high vision plan working at least 30 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Any spouse who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

SECTION 125. This policy is provided as part of the Employer's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this policy.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on January 1.

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

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, 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 eligibility period of 60 calendar day(s) of continuous active employment.

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 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. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

TERMINATION DATES

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

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

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

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

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

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

EYE CARE EXPENSE BENEFITS

If an Insured has Covered Expenses under this section, we pay benefits as described. The Insured can choose any provider at any time.

COVERED EXPENSES

Covered Expenses include the lesser of:

- a. the charge for the covered procedure furnished; or
- b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Eye Care Services.

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

DEDUCTIBLE AMOUNT

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

PARTICIPATING PROVIDERS

A Participating Provider is a provider who has agreed to participate in the VSP network and agrees to provide services and supplies to the Insured at a discounted fee. For questions related to providers or benefit payments, VSP's Customer Care Division is available at (800) 877-7195.

NON-PARTICIPATING PROVIDER

A Non-Participating Provider is any other 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, the Insured must advise the Participating Provider's office that he or she has coverage under this network plan. If the Insured receives services from a Participating Provider without this notification, the benefits may be limited to those for a Non-Participating Provider.

ASSIGNMENT OF BENEFITS

We pay benefits to the Participating Provider for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, we pay benefits to the Insured unless otherwise required by state regulation.

EXTENSION OF BENEFITS

If your policy terminates, we will pay claims for eye care services and supplies that you received or ordered prior to your policy's termination. You will have six months following the date of service to submit your claim.

EXPENSES INCURRED

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

PROOF OF LOSS

Written proof of loss must be given to us within 180 days after completion of the service for a claim to be covered. An exception may be made if the Insured shows it was not possible to submit the proof of loss within this period.

LIMITATIONS

This plan has the following limitation:

Some brands of spectacle frames may be unavailable at all locations for purchase as Covered Expenses, or may be subject to additional out-of-pocket expenses. Insureds may obtain details regarding frame brand availability from their treating provider or by calling VSP's Customer Care Division at (800) 877-7195.

EXCLUSIONS

This plan does not cover:

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits,
- Plano lenses (lenses with refractive correction of less than plus or minus .50 diopter) except as specifically allowed in the frames benefit section below,
- Services or materials that are cosmetic, including Plano contact lenses to change eye color and artistically painted Contact Lenses,
- Two pairs of glasses in lieu of Bifocals,
- Replacement of Spectacle Lenses, Frames, and/or contact lenses furnished under this plan that are lost or damaged, except at the normal intervals when services are otherwise available,
- Orthoptics or vision training and any associated supplemental testing,
- Medical or surgical treatment of the eyes,
- Contact lens modification, polishing or cleaning,
- The refitting of Contact Lenses after the initial 90-day fitting period,
- Contact Lens insurance policies or service contracts,
- Additional office visits associated with contact lens pathology,
- Local, state and/or federal taxes, except where law requires us to pay.

SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for which benefits payable under this section, You must first pay a Deductible for certain services as indicated on the Schedule of Benefits in the - Eye Care Expense Benefits section.

SERVICE	WHEN COVERED	PLAN MAXIMUM COVERED EXPENSE	
		<i>Participating Provider</i>	<i>Non-Participating Provider</i>
Vision Examination(s)			
Eye Exam	Once every 12 months	Covered in Full	Up to \$ 45.00
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 24 months	Up to \$130.00	Up to \$ 70.00
Contact Lenses (in lieu of Complete Pair of Spectacles)		Includes allowance for Contact Lens Fitting & Evaluation	
Elective	Once every 12 months	Up to \$130.00	Up to \$105.00
Medically Necessary**	Once every 12 months	Covered in Full	Up to \$210.00

Low Vision (for severe visual problems not correctable with regular lenses, as determined by the treating provider)
 Insureds can receive professional services for treatment of severe visual problems that are not correctable with regular lenses. The treating provider determines if an Insured's condition meets the criteria for coverage of this benefit. Insureds may contact VSP's Customer Care Division for details at (800-877-7195) for additional information.

**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. For Eye Care benefits that use either the EyeMed or VSP network, please refer to the limitations section on the Eye Care Expense Benefits page.

TIME OF PAYMENT. We will pay all benefits immediately when we receive due proof. Any balance remaining unpaid at the end of any period for which we are liable will be paid at that time.

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

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

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

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

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

INCONTESTABILITY. No statements, except fraudulent statements, made by the applicant in the application for such policy shall be used to void the policy or deny a claim as defined in the policy, commencing after the expiration of the 1 year period.

