1. TITLE PAGE

Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA

CERTIFICATE AND SUMMARY PLAN DESCRIPTION
GROUP EYE CARE INSURANCE

The Policyholder **SNOOZE IMPORT EXPORT, LLC**
SNOOZE AN A.M. EATERY

Policy Number **10-67284** **Insured Person**

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

Class Number 7

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 DO NOT INCLUDE COVERAGE OF PEDIATRIC DENTAL SERVICES AS REQUIRED UNDER THE ACA. COVERAGE OF PEDIATRIC DENTAL SERVICES IS AVAILABLE FOR PURCHASE IN THE STATE OF COLORADO AND CAN BE PURCHASED AS A STAND-ALONE PLAN. PLEASE CONTACT YOUR INSURANCE CARRIER, AGENT, OR CONNECT FOR HEALTH COLORADO TO PURCHASE EITHER A PLAN THAT INCLUDES PEDIATRIC DENTAL COVERAGE OR AN EXCHANGE-QUALIFIED STAND-ALONE DENTAL PLAN THAT INCLUDES PEDIATRIC DENTAL COVERAGE.

THE GROUP POLICY AND THIS CERTIFICATE ARE A LIMITED BENEFIT HEALTH COVERAGE AND ARE NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

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

Susan K. Wilkinson

President

2. SCHEDULE OF BENEFITS

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 7	Eligible Hourly Employee Electing EyeMed

EYE CARE EXPENSE BENEFITS

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

When a Participating Provider is used:	
Deductible Amount:	
Exams - Each Benefit Period	$15
Frames	$0
Lenses - Each Benefit Period	$15
When a Non-Participating Provider is used:	
Deductible Amount	$0

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

IMPORTANT INFORMATION

The following provides information regarding your rights and responsibilities regarding your coverage.

You have the right to:

- Be treated with respect and dignity without discrimination.
- Receive assistance in a prompt, courteous and responsible manner.
- To participate with your network provider in decision-making regarding your dental and/or vision care.
- To know your costs in advance for routine and emergency care.
- A fair and efficient process for resolving differences with us, our claim decisions or providers.
- 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.

You have the responsibility to:

- Read the details of your Certificate.
- Provide information to your provider that he/she needs to know to provide appropriate care.
- Let your provider know whether you understand the treatment plan he/she recommends and follow the treatment plan and instructions for care.
- Pay any cost-sharing balance 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.

3. CONTACT US

Contact us with any questions about this policy or coverage:

Administration & Billing Questions:

800-659-2223

PO Box 81889

Lincoln NE 68501

adminserv@employeeBenefitservice.com

Claim Questions:

800-487-5553

PO Box 82520

Lincoln NE 68501

4. TABLE OF CONTENTS

5. ELIGIBILITY
CONDITIONS FOR INSURANCE COVERAGE

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

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

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

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

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

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

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

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth.

An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence. A newborn adopted child will be covered from the date of birth if the Insured has agreed in writing to adopt the child prior to its birth and the child is ultimately placed in the Insured's residence.

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

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted or foster child.

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

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any eligible hourly employee electing EyeMed 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 plan is provided as part of the Employer's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this plan.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this plan at that time will have their coverage become effective on 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 following the eligibility period of 395 calendar day(s) of continuous active 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 January 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:

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.

6. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

An insured person has the freedom of choice to receive treatment from any Provider. (Participating Providers will charge a reduced amount, so savings may be realized for treatment performed by a Participating Provider as described in this Policy.)

No pre-approvals are requirement for services. Pre-treatment estimates of benefits are available.

Network Panel Participation
You may access a listing of Participating Providers on our web site at www.ameritas.com or call EyeMed at 866-939-3633. You may access the Colorado Vision Network Access plan at www.eyemed.com.

