



## Notice of Grievance Procedures

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

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

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

In Writing:	Nebraska Department of Insurance Terminal Building, Suite 220 941 "O" Street Lincoln, NE 68508
By Phone	402-471-2201 or 877-564-7323 - Consumer Affairs Hotline

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

#### I. Definitions

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

“Covered Person” means the policyholder, enrollee, claimant or a designated representative.

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

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

## **II. Our Internal Review**

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

If a decision cannot be made within 15 working days due to circumstances beyond our control, we may take up to an additional 15 working days. We will provide written notice to the Covered Person of the extension and the reasons for the delay on or before the fifteenth working day after receiving a grievance.

The time requirement for us to reach a decision for a standard review of an adverse determination is 15 working days.

### **A. Our Written Decision**

We will include the following information in our written decision:

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

### **B. Urgent Matters**

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

## Nebraska - IMPORTANT INFORMATION

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

### **Your Rights**

- You have the right to receive considerate and respectful care, with recognition of your personal dignity regardless of race, color, religion, sex, age, physical or mental handicap or national origin.
- You have the right to participate with your network provider in decision-making regarding your eye care.
- You have the right to know your costs in advance for routine and emergency care.
- You have the right to tell us when something goes wrong.
- Start with your provider. He/she is your primary contact.

If you have a problem that cannot be resolved with your provider, call our eyecare claims department for assistance at 866-289-0614.

You have the right to know about your PPO plan, covered services, network providers and your rights and responsibilities. This includes:

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

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

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

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

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

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

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

### **Your Responsibilities**

Read the details of your Certificate.

Provide information to your provider that he/she needs to know to provide appropriate care.

Feel free to call us to address any concerns you may have.

Let your provider know whether you understand the treatment plan he/she recommends and follow the treatment plan and instructions for care

Pay any coinsurance due as soon as possible for the care received so your provider can continue to serve you.

Be considerate of the rights of other patients and the provider office personnel.

Keep appointments or cancel in time for another patient to be seen in your place.

## **OUR PRACTICES**

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

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

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

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

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

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

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

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

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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.

<u>Benefit Class</u>	<u>Class Description</u>
Class 11	Eligible Full Time Employee Electing Vision

**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	\$10
Frames	\$0
Lenses - Each Benefit Period	\$25

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.***

## 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 and married child less than 26 years of age, for whom the Insured, the Insured's spouse is legally responsible, including natural born children, adopted children from the date of placement for adoption, and children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws. 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 age 26 or older who is Totally Disabled and becomes Totally Disabled as defined below 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.

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

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

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

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

**PARTICIPATING AND NON-PARTICIPATING PROVIDERS.** A Participating Provider is a Provider who has a contract with Us to provide services to Insureds at a discount. A Participating Provider is also referred to as a "Network Provider". The terms and conditions of the agreement with our network providers are available upon request. Members are required to pay the difference between the plan payment and the Participating Provider's



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

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

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

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

**CONDITIONS FOR INSURANCE COVERAGE**  
*ELIGIBILITY*

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

If employment is the basis for membership, a member of the Eligible Class for Insurance is any eligible full time employee electing vision working at least 20 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.

Substitutes And Seasonal Employees are excluded from the Eligible Class for Insurance.

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

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

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2<sup>nd</sup> birthday. The child may be added at birth or within 31 days of the 2<sup>nd</sup> birthday.

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

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any eligible full time employee electing vision working at least 20 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.

Substitutes And Seasonal Employees are excluded from the Eligible Class for Dependent Insurance.

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 on the first of the month falling on or first following the date of employment.

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

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

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

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

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

### ***TERMINATION DATES***

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

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

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

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

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

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

## **EYE CARE EXPENSE BENEFITS**

If an Insured has Covered Expenses under this section, we pay benefits as described. The Insured 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.

### **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, we pay benefits to the Insured.

### **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.

## LIMITATIONS

This plan has the following limitations.

- 1) This plan does not cover more than one Eye Exam in any 12-month period.
- 2) This plan does not cover more than one pair of ophthalmic Lenses in any 12-month period.
- 3) This plan does not cover more than one set of Frames in any 24-month period.
- 4) This plan does not cover Elective Contact Lenses more than once in any 12-month 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 in any 12-month 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 spherical equivalent.
- 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

## SCHEDULE OF EYE CARE SERVICES

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

<b>SERVICE</b>	<b>PLAN MAXIMUM COVERED EXPENSE</b>	
	<i>Participating Provider</i>	<i>Non-Participating Provider</i>
Eye Exam	Covered in Full	Up to \$ 35.00
<i>(All lenses are per pair)</i>		
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

\*The contact lenses allowance applies to the contact lens exam and lenses.

## GENERAL PROVISIONS

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

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

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

**PROOF OF LOSS.** Written proof of loss must be given to us within 12 months after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 12 month period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible. For Eye Care benefits that use either the EyeMed or VSP network, please refer to the limitations section on the Eye Care Expense Benefits page.

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

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

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

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

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

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

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

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

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



**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](http://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](mailto: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/](http://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.