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

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

ERISA INFORMATION AND NOTICE OF YOUR RIGHTS

A. General Plan Information

Name of Plan: Centennial Plastics, Inc. Vision Plan

Name, Address of Plan Sponsor: CENTENNIAL PLASTICS, INC.
1830 CENTENNIAL AVE
HASTINGS, NE 68901

Plan Sponsor Tax ID Number: 47-0841062

Plan Number: 505

Type of Plan: Vision

Name, Address, Phone
Number of Plan Administrator: CENTENNIAL PLASTICS, INC.
1830 CENTENNIAL AVE
HASTINGS, NE 68901
402-462-2227

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

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

Sources of Contributions: Employer/Member

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

Plan Fiscal Year End: 1/1 to 12/31

Type of Administration: Insurer

Contract & Claim Administration Ameritas Life Insurance Corp.

B. Notice of Legal Process

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

C. Eligibility and Benefits Provided Under the Group Policy

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

D. Qualified Medical Child Support Order ("QMCSO")

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

E. Termination Of The Group Policy

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

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

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

F. Claims For Benefits

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

G. Continuation of Coverage Provisions (COBRA)

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

i. Definitions For This Section

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

A Qualifying Event occurs when:

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

referred to as Qualifying Event 4);

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

ii. Electing COBRA Continuation

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

iii. Notice Requirements

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

the Plan Administrator of the disability in writing within 60 days of the later of:

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

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

iv. COBRA Continuation Period

1. 18-month COBRA Continuation

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

2. 29-month COBRA Continuation

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

3. 36-Month COBRA Continuation

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

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

36 months.

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

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

v. **Premium Requirements**

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

18 month continuation - 102%

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

36 month continuation - 102%

vi. **When COBRA Continuation Ends**

COBRA continuation ends on the earliest of:

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

H. Your Rights under ERISA

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by

the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Rights

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

FAMILY AND MEDICAL LEAVE

**as Federally Mandated
Family and Medical Leave**

If You become eligible for a family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA) (including any amendments to such Act) Your coverage may be continued on the same basis as if You were an Actively at Work employee for up to 12 weeks during the 12 month period, as defined by your Plan Administrator, for any of the following reasons:

- (a) to care for Your child after the birth or placement of a child with You for adoption or foster care; so long as such leave is completed within 12 months after the birth or placement of the child;
- (b) to care for Your spouse, child, foster child, adopted child, stepchild, or parent who has a serious health condition; or
- (c) for Your own serious health condition.

In the event You or Your spouse are both covered as employees of the Plan Administrator, the continued coverage may not exceed a combined total of 12 weeks. In addition, if the leave is taken to care for a parent with a serious health condition, the continued coverage may not exceed a combined total of 12 weeks.

Conditions

1. If, on the day Your coverage is to begin, You are already on an FMLA leave of absence You will be considered Actively at Work. Coverage for You and any eligible dependents will begin in accordance with the terms of the Plan. However, if Your leave of absence is due to Your own or any eligible dependent's serious health condition, benefits for that condition will not be payable to the extent benefits are payable under any prior group plan.
2. You are eligible to continue coverage under FMLA if:
 - (a) You have worked for your Employer for at least one year;
 - (b) You have worked at least 1,250 hours over the previous 12 months;
 - (c) Your Employer employs at least 50 employees within 75 miles from Your worksite; and
 - (d) You continue to pay any required premium for Yourself and any eligible dependents in a manner determined by your Plan Administrator.
3. In the event You choose not to pay any required premium during Your leave, Your coverage will not be continued during the leave. You will be able to reinstate Your coverage on the day You return to work, subject to any changes that may have occurred in the Plan during the time You were not covered. You and any covered dependents will not be subject to any evidence of good health requirement provided under the Plan. Any partially-satisfied waiting periods, including any limitations for a preexisting condition, which are interrupted during the period of time premium was not paid will continue to be applied once coverage is reinstated.
4. You and Your dependents are subject to all conditions and limitations of the Plan during Your leave, except that anything in conflict with the provisions of the FMLA will be construed in accordance with the FMLA.
5. If requested by Ameritas Life Insurance Corp., You or CENTENNIAL PLASTICS, INC. must submit proof acceptable to Ameritas that Your leave is in accordance with FMLA.
6. This FMLA continuation is concurrent with any other continuation option except for COBRA, if applicable. You may be eligible to elect any COBRA continuation available under the Plan following the day Your FMLA continuation ends.
7. FMLA continuation ends on the earliest of:
 - (a) the day You return to work;
 - (b) the day You notify your Plan Administrator that You are not returning to work;
 - (c) the day Your coverage would otherwise end under the Plan; or
 - (d) the day coverage has been continued for 12 weeks.

