This Certificate of Coverage (“Certificate”) explains the benefits available to You under a Policy between Ameritas Life Insurance Corp. of New York (hereinafter referred to as “We”, “Us”, or “Our”) and the Policyholder. This Certificate is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

This Certificate offers You the option to receive Covered Services on two benefit levels:

1. **In-Network Benefits.** In-network benefits are the highest level of coverage available. In-network benefits apply when Your care is provided by Participating Providers. You should always consider receiving dental care services first through the in-network benefits portion of this Certificate.

2. **Out-of-Network Benefits.** The out-of-network benefits portion of this Certificate provides coverage when You receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider’s charge. Some Covered services, such as Orthodontics are only Covered when received from Participating Providers and are not Covered as out-of-network benefits. See the Schedule of Benefits section of this Certificate for more information.

**READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE POLICY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.**

You have the right to return this Certificate. Examine it carefully. If you are not satisfied, You may return this Certificate to Us and ask Us to cancel it. Your request must be made in writing within ten (10) days from the date You received this Certificate. We will refund any Premium paid including any Certificate fees or other charges.

This Certificate is governed by the laws of New York State.

**The insurance evidenced by this Certificate provides Eye Care insurance ONLY.**

William W Lester, President
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SECTION I

Definitions

Defined terms will appear capitalized throughout the Certificate.

**Acute:** The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

**Allowed Amount:** The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how the Allowed Amount is calculated. If your Non-Participating Provider charges more than the Allowed Amount, You will have to pay the difference between the Allowed Amount and the Provider’s charge, in addition to any Cost-Sharing requirements.

**Appeal:** A request for Us to review a Utilization Review decision or a Grievance again.

**Balance Billing:** When a Non-Participating Provider bills You for the difference between the Non-Participating Provider’s charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

**Certificate:** This Certificate issued by Ameritas Life Insurance Corp. of New York, including the Schedule of Benefits and any attached riders.

**Child, Children:** The Student's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the Who is Covered section of this Certificate.

**Coinsurance:** Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

**Copayment:** A fixed amount You pay directly to a Provider for a Covered Service when you receive the service. The amount can vary by the type of Covered Service.

**Cost-Sharing:** Amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

**Cover, Covered or Covered Services:** The services paid for, arranged or authorized for You by Us under the terms and conditions of this Certificate.

**Deductible:** The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service that You owe before We begin to pay for a particular Covered Service.

**Dependents:** The Student's Spouse and Children.

**Emergency Dental Care:** Emergency dental treatment required to alleviate pain and suffering caused by dental disease or trauma.

**Exclusions:** Services that We do not pay for or Cover.

**External Appeal Agent:** An entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

**General Dentist:** A dentist licensed under Title 8 of the New York State Education Law (or comparable state law, if applicable) who is not a Specialist.
Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

Hospital: A short term, acute, general Hospital, which:
- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care. Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

In-Network Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the Covered Service that You are required to pay to a Participating Provider. The amount can vary by the type of Covered Service.

In-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Participating Providers. The In-Network Deductible applies before any Copayments or Coinsurance are applied. The In-Network Deductible may not apply to all Covered Services. You may also have an In-Network Deductible that applies to a specific Covered Service that You owe before We begin to pay for a particular Covered Service.

Maximum Amount: The maximum amount payable for each covered person per Plan Year. The Maximum Amount is shown on the Schedule of Benefits.

Medically Necessary: See the How Your Coverage Works section of this Certificate for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Student or a covered Dependent for whom required Premiums have been paid. Whenever a Member is required to provide a notice, “Member” also means the Member’s designee.

Non-Participating Provider: A Provider who doesn’t have a contract with Us to provide services to You. You will pay more to see a Non-Participating Provider.

Out-of-Network Coinsurance: Your share of the costs of a Covered Service calculated as a percent of the Allowed Amount for the service that You are required to pay to a Non-Participating Provider. The amount can vary by the type of Covered Service.