The information contained in the enclosed network directory or on our web site concerning providers may change at any time and without notice. There is no guarantee that the provider you select from the list will still be a network provider at the time you plan to have services performed. Some providers may not participate in the network at all locations where they practice. Prior to making an appointment and again at the time of the appointment, please verify with the provider that they participate in the network. If you are not able to keep your appointment, please give the participating provider at least 24 hours advanced notice of your need to cancel or reschedule. This allows providers to properly schedule patient visits.

For informational purposes only: At the time this packet was printed, there were no network providers located in the following Colorado counties:

EyeMed Vision: Baca, Bent, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Dolores, Garfield, Gilpin, Grand, Hinsdale, Jackson, Kiowa, Kit Carson, Lake, Mineral, Moffat, Montezuma, Morgan, Ouray, Park, Pitkin, Rio Blanco, Saguache, San Juan, San Miguel, Sedgwick, Washington, Yuma

7. BENEFIT COVERAGE (WHAT IS COVERED)
EYE CARE EXPENSE BENEFITS

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

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

A. the provider's charge, or

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

BENEFIT PERIOD means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

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

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

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

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

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

ASSIGNMENT OF BENEFITS
We pay benefits to the Participating Provider for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, the Insured can make an Assignment of Benefits, which we will honor.

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

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

SCHEDULE OF EYE CARE SERVICES

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

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

8. LIMITATIONS/EXCLUSIONS
(What is Not Covered and Pre-existing Condition Limitations)

EYE MED EYE CARE EXPENSE BENEFITS LIMITATIONS

This plan has the following limitations.

1) This plan does not cover more than one Eye Exam per Benefit Period.

2) This plan does not cover more than one pair of ophthalmic Lenses per Benefit Period.

3) This plan does not cover more than one set of Frames every other Benefit Period.

4) This plan does not cover Elective Contact Lenses more than once per Benefit Period. Contact Lenses and associated expenses are in lieu of any other Lens benefit.

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

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

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

7) This plan does not cover Plano Lenses.

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

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

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

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

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

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

9. MEMBER PAYMENT RESPONSIBILITY

Members may be required to pay all or a portion of the premium amount for their coverage or their enrolled dependent coverage, as determined by the Policyholder.

Members are responsible for paying their share of covered expenses and the entire dentist's charge for Non Covered Services. Such cost sharing may include deductible amounts and coinsurance amounts.

For services performed by a Participating Provider, the member pays the difference between the plan payment and the Participating Provider's discounted fee. For services performed by a Non Participating Provider, the member pays the difference between the plan payment and the Provider's actual charge for the service.

10. CLAIMS PROCEDURES (HOW TO FILE A CLAIM)

CLAIM FORMS. We will furnish to the person making the claim or to the Policyholder for delivery to that person, the claim forms usually used for filing proof of loss. If these forms are not sent by 15 days after we receive notice of claim, the person making the claim will be deemed to have complied with the proof of loss requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

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.

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.

TIME OF PAYMENT. We will pay all benefits in accordance with state requirements. Clean claims will be paid, denied, or settled within thirty calendar days if received electronically and within 45 days if received by other means. If additional information is required to administer the claim, we will notify the insured, patient, provider, or policyholder within 30 calendar days or receipt of the claim. Except in cases where fraud is involved, all claims will be paid, denied, or settled within 90 calendar days of our receipt. 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.

11. GENERAL POLICY PROVISIONS

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. All misrepresentations must be intentional misrepresentations of a material fact. 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 two years, 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

CONFORMITY WITH LAW. Any policy provision that conflicts with the laws of the state in which the policy is issued, is automatically changed to meet the minimum requirements of those laws.

ENTIRE CONTRACT. The policy and the application of the Policyholder constitute the entire contract between the parties. A copy of the Policyholder's application is attached to the policy when issued. All statements made by the Policyholder or an Insured will, in the absence of fraud, be considered representations and not warranties. No statement made to obtain insurance will be used to avoid the insurance or reduce the benefits of this policy unless it is in a written application signed by the Policyholder or Insured. A copy of this must have been given to the Policyholder or Insured.

