Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA

CERTIFICATE
GROUP EYE CARE INSURANCE

The Policyholder **CONROE INDEPENDENT SCHOOL DISTRICT**

Policy Number **10-350759** **Insured Person**

Plan Effective Date **September 1, 2013** **Certificate Effective Date**
Refer to Exceptions on 9070.

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.

JoAnn M Martin

President

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Ameritas Life Insurance Corp.'s toll-free telephone number for information or to make a complaint at:

1-877-897-4328 (Toll-Free)

You may also write to Ameritas Life Insurance Corp.:

Ameritas Life Insurance Corp.
P.O. Box 82657
Lincoln, Nebraska 68501-2657

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance

P.O. Box 149104
Austin, TX 78714-9104
FAX# (512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:
Should you have a dispute concerning your premium or about a claim, you should contact the agent or the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:
This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de Ameritas Life Insurance Corp. para informacion o para someter una queja al:

1-877-897-4328 (Toll-Free)

Usted tambien puede escribir a Ameritas Life Insurance Corp.:

Ameritas Life Insurance Corp.
P.O. Box 82657
Lincoln, Nebraska 68501-2657

Puede communicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas

P.O. Box 149104
Austin, TX 78714-9104
FAX# (512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS:
Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el agente o la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:
Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

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 1	All Eligible Employees

EYE CARE EXPENSE BENEFITS

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

Deductible Amount:

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

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 any of the following:

a. an Insured's spouse or,

b. each child less than 26 years of age, for whom the Insured or the Insured's spouse is legally responsible, or is eligible under the federal laws identified below, including:

   i. natural born children;

   ii. adopted children, eligible from the date of placement for adoption; or,

   iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

Spouses of Dependents and children of Dependents may not be enrolled under this policy. Additionally, if the Policyholder's separate medical plans are considered to have "grandfathered status" as defined in the federal Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, Dependents may not be eligible Dependents under such medical plans if they are eligible to enroll in an eligible employer-sponsored health plan other than a group health plan of a parent for plan years beginning before January 1, 2014. Dependents that are ineligible under the Policyholder's separate medical plans will be ineligible under this Policy as well; or,

c. each child over the limiting age who:

   is Totally Disabled as defined below; and

   becomes Totally Disabled while insured as a dependent under b. above.

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

d. each unmarried grandchild less than 25 years of age, if such children are dependents of the Insured for federal income tax purposes at the time application for coverage of the child is made

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 17.5 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 first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent.

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

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

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

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

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 17.5 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.

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 September 1.

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

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

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

OPEN ENROLLMENT. If a Member does not elect to participate when initially eligible, the Member may elect to participate at the Policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on September 1.

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.

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

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

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

TERMINATION DATES

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

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

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

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

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

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

Strike or Lockout
For Employees Only

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

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

   provided premiums are paid by the Insured.

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

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

3. Termination
   Such insurance will stop on the earlier of:
   a. the last day of the period for which the premium is paid;
   b. the date coverage would normally stop under the terms of the policy;
   c. the date the Insured becomes eligible under another group health plan;
   d. the date coverage has been continued for six months;
   e. the date seventy-five percent (75%) of the covered employees continue coverage;
   f. the date the policy terminates.

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

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

EYE CARE EXPENSE BENEFITS

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

AMOUNT PAYABLE
The Amount Payable for Covered Expenses is the lesser of the provider's charge, or the Maximum Covered Expense for such services or supplies. This is shown in the Schedule of Eye Care Services below.

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

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

NON-CONTRACTING PROVIDER
A Non-Contracting Provider is any other provider. Non-Contracting providers may be referred to as Affiliate or Open Access Providers. Non-Contracting Providers are not subject to our Quality Management Programs. Your out-of-pocket expenses may be greater when you visit a Non-Contracting Provider. However, more cost savings or convenience may be available through VSP arrangements with Affiliate Providers. You may contact VSP's Customer Care Division for details at (800) 877-7195).

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

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

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

ASSIGNMENT OF BENEFITS
Unless we receive a written Assignment of Benefits to the contrary, we pay benefits to the Contracting Provider for services and supplies performed or furnished by them. When a Non-Contracting Provider performs services, we pay benefits to the Insured unless arranged differently through an Affiliate or Open Access provider, or otherwise required by state regulation.

EXTENSION OF BENEFITS
If your policy terminates, we will pay claims for eye care services and supplies that you received or ordered prior to your policy's termination. You will have six months following the date of service to submit your claim. If it was not reasonably possible to submit a claim within the period stated above, we will not reduce or deny the claim for this reason if the claim is submitted as soon as is reasonably possible.

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

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

LIMITATIONS
This plan has the following limitation:

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

EXCLUSIONS
This plan does not cover:

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

SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for which benefits 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.

		PLAN MAXIMUM COVERED EXPENSE	
SERVICE	**WHEN COVERED**	*Contracting Provider*	*Non-Contracting Provider**
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 12 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.

*Insureds may receive additional savings and some services may be covered in full by choosing to visit an Affiliate Non-Contracting Provider.

[%]Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Customer LASIK patients as determined by the VSP Contracting Provider. Frame allowance may be applied towards non-prescription sunglasses, exhausting both frame and lens eligibility.