Definitions

Prior Group Plan means the group plan providing similar benefits (whether insured or self insured including HMO's and other prepayment plans provided by your Plan Administrator) in effect immediately prior to the effective date of this Plan.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Serious Health Condition is defined as stated in the FMLA.

Important Notice

Contact your Plan Administrator for additional information regarding FMLA.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS as Federally Mandated

Definitions

Health Coverage means hospital, surgical, medical, dental, vision, or prescription drug coverage provided under the Plan. Health Coverage is subject to change as a result of open enrollments or plan modifications.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to such ACT and any interpretive regulations or rulings).

Service in the Uniformed Services means the performance of duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

Uniformed Services means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

Continuation of Group Health Coverage

1. **For You and Your Eligible Dependents:** If Health Coverage ends because of Your service in the Uniformed Services, You may elect to continue such Health Coverage, if required by USERRA, until the earlier of:
 - (a) the end of the period during which You are eligible to apply for reemployment in accordance with USERRA; or
 - (b) 24 consecutive months after coverage ended.
2. To continue coverage, You or Your dependent must pay the required premium, (including Your former employer's share and any retroactive premium), unless Your service in the Uniformed Service is for fewer than 31 days, in which event You must pay Your share, if any, of the premium. The Plan Administrator will inform You or Your dependent of procedures to pay premiums.
3. **End of Continuation.** A Covered Person's continued Health Coverage will end at midnight on the earliest of:
 - (a) the day Your former employer ceases to provide any group health plan to any employee;

- (b) the day premium is due and unpaid;
- (c) the day a Covered Person again becomes covered under the Plan;
- (d) the day Health Coverage has been continued for the period of time provided in part 1.(a) or (b) above (or any longer period provided in the Plan); or
- (e) the day the Plan terminates.

Any Health Coverage for an eligible dependent will also end as provided in the "Termination Dates" provision of the Plan.

4. **Other Continuation Provisions.** In the event Health Coverage is continued under any other continuation provision of the Plan, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation period for which premium is paid in whole or in part by your Plan Administrator, then the premium You are required to pay may increase for the remainder of the period provided above.

Reemployment (following service in the Uniformed Services)

Following Your discharge from such service, You may be eligible to apply for reemployment with Your former employer in accord with USERRA. Such reemployment includes Your right to elect reinstatement in any then existing health coverage provided by your Plan Administrator.

Important Notice

In the event of a conflict between this provision and USERRA, the provisions of USERRA, as interpreted by Your former employer, will apply.

**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.

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.

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

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

This Notice applies to the Group Divisions of Ameritas Life Insurance Corp. and Ameritas Life Insurance Corp. of New York. 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.

Ameritas Privacy Office Contact Information: 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. Please direct any questions about this Notice or requests for further information, or to file a complaint: The Privacy Office, Attn. HIPAA Privacy, P.O. Box 81889, Lincoln, NE 68501-1889, or e-mail us at privacy@ameritas.com.

YOUR RIGHTS

YOU HAVE THE RIGHT TO:

Get a copy of your claims records

- You can ask to see or get a copy of your claims records we maintain about you. Ask us how to do this.
- We will provide a copy or a summary of your claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Correct your claims records

- You can ask us to correct your claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days

Request confidential communication

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit the information we share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect payment for your care.

Get a list of those with whom we've shared your information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).
- We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this Privacy Notice

You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you believe your privacy rights have been violated

- You can complain if you feel we have violated your rights by contacting us using the contact information above.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- **Answer coverage questions from your family and friends.**
At your directions we will share information with your family, close friends, or others involved in payment for your care.
- **Share information in a disaster relief situation.**

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We will not share your personal information for marketing purposes or sell your personal information unless you give us your written permission to do so.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.

Example: We use health information about you to develop better coverage and service offerings for our insured members, including you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.

Example: We share information about you with other health benefit plans that you might also be covered by to coordinate payment for your health services.

Administer your health plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways– usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues – We can share your health information in certain situations such as to help prevent disease or to report suspected abuse, neglect or domestic violence.

Comply with the law – We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Address workers’ compensation, law enforcement, and other government requests – We can share health information about you:

- For workers’ compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.

Respond to lawsuits and legal actions – We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

This Revised Notice is effective 9/23/13.