Out-of-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Non-Participating Providers. The Out-of-Network Deductible applies before any Copayments or Coinsurance are applied. The Out-of-Network Deductible may not apply to all Covered Services. You may also have an Out-of-Network Deductible that applies to a specific Covered Service that You owe before We begin to pay for a particular Covered Service.

Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of dental care services We do not Cover.
**Participating Provider:** A Provider who has a contract with Us to provide services to You. A list of Participating Providers and their locations is available on Our website at www.ameritas.com or upon Your request to Us. The list will be revised from time to time by Us.

**Physician or Physician Services:** Health care services a licensed medical Physician (M.D.-Medical Doctor or D.O.-Doctor of Osteopathic Medicine) provides or coordinates.

**Plan Year:** A calendar year ending on December 31 of each year.

**Policyholder:** The institution of higher education that has entered into an agreement with Us.

**Preauthorization:** A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, or device that the Covered Service, procedure, treatment plan, or device is Medically Necessary. We indicate which Covered Services require preauthorization in the Schedule of Benefits section of this certificate.

**Premium:** The amount that must be paid for Your insurance coverage.

**Primary Care Dentist ("PCD"):** A participating dentist who directly provides or coordinates a range of dental services for You.

**Provider:** An appropriately licensed, registered or certified dentist, dental hygienist, or dental assistant under Title 8 of the New York State Education Law (or other comparable state law, if applicable) that the New York State Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Provider’s services must be rendered within the lawful scope of practice for that type of Provider in order to be Covered under the Certificate.

**Referral:** An authorization given to one Participating Provider from another Participating Provider (usually from a PCD to a Specialist) in order to arrange for additional care for a Member.

**Schedule of Benefits:** The section of this Certificate that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, and other limits on Covered Services.

**Service Area:** The geographical area, in which We provide coverage. Our Service Area consists of all counties within New York State.

**Specialist:** A dentist who focuses on a specific area of dentistry, including oral surgery, endodontia, periodontia, orthodontia and pediatric dentistry, or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

**Spouse:** The person to whom the Student is legally married, including a same sex Spouse. Spouse also includes a domestic partner.

**Student:** The person to whom this Certificate is issued.

**UCR (Usual, Customary and Reasonable):** The cost of a dental service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

**Us, We, Our:** Ameritas Life Insurance Corp. of New York and anyone to whom We legally delegate performance, on Our behalf, under this Certificate.

**Utilization Review:** The review to determine whether services are or were Medically Necessary or experimental or investigational (including treatment for a rare disease or a clinical trial).

**You, Your:** The Member.
SECTION II
How Your Coverage Works

A. Your Coverage under this Certificate.
Your School (referred to as the “Policyholder”) has purchased a eye care insurance Policy from Us. We will
provide the benefits described in this Certificate to covered Members of the School, that is, to students of the
School and/or their covered Dependents. However, this Certificate is not a contract between You and Us. You
should keep this Certificate with Your other important papers so that it is available for Your future reference.

B. Covered Services.
You will receive Covered Services under the terms and conditions of this Certificate only when the Covered
Service is:

- Medically Necessary;
- Provided by a Participating Provider for in network coverage;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Certificate;
- Received while Your Certificate is in force.

C. Participating Providers.
To find out if a Provider is a Participating Provider, and for details about licensure and training:

- Check Your Provider directory, available at Your request.
- Call 800-659-5556, the number on Your ID card; or.

Participating and Non-Participating Providers are available nationwide.

D. The Role of Primary Care Dentists.
This Certificate does not have a gatekeeper, usually known as a Primary Care Dentist (“PCD”).

E. Access to Providers and Changing Providers.
Sometimes Providers in Our Provider directory are not available. When making appointments with Participating Providers, call the office to make sure he or she is in the network.

To see a Provider, call his or her office and tell the Provider that You are an Ameritas Life Insurance Corp. of
New York plan Member, and explain the reason for Your visit. Have Your ID card available. The Provider’s office may ask You for Your Member ID number. When You go to the Provider’s office, bring Your ID card with You.

We Cover the services of Non-Participating Providers. However, some services are only Covered when you go
to a Participating Provider. See the Schedule of Benefits section of this Certificate for the Non-Participating Provider services that are Covered. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to in-network and out-of-network services.