COORDINATION OF BENEFITS

This section applies if an Insured person has eye care coverage under more than one Plan definition below. All benefits provided under this policy are subject to this section.

EFFECT ON BENEFITS. The Order of Benefit Determination rules below determine which Plan will pay as the primary Plan. If all or any part of an Allowable Expense under this Plan is an Allowable Expense under any other Plan, then benefits will be reduced so that, when they are added to benefits payable under any other Plan for the same service or supply, the total does not exceed 100% of the total Allowable Expense.

If another Plan is primary and this Plan is considered secondary, the amount by which benefits have been reduced during the Claim Determination Period will be used by us to pay the Allowable Expenses not otherwise paid which were incurred by you in the same Claim Determination Period. We will determine our obligation to pay for Allowable Expenses as each claim is submitted, based on all claims submitted in the current Claim Determination Period.

DEFINITIONS. The following apply only to this provision of the policy.

1. "Plan" refers to the group policy and any of the following plans, whether insured or uninsured, providing benefits for eye care services or supplies:

    a. Any group or blanket insurance policy.

    b. Any group Blue Cross, group Blue Shield, or group prepayment arrangement.

    c. Any labor/management, trusteed plan, labor organization, employer organization, or employee organization plan, whether on an insured or uninsured basis.

    d. Any coverage under a governmental plan that allows coordination of benefits, or any coverage required or provided by law. This does **not** include a state plan under Medicaid (TitleXVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non-governmental program.

2. "Plan" does **not** include the following:

    a. Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through individual HMOs or other prepayment arrangements.

    b. Coverages for school type accidents only, including athletic injuries.

3. "Allowable Expense" refers to any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plans covering the Insured person for whom that claim is made. When a Plan provides services rather than cash payments, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had a claim been made for them.

4. "Claim Determination Period" refers to a Benefit Period, but does not include any time during which a person has no coverage under this Plan.

5. "Custodial Parent" refers to a parent awarded custody of a minor child by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

ORDER OF BENEFIT DETERMINATION. When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

1. A Plan that does not have a coordination of benefits provision is always considered primary and will pay benefits first.

2. If a Plan also has a coordination of benefits provision, the first of the following rules that describe which Plan pays its benefits before another Plan is the rule to use:

    a. The benefits of a Plan that covers a person as an employee, member or subscriber are determined before those of a Plan that covers the person as a dependent.

    b. If a Dependent child is covered by more than one Plan, then the primary Plan is the Plan of the parent whose birthday is earlier in the year if:

        i. the parents are married;

        ii. the parents are not separated (whether or not they ever have been married); or

        iii. a court decree awards joint custody without specifying that one party has the responsibility to provide Eye Care coverage.

        If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

    c. If the Dependent child is covered by divorced or separated parents under two or more Plans, benefits for that Dependent child will be determined in the following order:

        i. the Plan of the Custodial Parent;

        ii. the Plan of the spouse of the Custodial Parent and then;

        iii. the Plan of the non-Custodial Parent.

        However, if the specific terms of a court decree establish a parent's responsibility for the child's Eye Care expenses and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Claim Determination Periods or Benefit Periods commencing after the Plan is given notice of the court decree.

    d. The benefits of a Plan that cover a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    e. With respect to categories of non-dependent as related to dependent coverage, the benefits of the plan which covers the person as an employee, member, or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent. There is one exception. If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent.

f. The benefits of a Plan that has covered a person for a longer period will be determined first.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION. We may without your consent and notice to you:

1. Release any information with respect to your coverage and benefits under the policy; and

2. Obtain from any other insurance company, organization or person any information with respect to your coverage and benefits under another Plan.

You must provide us with any information necessary to coordinate benefits.

FACILITY OF PAYMENT. When other Plans make payments that should have been made under this Plan according to the above terms, we may pay to any organizations making these payments any amounts that we decide will satisfy the intent of the above terms. Amounts paid in this way will be benefits paid under this Plan. We will not be liable to the extent of these payments.

RIGHT OF RECOVERY. When we make payments for Allowable Expenses in excess of the amount that will satisfy the intent of the above terms, we will recover these payments, to the extent of the excess, from any persons or organizations to or for whom these payments were made. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 90 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90-day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible, and unless the claimant does not have the legal capacity to provide proof of loss, proof of loss is provided not later than the first anniversary of the date proof of loss is otherwise required. For Eye Care benefits that use either the EyeMed or VSP network, please refer to the limitations section on the Eye Care Expense Benefits page.

TIME OF PAYMENT. We will pay all benefits no later than the 60th day after the date the Proof of Loss is received. Any balance remaining unpaid at the end of any period for which we are liable will be paid at that time.

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

Direct Payment of the Texas Department of Human Services

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

Benefit Payment to Parent of a Dependent Child

Regardless of any policy provision to the contrary, if:

1. a minor child is a dependent under this policy; and

2. such dependent child incurs expenses;

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

We will <u>not</u> pay benefits to the managing conservator in the following situations:

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

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

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may pay the benefit up to an amount not to exceed $5,000 to the insured or the insured's assignee.

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

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

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

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

1. The Policy would not have been issued if we had known the truth; and

2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

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

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

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 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.

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 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 by 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 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.