No change in this policy will be valid unless approved in writing by one of our officers and given to the Policyholder for attachment to the policy. No agent has the authority to change this policy or waive any of its provisions. Any change in this policy will be valid even though an Insured may not have agreed to it.

INSURANCE DATA. The Policyholder will furnish, at our request, data necessary to administer this policy. The data will include, but not be limited to data:

i. necessary to calculate premiums;

ii. necessary to determine a person's effective date or termination date of insurance;

iii. necessary to determine the proper coverage level of insurance.

We shall have the right to inspect any of the Policyholder's records we find necessary to properly administer this policy. Any inspections will be at a time and place convenient to the Policyholder.

We will not refuse to insure a person who is eligible to be insured just because the Policyholder fails or errs in giving us the data necessary to include that person for coverage. An Insured's insurance will not stay in force nor an amount of insurance be continued after the termination date, according to the Conditions for Insurance, because the Policyholder fails or errs in giving us the necessary data concerning an Insured's termination.

CERTIFICATES. We will issue certificates to the Policyholder showing the coverage under the policy. The Policyholder will distribute a certificate to each insured Member. If the terms of the certificate differ from the policy, the terms stated in the policy will govern.

PARTICIPATION REQUIREMENTS. There are two requirements that must be met in order for the policy to be placed in force, and to remain in force:

a. a certain percentage of all Members qualified for insurance must be insured at all times; and

b. a certain number of Insureds must be insured at all times.

The Participation Requirements are as follows:

Percentage of Members-	60%
Number of Members-	330

CONSIDERATION. This policy is issued to the Policyholder in consideration of the application and the payment of premiums specified in this policy.

TERMS AND CONDITIONS. Payment of any benefit under this policy is subject to the definitions and all other terms of this policy pertinent to the benefit.

12. TERMINATION / NONRENEWAL / CONTINUATION

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 grace period; 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 grace period; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the th of the month falling on or next following 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.

Termination of Employment

Employees and Dependents

Please contact the person who handles the policyholder's insurance matters to see if these provisions are available to you.

Eligibility

The employee has the right to elect continuation for himself and his and dependents if:

1. The employee's eligibility to receive coverage has ended for any reason other than discontinuance of the group policy in its entirety or with respect to an insured class;

2. Any premium required from or on behalf of the employee has been paid to the termination date;

3. The employee has been continuously insured under the policy, or under a similar policy, for at least six months prior to termination.

The employer is not required to offer continuation for any person who is covered by Medicare or Medicaid.

Continuation Period

Upon termination of employment, death, or change in marital status, the employee or dependents has the right to continue the coverage for a period of 18 months after loss of coverage or until such employee or dependents becomes eligible for other group coverage. However, should new coverage exclude a condition covered under the continued plan, coverage under the prior employer's plan may be continued for the excluded condition only for the 18 months or until the new plan covers the condition, whichever occurs first.

Notice Requirements of the Employer

The employer shall notify the employee in writing of their right to continue health care coverage upon termination from employment. A written communication signed by the employee or a notice postmarked within 10 days of termination mailed by the employer to the last-known address shall meet the notice requirements. The notice shall inform the employee of:

1. The right to elect to continue the existing coverage;

2. The amount such employee shall pay monthly to the employer to retain the coverage, which payment shall include the employer's contribution for such employee in addition to the employee's own contribution.

3. The "how, where and when" the payment to the employer must be made;

4. The fact that loss of coverage will result if timely payment is not made to the employer.

The employee shall notify the employer in writing of the employee's election to continue coverage and shall make proper payment as soon as possible upon notification by the employer of termination. However, in no case shall such notification occur or such payment be made more than 30 days after the date of termination unless the employer failed to provide timely notice (10 day notice period - see above).

Failure to Provide Notice

If the employer fails to notify an eligible employee of the right to elect continuation, the employee shall have the option to retain coverage if, within 60 days of the date the employment is terminated, the employee makes the proper payment to the employer to provide continuous coverage.