G. Services Subject To Preauthorization.
Our Preauthorization is not required before You receive certain Covered Services.

H. Pre-Determination/Pre-Treatment Estimates.
We allow You to request and obtain an estimate of coverage. You or Your Provider may contact Us and request a pre-determination of benefits, also known as a pre-treatment estimate. If We determine that an alternative procedure or treatment is more appropriate than the requested service, You may appeal Our decision...
through an internal Appeal or external appeal. See the Utilization Review and External Appeal sections of this Certificate for Your right to an internal appeal and external appeal.

I. Medical Management.
The benefits available to You under this Certificate may be subject to pre-service, concurrent, and retrospective reviews to determine when services should be covered by Us. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

J. Medical Necessity.
We Cover certain benefits described in this Certificate as long as the dental service, procedure, treatment, test, device, or supply (collectively, “service”) is Medically Necessary e.g. periodontal surgery. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:
- Your dental records;
- Our dental policies and clinical guidelines;
- Dental opinions of a professional society, peer review committee or other groups of Providers;
- Reports in peer-reviewed dental literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of health care professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:
- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of dental practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

See the Utilization Review and External Appeal sections of this Certificate for Your right to an internal Appeal and external appeal of Our determination that a service is not Medically Necessary.

K. Important Telephone Numbers and Addresses.

- CLAIMS
  P.O. Box 82595
  Lincoln NE  68501-2595
  Fax: 402-467-7336
  group@ameritas.com
  (Submit claim forms to this address.)
COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
P.O. Box 82657
Lincoln NE  68501-2657
877-897-4328

CUSTOMER SERVICE
800-659-5556
Customer Service Representatives are available Monday - Thursday 7 am to Midnight and Friday 7 am to
6:30 pm Central Time.

OUR WEBSITE
www.ameritas.com
SECTION III

Access to Care and Transitional Care

A. When Your Provider Leaves the Network
If You are in an ongoing course of treatment when Your Provider leaves Our network, then You may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date Your Provider’s contractual obligation to provide services to You terminates.

In order for You to continue to receive Covered services for up to 90 days, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, Authorization, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider’s ability to practice, continued treatment with that Provider is not available.

B. New Members In a Course of Treatment
If You are in an ongoing course of treatment with a Non-Participating Provider when Your coverage under this Certificate becomes effective, You may be able to receive network level Covered Services for the ongoing treatment from the Non-Participating Provider for up to 60 days from the effective date of Your coverage under this Certificate. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease.

In order for You to continue to receive Covered services for up to 60 days the Non-Participating Provider must agree to accept as payment Our fees for such services. The provider must also agree to provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Service as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.
SECTION IV

Cost-Sharing Expenses and Allowed Amount

A. Deductible.
Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Certificate for Covered in-network and out-of-network Services during each Plan Year before We provide coverage. If You have other than individual coverage, the individual Deductible applies to each person covered under this Certificate. Cost-Sharing amounts incurred with Participating Providers and Non-Participating Providers accumulate to the Deductible.

You have a combined In-Network and Out-of-Network Deductible. Cost-Sharing for out-of-network services applies towards Your In-Network Deductible. Cost-Sharing for in-network services applies toward Your Out-of-Network Deductible. Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible.

B. Copayments.
There are no Copayments for Covered Services under this Certificate.

C. Coinsurance.
Except where stated otherwise, after You have satisfied the Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your in-network or out-of-network benefit as shown in the Schedule of Benefits section of this Certificate. You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount.

D. Out-of-Pocket Limit.
This Certificate does not have an Out-of-Pocket Limit.

E. In and Out-of-Network Annual Maximum.
This Certificate has an in and out-of-network annual maximum for non-orthodontic benefits described in the Schedule of Benefits section of this Certificate. Once You have met the in and out-of-network annual maximum for non-orthodontic Covered Services in the Schedule of Benefits section of this Certificate, no more benefits will be payable for the remainder of that Plan Year. If you have other than individual coverage, the individual in and out-of-network annual maximum applies to each person covered under this Certificate. Once a person within a family meets the individual in and out-of-network annual maximum, no more benefits will be payable for that person. If other than individual coverage applies, when persons in the same family covered under this Certificate have collectively met the family in and out-of-network annual maximum in the Schedule of Benefits section of this Certificate, no more benefits will be payable for the family for the remainder of that Plan Year.

