



A STOCK COMPANY  
LINCOLN, NEBRASKA

**CERTIFICATE  
GROUP EYE CARE INSURANCE**

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**The Policyholder**      **LAKE COUNTY BOARD OF COUNTY COMMISSIONERS**

**Policy Number**      **10-29744**      **Insured Person**

**Plan Effective Date**      **October 1, 2006**      **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.

If you should have any questions regarding your coverage or claim payments, you may contact us toll-free at 800-877-7195.

*JoAnn M Martin*

President

## IMPORTANT INFORMATION TO INSUREDS

### **We are here to serve you . . .**

You have the right to receive medically appropriate care in a timely and convenient manner and to be an active participant in any decision making regarding treatment, care and services provided to you or one of your family members who are covered under this plan.

In order to provide you the best possible service, it is important that you provide any necessary information to your provider that will facilitate effective medical care and that you cooperate with your provider(s) by keeping appointments and following recommended treatment.

Please review your certificate of coverage carefully so that you fully understand the benefits provided. If you have a question about your policy or if you need assistance with a problem, feel free to contact us at the number shown below.

If you have a grievance or complaint regarding an adverse decision, you may call us below or document your concerns in writing. Written documentation can be sent to the following:

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

The complaint will be reviewed by an internal panel consisting of employees. If the initial claim was denied based on medical necessity or paid as an alternate benefit, then a licensed provider will be involved in the review of the appeal. A written decision will be sent to the claimant within at least 15 business days following the receipt of the appeal.

### **If you are not satisfied . . .**

Should you feel you are not being treated fairly, we want you to know you may contact the Florida Department of Insurance with your complaint and seek assistance from the governmental agency that regulates insurance.

To contact the Department, write or call:

**Division of Consumer Services  
Florida Department of Insurance  
200 East Gaines Street  
Tallahassee, FL 32399 0300  
(850) 413-3132**

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**SCHEDULE OF BENEFITS  
OUTLINE OF COVERAGE**

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

Benefit Class

Class Description

Class 1

All Eligible Employees

**EYE CARE EXPENSE BENEFITS**

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

Deductible Amount:

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

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

## DEFINITIONS

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

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

**INSURED** refers to a person:

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

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

**DEPENDENT** refers to:

- a. an Insured's spouse.
- b. each unmarried child through the end of the calendar year in which they turn age 25, for whom the Insured or the Insured's spouse, is legally responsible, including:
  - i. natural born children;
  - ii. any child placed with the Insured for adoption, a foster child or other child in court-ordered custody, placed pursuant to Chapter 63 of Florida Code.
  - iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

The child must be dependent upon the certificateholder for support and either living in the household of the certificateholder or is a full or part-time student.

- c. each child age 25 or older who:
  - i. is Totally Disabled due to mental or physical reasons; and
  - ii. 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.

**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 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 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. Coverage for a newborn child of a covered dependent other than a spouse will stop on the date the child attains eighteen months of age.

An adopted child, foster child and other child in court-ordered custody placed pursuant to Chapter 63 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 child shall consist of coverage for all covered Eye Care expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, including the necessary care or treatment of congenital defects, birth abnormalities, including premature birth.

The Insured may give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. If timely notice is given, we will not charge an additional premium for the 31-day notice period. If timely notice is not given, we will charge the applicable additional premium from the date of birth or placement for an adopted child. We will not deny coverage for a child due to the failure of the Insured to notify us within 60 days of the child's birth or placement.

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 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 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 Policyholder'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 the Policyholder's next 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 October 1.

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

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

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the eligibility period of 30 calendar day(s) of continuous active employment.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

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

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

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

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

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

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

- i. 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
- ii. 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 **earliest of:**

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

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

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

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. For those Dependents whose coverage terminates because they no longer meet the definition of a Dependent as a result of a limiting age (See "Definitions"), insurance will continue in force throughout the remainder of that year but will automatically terminate December 31 of the year following the attainment of that limiting age.

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

## EYE CARE EXPENSE BENEFITS

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

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

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

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

**DEDUCTIBLE AMOUNT.** The Deductible Amount shown in the Schedule of Benefits is an amount of Covered Expenses for which no benefits are payable. It applies separately to the Covered Expenses incurred by each Insured. Benefits will be paid only for those Covered Expenses that are over the deductible amount.

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

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

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

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

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

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

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

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

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

Such payment is limited to once in any 12 month period and is in lieu of lens and frame benefits under this policy.

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

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

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

## SCHEDULE OF EYE CARE SERVICES

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

<i>SERVICE</i>	<i>MAXIMUM COVERED EXPENSE</i>	
	<i>Participating Provider</i>	<i>Non-Participating Provider</i>
Eye Examination	Covered in Full	Up to \$ 52.00
<i>(All lenses are per pair)</i>		
Single Vision Lenses	Covered In Full	Up to \$ 55.00
Lined Bifocal Lenses	Covered In Full	Up to \$ 75.00
Lined Trifocal Lenses	Covered In Full	Up to \$ 95.00
Lenticular Lenses	Covered In Full	Up to \$125.00
Frame	Up to \$120.00	Up to \$ 45.00
Contact Lenses (Medically Necessary)	Covered In Full	Up to \$210.00
Contact Lenses (Elective)	Up to \$120.00	Up to \$105.00

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

## GENERAL PROVISIONS

**NOTICE OF CLAIM.** Written notice of a claim must be given to us within 30 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 30 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

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

**PROOF OF LOSS.** Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90-day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible.

**TIME OF PAYMENT.** We will pay all benefits within 45 days of when we receive due proof.

If benefits are contested or denied, we will notify the Insured, in writing, which benefits are contested or denied within 45 days of when we received due proof. We will pay or deny any balance remaining on benefits for a claim within 60 days upon receipt of any additional information requested from the Insured. In no event will we hold a claim without paying or denying benefits any later than 120 days.

Payment is considered to be made on the date a draft or other valid instrument is placed in the United States mail in a properly addressed post paid envelope or, if not so posted, on the date of delivery.

We will pay interest at the rate of 10 percent per year on overdue payments on benefits for valid claims.

We will investigate any claim of improper billing of a claim by a Provider upon written notification by an Insured. We will determine if the Insured was properly billed for only those procedures that the Insured actually received. If we determine that the Insured was improperly billed, we will notify the Insured and the provider of our findings and will reduce the amount of payment by the amount determined to be improperly billed. If a reduction is made due to such notification by the Insured, we will pay the Insured 20 percent of the reduction up to \$500.

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

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

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

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

**LEGAL PROCEEDINGS.** No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than the applicable statute of limitations 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 First Ameritas Life Insurance Corp. of New York, are required by federal law to maintain the privacy of your protected health information and to provide notice of the legal duties and privacy practices with respect to your protected health information. This Notice fulfills the "Notice" requirements of the Final Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you have any questions about any part of this Notice of Protected Health Information Privacy Practices or desire to have further information concerning the information practices at the UNIFI Companies, please direct your inquiries to: The Privacy Office, Attn. HIPAA Privacy, P.O. Box 81889, Lincoln, NE 68501-1889, or e-mail us at [privacy@ameritas.com](mailto:privacy@ameritas.com).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## **AUTHORIZED USES AND DISCLOSURES**

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Individual Rights Contact**

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

### **Effective Date**

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