If the employer fails to make payment to the insurer, with the result that the employee's coverage is terminated, the employer shall become liable for the employee's coverage, but to no greater extent than the amount of the premium.

13. APPEALS AND COMPLAINTS

Notice of Grievance Procedures

In accordance with 3 CCR 702 Reg. 4-2-17 and
3 CCR 702 Reg. 4-2-21
of the Colorado Insurance Regulations

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

Please read this notice carefully to see important information about how to file grievances with us. We can help you file a grievance or review any questions about our benefit decisions or claims payments. You also have the right to contact the Colorado Division of Insurance if you have a question or concern regarding your coverage, using the contact information below:

In Writing:	Colorado Division of Insurance 1560 Broadway, Suite 850 Denver, CO 80202
By phone:	800-930-3745
Website:	www.dora.state.co.us/insurance

I. Definitions

"Adverse Determination" means a determination made by us or our designee that a request for a benefit has been reviewed and, based upon the information provided, does not meet our requirement for medical necessity, or is determined to be experimental or investigational, and is therefore denied, reduced or terminated. An adverse determination also includes a denial due to a contractual exclusion when the Covered Person is able to present evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply to the denied benefit.

"Grievance" means a written complaint on by or on behalf of a Covered Person regarding claims payment, handling, or reimbursement for health care services, including a grievance concerning an adverse determination.

"Designated Representative" means a Person, including the treating provider or a Person to whom the Covered Person has given express written consent to represent the Covered Person, or a Person authorized by law to provide substituted consent for a Covered Person, including but not limited to a guardian, agent under a power of attorney, a proxy or a designee of the Colorado Department of Health Care Policy and Financing.

"Utilization Review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings.

II. Levels of Review

The following levels of review will be available to a Covered Person and/or designated representative:

First Level Grievance Review - for written grievances, including those resulting from an adverse determination.

Voluntary Second Level Grievance Review - following first-level reviews if grievance not resolved.

Expedited Review - only for adverse determinations of requests for urgent care pre-treatment benefit estimates.

External Review - available following either the first or second level review for adverse determinations.

A. First Level Grievance Review

A written grievance concerning any matter, including an adverse determination, may be submitted by a Covered Person or his or her designated representative, within 180 calendar days of receipt of the adverse determination. A Covered Person does not have the right to attend or to have a representative in attendance at the first level review, but the Covered Person is entitled to submit written comments, documents, records and other material relating to the request for benefits for the reviewer(s) to consider when conducting the review. For review of a benefit denial due to a contractual exclusion, the Covered Person must be able to provide evidence from a medical professional that there is a reasonable medical basis that the exclusion does not apply. The Covered Person has the right to receive upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the Covered Person's request for benefits. We will send a written decision to the Covered Person and designated provider no later than thirty (30) calendar days after receiving a request for first level review. The review of an adverse determination will be conducted by a clinical peer other than the Person or Persons who made the initial determination on the matter.

B. Voluntary Second Level Grievance Review

In any case where the first level grievance review process or expedited review process involving an adverse determination does not resolve a difference of opinion, the Covered Person or their designated representative may request a second level review. We will provide the Covered Person, upon request, information relating to the voluntary second level review so that the Covered Person can make an informed decision whether to submit the adverse determination to a voluntary second level review. The request for a second level review should be made within thirty (30) calendar days after receipt of the decision resulting from the first level review. The Covered Person may designate the provider(s) to whom we shall send a copy of the review decision.

We will appoint a review panel to review the request. The panel will include a minimum of three (3) people, the majority of whom will not have been previously involved in the grievance. If the review is regarding an adverse determination, the majority of Persons reviewing the request will be clinical peers who have appropriate expertise.

The review panel will meet within sixty (60) calendar days after receiving a request from a Covered Person or designated representative for a voluntary second-level review. The Covered Person shall be notified at least twenty (20) calendar days in advance of the review date.