F. Your Additional Payments for Out-of-Network Benefits.
When You receive Covered Services from a Non-Participating Provider, in addition to the applicable Copayments, Deductible and Coinsurance described in the Schedule of Benefits section of this Certificate, You must also pay the amount, if any, by which the Non-Participating Provider’s actual charge exceeds Our Allowed Amount. This means that the total of Our coverage and any amounts You pay may be less than the Non-Participating Provider’s actual charge.

When You receive Covered Services from a Non-Participating Provider, We will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services You received. Sometimes, applying these rules will change the way that We pay for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. For example,
Your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. We will make one inclusive payment in that case, rather than a separate payment for each billed code.

G. **Allowed Amount.**
“Allowed Amount” means the maximum amount We will pay for the services or supplies covered under this Certificate, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount for Non-Participating Providers will be determined as follows:

1. **For Providers, the allowed amount will be the lesser of:**

   The Provider's Charge

The Non-Participating Provider’s actual charge may exceed Our Allowed Amount. You must pay the difference between Our Allowed Amount and the Non-Participating Provider’s charge. Contact Us at 800-659-5556, the number on Your ID card, or visit Our website at www.ameritas.com for information on Your financial responsibility when You receive services from a Non-Participating Provider.
SECTION V
Who Is Covered

A. Who is Covered Under this Certificate.
You, the Student to whom this Certificate is issued, are covered under this Certificate. Members of Your family may also be covered depending upon the type of coverage You selected.

B. Types of Coverage.
We offer the following types of coverage:

1. Individual. If You selected individual coverage, then You are covered.
2. Individual and Spouse. If You selected individual and Spouse coverage, then You and Your Spouse are covered (Including same sex Spouse, as allowed by state law).
3. Individual and Child/Children. If You selected individual and child/children coverage, then You and Your Child or Children, as described below, are covered.
4. Family. If You selected family coverage, then You and Your Spouse and Your Child or Children, as described below, are covered.

C. Children Covered Under this Certificate.
If You selected individual and child/children or family coverage, Children covered under this Certificate include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child’s adoption. Coverage lasts until the end of the month in which the Child turns 19 years of age. Any unmarried Child who is a student at an accredited institution of learning is considered a Child until age 24 and coverage will last until the end of the month in which the Child turns 24 years of age. Coverage also includes Children for whom You are a legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child’s coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child’s incapacity. We have the right to check whether a Child is and continues to qualify under this section.

Coverage shall continue for a Child who is a full-time student when the Child takes a medical leave of absence from school due to illness for a period of 12 months from the last day of attendance in school. However, coverage of the Child is not provided beyond the age at which coverage would otherwise terminate. To qualify for such coverage, We may require that the leave be certified as Medically Necessary by the Child’s Physician who is licensed to practice in the state of New York.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Student and all other prospective or covered Members in relation to eligibility for coverage under this Certificate at any time.

D. Enrollment.
You can enroll under this Certificate during an enrollment period established by Your Policyholder. If you, the Student, elect coverage before becoming eligible or within 30 days of becoming eligible for other than a special
enrollment period, coverage begins on the date You become eligible or on the date determined by Your Policyholder.

If You do not enroll during the enrollment period established by Your Policyholder, or during a special enrollment period as described below, You must wait until the next annual enrollment period to enroll.

**E. Special Enrollment Periods.**
Outside of the annual enrollment period established by Your Policyholder, You can enroll for coverage within 30 days of the date the Student gains a Dependent through marriage, birth, adoption, or placement for adoption.

We must receive notice and any Premium payment within 30 days of one of these events.

If You have a newborn or adopted newborn Child and We receive notice of such birth within 30 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-b of the New York Domestic Relations Law within 30 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. If You have individual or individual and Spouse coverage You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any additional Premium within 30 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which We receive notice, provided that You pay any additional Premium when due.