The Covered Person or designated representative has the right to appear in Person or through conference call at the review meeting and can present written comments or materials relating to the review. These documents should be sent to us at least five (5) calendar days prior to the meeting. Any new material developed after the 5-day deadline must be sent as soon as practicable.

The Covered Person has the right to receive, upon request, a copy of the materials that we intend to present at the review meeting at least five (5) calendar days prior to the meeting. Any new material developed after the 5-day deadline will be provided as soon as practicable if the Covered Person had requested materials previously.

The Covered Person has the right to have an attorney at the review meeting and should advise us of this no later than seven (7) calendar days prior to the meeting. If the decision to have an attorney present is made after the 7-day deadline, notice will be provided to us as soon as practicable. If we plan to have an attorney present, we will advise the Covered Person at the time we advise the review date.

If we plan to make an audio or video recording of the review, we will advise the Covered Person at the time we advise the review date. Such a recording may be provided to any external review entity should one be held after the Second Level Review.

The review panel will issue a written decision to the Covered Person within seven (7) calendar days of the review meeting.

C. Expedited Review – Available for Adverse Pre-Treatment Benefit Estimates Only

Pre-authorization of benefits is not required under our plans. For urgent care situations, an expedited review of an elective pre-treatment benefit determination can be requested orally or in writing. A request for a concurrent expedited External Review may be made at the same time (see below for more information on External Review). Expedited reviews of an adverse determination will be reviewed by clinical peers in the same or similar specialty as would normally manage the case under review, different from those who were involved in the initial adverse determination. A Covered Person or representative does not have the right to attend the expedited review, but can submit related written comments, documents and records.

We will make a decision and notify the Covered Person or their designated representative no later than seventy-two (72) hours after the carrier's receipt of request. Written confirmation of the decision will be provided within three (3) calendar days of the decision, if the initial notification was not in writing.

If the expedited review does not resolve a difference of opinion, a voluntary second level review is available, as described in B. above.

D. Independent External Review for Adverse Determinations (Benefit Decisions Based on Medical Necessity)

The Covered Person has a right to request an independent external review if there still remains a difference of opinion following any internal reviews or if we fail to properly follow required Internal Review procedures.

The Covered Person or representative can request an External Review four (4) months after receipt of an adverse decision following a First Level Grievance Review, or sixty (60) calendar days after receipt of an adverse decision following a Second Level Grievance Review. Requests for external review must be made in writing to us and include a completed external review request form as specified by the Division of Insurance and a consent form authorizing us to disclose any health information necessary during the review. New information may also be submitted by the Covered Person or provider related to the matter in question. There is no minimum dollar amount for a claim to be eligible for an external review.

If we were to deny a request for a standard external review, we will send notification in writing or electronically, including the specific reasons for the denial and information about how to appeal the denial of the request with the Division of Insurance. A copy of this denial will be sent to the Division at the same time it is sent to the Covered Person.

When we receive a request for external review, we will send a copy to the Commissioner of Insurance within two (2) working days, If the request is incomplete, we will notify the covered person within five (5) days after receipt of an incomplete request for a standard external review and within 24 hours of receipt of an incomplete request for an expedited external review.

If we reverse an adverse determination based on new or additional information submitted to us, before the required time for notifying the Commissioner, we will notify the covered person within one (1) business day of the reversed decision by electronic or fax delivery, or by telephone followed by written confirmation.

Within two (2) business days of receipt of a request, the Division of Insurance will randomly select an independent review organization that does not have a conflict of interest to review the matter. Upon selection, the Division will notify us of the name and address of the independent external review organization where the appeal should be sent.

Within one (1) business day, we will then notify the Covered Person of this information, electronically, by fax, or by telephone followed by written confirmation. The notice will include a written description of the independent external review entity the Commissioner selected and information regarding how the Covered Person may provide the Commissioner with any documentation regarding potential conflict of interest concerns. The Covered Person has two (2) business days after that to submit such documentation.

Within one (1) business day after the Commissioner determines necessary, the Commissioner will assign a different entity and notify us of the new information so that we can send the appeal information.

Within five (5) business days of receipt of the notice from us, the Covered Person may submit additional information to the independent external review entity for consideration during the review. The independent entity may also choose to accept additional information after the five day period but is not required to do so. Information received will be forwarded to us within one (1) business day of receipt.

The independent external review entity is not bound by any determinations made by us.

We will provide all requested information to the independent review entity within five (5) business days, including an index of submitted materials.

Within two (2) days after receipt of these materials, the independent review entity will send the Covered Person the index.

If the review entity requests additional information from the Covered Person, the provider, or us, the information must be submitted within five (5) business days or an explanation as to the unavailability of such information must be submitted within that time frame.

The independent review entity will communicate its decision within forty-five (45) calendar days after receipt of the request for the external review. Written notification will be sent to the Covered Person, the carrier, the provider, and the Commissioner.

If the independent review entity decides that a benefit is payable:

a. For prospective pre-treatment estimate reviews, we will approve the benefit within one (1) business day.
b. For retrospective treatment claim reviews, we will approve the benefit within five (5) business days.

We will provide written notice of the approval to the Covered Person or designated representative within one (1) business day of our approval. Coverage will be subject to the terms and conditions of the policy.

External review decisions are binding on us and the Covered Person, except to the extent there are other remedies available under federal or state law. Additional external review requests for the same matter are not permitted.

Further details about the external review process will be provided upon request or at the time an external review is requested.

E. Expedited External Review

No pre-authorizations are required under our policies. However, the Covered Person or designated representative has a right to request an expedited external review of a request for a pre-treatment estimate of benefits if the Covered Person has a medical condition where the timeframes for completion of a standard external review would seriously jeopardize the health of the Covered Person. All requests for an expedited external review must include a physician's certification that the Covered Person's medical condition meets the criteria as defined above. Upon receipt of a request for an expedited external review, we will send a copy of the request to the Commissioner of Insurance within one (1) business day electronically or by telephone or fax.

Other steps described above will be performed in an expeditious manner. The Commissioner will randomly assign the independent external review entity within one (1) business day of receipt of the request for an expedited external review. Within one (1) business day of receiving such notice from the Commissioner, we will notify the Covered Person of such entity, followed up in writing if such notice was made by telephone. We will immediately submit all related information to the independent review entity in the most expeditious manner.

The independent review entity will communicate its determination within 72 hours to the Covered Person, the carrier, the provider, and the Commissioner.

III. Written Decision

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

1. The names, titles and qualifying credentials of the Persons participating in the grievance review process.

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. A description of our review procedures, any time limits applicable to such procedures, and any appeals rights.

5. A description of any additional material or information necessary and an explanation of why such material or information is necessary for any further review.

6. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or a statement that such rule, guideline, or protocol, was relied upon and that a copy will be provided free upon request.

7. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limitation, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the Covered Person's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

8. For first level reviews, a description of the process to obtain a second level grievance review and the time frame for review. Following a second level review, a description of the process to request an independent external review.

9. Notice of the Covered Person's right to contact the Colorado Division of Insurance.

Additional Review Rights

The Covered Person whose claim has been denied in whole or in part, and who has exhausted his or her administrative remedies, shall be entitled to have his or her claim reviewed from the beginning in any court with jurisdiction and to a trial by jury.

You always have the right to contact the Department of Insurance:

Colorado Division of Insurance
1560 Broadway Suite #850
Denver, CO 80202
(303) 894-7490

(800) 930-3745 - Toll Free if calling from outside Denver metro area

Cultural and Linguistic Support
We want to be sure this information is helpful to you. Interpreting services are available toll free at 800-487-5553. Upon request, we will provide certificates of coverage and provider directories in Spanish, or

large print for the visually impaired. We are prepared to help hearing impaired members who access TDD or TTY “text telephone” systems when contacting us.

Servicios de idiomas sin costo. Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 800-487-5553.