In all other cases, the effective date of Your coverage will depend on when We receive Your selection. If Your selection is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month, as long as Your applicable Premium payment is received by then. If Your selection is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month, as long as Your applicable Premium payment is received by then.

**F. Domestic Partner Coverage.**
This Certificate covers domestic partners of Students as Spouses. If You selected family coverage, Children covered under this Certificate also includes the Children of Your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months, where such registry exists; or
2. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.
   a. The affidavit must be notarized and must contain the following:
      • The partners are both 18 years of age or older and are mentally competent to consent to contract;
      • The partners are not related by blood in a manner that would bar marriage under laws of the State of New York;
      • The partners have been living together on a continuous basis prior to the date of the application;
      • Neither individual has been registered as a member of another domestic partnership within the last six (6) months; and
   b. Proof of cohabitation (e.g., a driver’s license, tax return or other sufficient proof); and
   c. Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
      • A joint bank account;
      • A joint credit card or charge card;
      • Joint obligation on a loan;
      • Status as an authorized signatory on the partner’s bank account, credit card or charge card;
• Joint ownership of holdings or investments;
• Joint ownership of residence;
• Joint ownership of real estate other than residence;
• Listing of both partners as tenants on the lease of the shared residence;
• Shared rental payments of residence (need not be shared 50/50);
• Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
• A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
• Shared household budget for purposes of receiving government benefits;
• Status of one (1) as representative payee for the other’s government benefits;
• Joint ownership of major items of personal property (e.g., appliances, furniture);
• Joint ownership of a motor vehicle;
• Joint responsibility for child care (e.g., school documents, guardianship);
• Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
• Execution of wills naming each other as executor and/or beneficiary;
• Designation as beneficiary under the other’s life insurance policy;
• Designation as beneficiary under the other’s retirement benefits account;
• Mutual grant of durable power of attorney;
• Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
• Affidavit by creditor or other individual able to testify to partners’ financial interdependence; or
• Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.
SECTION VI

Dental Care

Please refer to the Schedule of Benefits/Table of Dental Procedures section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

We Cover the following dental care services:

A. Emergency Dental Care. We Cover Emergency Dental Care as outlined in the Schedule of Benefits/Table of Dental Procedures section of this certificate.

B. Preventive Dental Care. We Cover Preventive Dental Care as outlined in the Schedule of Benefits/Table of Dental Procedures section of this certificate.

C. Routine Dental Care. We Cover Routine Dental Care as outlined in the Schedule of Benefits/Table of Dental Procedures section of this certificate.

D. Endodontics. We Cover Endodontic services as outlined in the Schedule of Benefits/Table of Dental Procedures section of this certificate.

E. Periodontics. We Cover Periodontic services as outlined in the Schedule of Benefits/Table of Dental Procedures section of this certificate.

F. Prosthodontics. We Cover Prosthodontic services as outlined in the Schedule of Benefits/Table of Dental Procedures section of this certificate.

G. Oral Surgery. We Cover Oral Surgery as outlined in the Schedule of Benefits/Table of Dental Procedures section of this certificate.
SECTION VII

Exclusions and Limitations

No coverage is available under this Certificate for the following:

A. Aviation.
We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Convalescent and Custodial Care.
We do not Cover services related to rest cures, custodial care or transportation. “Custodial care” means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

C. Cosmetic Services.
We do not Cover cosmetic services or surgery unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeals sections of this Certificate unless medical information is submitted.

D. Experimental or Investigational Treatment.
We do not Cover any health care service, procedure, treatment, or device that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under the Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

E. Felony Participation.
We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection.

F. Foot Care.
We do not Cover foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.

G. Government Facility.
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

H. Medical Services.
We do not Cover medical services or dental services that are medical in nature, including any Hospital charges or prescription drug charges.

I. Medically Necessary.
In general, we do not cover any dental service, procedure, treatment, test or device that we determine is not medically necessary. If an external appeal agent certified by the state overturns our denial, however, we will cover the service, procedure, treatment, test or device for which coverage has been denied, to the extent that such service, procedure, treatment, test or device, is otherwise covered under the terms of this certificate.