14. DEFINITIONS

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

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

INSURED refers to a person:

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

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

c. for whom the insurance has become effective.

DOMESTIC PARTNER: Refers to two unrelated individuals who share the necessities of life, live together, and have an emotional and financial commitment to one another, similar to that of a spouse.

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

CIVIL UNION. That union as defined under the Colorado Civil Unions Act.

DEPENDENT refers to:

a. an Insured's spouse or Domestic Partner or a person who is a Partner in a Civil Union with you.

b. each unmarried and married child less than 26 years of age, for whom the Insured, the Insured's spouse, the Insured's Partner in a Civil Union, or the Insured's Domestic Partner is legally responsible, including natural born children, a child of a Partner in a Civil Union, adopted children from the date of placement for adoption, and children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws. Grandchildren, spouses of Dependents and other Dependent family members under the age of 26 are not eligible for coverage under this plan.

c. each unmarried child of any age who is Disabled as defined below; or becomes Disabled as defined below.

   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.

DISABLED refers to an Insured's Dependent who is medically certified as disabled and dependent upon the Insured for support and maintenance.

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

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

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider is a Provider who has a contract with Us to provide services to Insureds at a discount. A Participating Provider is also referred to as a "Network Provider". The terms and conditions of the agreement with our network providers are available upon

request. Members are required to pay the difference between the plan payment and the Participating Provider's contracted fees for covered services. A Non-Participating Provider is any other provider and may also be referred to as an "Out-of-Network Provider." Members are required to pay the difference between the plan payment and the provider's actual fee for covered services. 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.

ERISA INFORMATION AND NOTICE OF YOUR RIGHTS

A. General Plan Information

Name of Plan:	Eye Care Insurance
Name, Address of Plan Sponsor:	SNOOZE IMPORT EXPORT, LLC 3001 BRIGHTON BLVD STE 303 DENVER, CO 80216
Plan Sponsor Tax Id Number:	27-1669743
Plan Number:	501
Type of Plan:	Group Insurance Plan
Name, Address, Phone Number of Plan Administrator:	JEREMY EDMONDS SNOOZE IMPORT EXPORT, LLC 3001 BRIGHTON BLVD STE 303 DENVER, CO 80216 720-779-2564
Name, Address of Registered Agent for Service of Legal Process:	Plan Sponsor
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:	December 31
Type of Administration:	
General Administration	Plan Sponsor
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

Your Information. Your Rights. Our Responsibilities.

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes how the Group Divisions of Ameritas Life Insurance Corp. and Ameritas Life Insurance Corp. of New York use and disclose your protected health information, and how we guard that information. We are required to abide by the terms of this notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary, and to make a new Notice effective for all protected health information maintained by us. If we do make changes to this Notice, a copy of the new Notice will be placed on our web site at www.ameritas.com and/or sent to you if the changes are material. If you reside in a state whose law provides stricter privacy protections than those provided by HIPAA, we will maintain the privacy of your health information as required by your stricter state law.

how we use or disclose information

We must use and disclose your health information to provide that information:

- To you, or someone who has the legal right to act for you (your personal representative), in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to see that we are complying with federal privacy law and administrative simplification provisions of HIPAA.

We have the right to use and disclose your health information for your treatment, to pay for your health care, and to operate our business. For example, we typically use your information in the following ways:

- **For Payment.** We may use or disclose health information to collect premiums due to us, to determine your coverage, or to process claims for health care services you receive. For example, we may tell a provider whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your provider to help them provide health care services to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we may use health information for operational activities such as quality assessment and improvement.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on the use and disclosure of the information in accordance with federal law.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information about you if state or federal laws require it.
- **To Persons Involved With Your Care.** We may use or disclose your health information a person involved in your care or who helps you pay for your care, such as a family member or close personal friend, when you are incapacitated, emergency situations, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests.
- **To Law Enforcement.** We may disclose your health information to a law enforcement official to provide limited information to locate a missing person or report a crime.
- **To Correctional Institutions or Law Enforcement Officials.** We may disclose your health information if you are an inmate of a correctional institution or under the custody of law enforcement, but only if necessary for the institution to provide you with health care; to protect your health and safety, or the health and safety of others; or for the safety and security of the correctional institution.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public. For example, we may disclose information to a public health agency or law enforcement in the event of a natural disaster.
- **For Public Health Activities** such as reporting disease outbreaks to a valid public health authority.
- **For Reporting Victims of Abuse, Neglect, or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social services or protective service agencies.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits, and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** to respond to a court order, search warrant, or subpoena.
- **For Specialized Government Functions** such as national security and intelligence activities, the protective services for the President and others, or if you are a member of the military, as required by the armed forces.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than allowed by the contract and federal law.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers' compensation laws that govern job-related injuries or illness.

- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Cadaveric Organ, Eye, or Tissue Donation.** We may disclose information to entities that handle procurement, banking, or transplantation of organs, eyes, or tissue to facilitate donation and transplantation.

Except for uses and disclosures described and limited as explained in this notice, we will use and disclose your health information only with written permission from you. We will not share your personal information for marketing purposes or sell your personal information unless you give us written permission to do so.

our responsibilities

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

your rights

- **Right to Inspect and Copy.** You have the right to inspect and copy certain protected health information that may be used to make decisions about your plan benefits. Your request must be in writing and submitted to the Ameritas Privacy Office at the contact information below. We will usually provide access to your protected health information within 30 days of receiving the request. We reserve the right to charge a fee for the costs of copying, mailing, or other supplies associated with your request. You may also ask your providers for access to your records. We may deny your request in very limited circumstances. If we deny your request to inspect or obtain a copy of your protected health information, we will inform you in writing of the reason(s) within 30 days.
- **Right to Amend.** You have the right to request that we amend, correct, or delete your protected health information in our records if you believe that it is inaccurate or incomplete. Your request must be in writing and sent to the Ameritas Privacy Office at the contact information below. In addition, you must provide a reason that supports your request. We will respond to your request in writing within 30 days. We may deny your request for an amendment if it is not in writing, or does not include a reason to support the request. If we deny your request, we will communicate the reason(s) for denial. If we deny your request, you have the right to file a written statement of disagreement and any future disclosures of the disputed information will include your statement.
- **Right to Request Confidential Communication.** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Your request must be in writing and submitted to the Ameritas Privacy Office at the contact information below. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- **Right to an Accounting of Disclosures of Your Protected Health Information.** You have the right to receive a list of the times we've shared your health information for up to six years prior to the date you ask, who we share it with, and why. Your request must be in writing and submitted to the Ameritas Privacy Office at the contact information below. We will include all the disclosures, except those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Know the Reasons for an Unfavorable Underwriting Decision.** You have the right to know the reason(s) for an unfavorable underwriting decision. Your request must be in writing, and must be asked for within 90 days from when the adverse underwriting decision is sent. We will respond within 21 days. Previous unfavorable underwriting decisions may not be used as a basis for future underwriting decisions unless we make an independent evaluation of basic facts. Your genetic information cannot be used for underwriting purposes.
- **Ask Us to Limit the Information We Share.** You can send us a written request at the contact information below to not use or share certain health information for treatment, payment, or health care operations. We are not required to agree to these requests.
- **Get a Copy of this Privacy Notice.** You can ask us for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

exercising your rights

- Submitting a Written Request. If you have any questions about this Notice, want more information about exercising your rights, or want to obtain an authorization form please contact us at: The Privacy Office, Attn. HIPAA Privacy, P.O. Box 82520, Lincoln, NE 68501-2520, e-mail us at privacy@ameritas.com, or call 1-800-487-5553
- Filing a Complaint. If you believe your privacy rights have been violated, you may file a complaint with us at the contact information listed above. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C., 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

This revised notice is effective 9/30/17.