**J. Medicare or Other Governmental Program.**
We do not cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

**K. Military Service.**
We do not cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

**L. No-Fault Automobile Insurance.**
We do not cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if you do not make a proper or timely claim for the benefits available to you under a mandatory no-fault policy.

**M. Pre-Existing Conditions.**
For a period of 12 months from the enrollment date, we do not cover any conditions for which medical advice was given, treatment was recommended by or received from a physician within six (6) months before the effective date of your coverage. The 12-month exclusionary period may be shortened by crediting the time you were covered under creditable coverage. We will credit the time you were covered under another dental plan, if you were enrolled in the prior coverage within 63 days before enrolling in this certificate. We will not treat genetic information as a pre-existing condition in the absence of a diagnosis of the condition related to such information.

**N. Services Not Listed.**
We do not cover services that are not listed in this certificate as being covered.

**O. Services Provided by a Family Member.**
We do not cover services performed by a member of the covered person’s immediate family. “Immediate family” shall mean a child, spouse, mother, father, sister, or brother of you or your spouse.

**P. Services Separately Billed by Hospital Employees.**
We do not cover services rendered and separately billed by employees of hospitals, laboratories or other institutions.

**Q. Services with No Charge.**
We do not cover services for which no charge is normally made.

**R. War.**
We do not cover an illness, treatment or medical condition due to war, declared or undeclared.

**S. Workers’ Compensation.**
We do not cover services if benefits for such services are provided under any state or federal workers’ compensation, employers’ liability or occupational disease law.
SECTION VIII

Claim Determinations

A. Claims.
A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us. See the Coordination of Benefits section of this Certificate for information on how We coordinate benefit payments when You also have group health coverage with another plan.

B. Notice of Claim.
Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling 800-659-5556; the number on your ID card or visiting Our website at www.ameritas.com.

Completed claim forms should be sent to the address in the How Your Coverage Works section of this Certificate or to the address on Your ID card. You may also submit a claim to Us electronically by using the instructions in the How Your Coverage Works section of this Certificate or the instructions on Your ID card or by visiting Our website www.ameritas.com.

C. Timeframe for Filing Claims.
Claims for services must be submitted to Us for payment within 120 days; after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120 days, You must submit it as soon as reasonably possible.

D. Claims for Prohibited Referrals.
We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a(1) of the New York Public Health Law.

E. Claim Determinations.
Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our Claim determination procedure applies to contractual benefit denials. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Certificate.

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Certificate.

F. Pre-service Claim Determinations.
1. A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.
If we need additional information, we will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If we receive the information within 45 days, we will make a determination and provide notice to you (or your designee) in writing, within 15 days of our receipt of the information. If all necessary information is not received within 45 days, we will make a determination within 15 calendar days of the end of the 45-day period.

2. Urgent Pre-service Reviews. With respect to urgent pre-service requests, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If we need additional information, we will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to you (or your designee) by telephone within 48 hours of the earlier of our receipt of the information or the end of the 48-hour period. Written notice will follow within three (3) calendar days of the decision.

G. Post-service Claim Determinations.
A post-service claim is a request for a benefit for a service or treatment that you have already received. If we have all information necessary to make a determination regarding a post-service claim, we will make a determination and notify you (or your designee) within 30 calendar days of the receipt of the claim. If we need additional information, we will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to you (or your designee) in writing within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day period.
SECTION IX
New York
Grievance Procedures

A. Grievances.
Our Grievance procedure applies to any issue not relating to a medical necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to Providers.

B. Filing a Grievance.
You can contact Us by phone at 877-897-4328 or the number on Your ID card, in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of benefits for urgent care. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

C. Grievance Determination.
Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered health care professional will look into it. We will decide the Grievance and notify You in writing within the following timeframes:

<table>
<thead>
<tr>
<th>Grievance Type</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expedited/Urgent Grievances:</td>
<td>By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.</td>
</tr>
<tr>
<td>Pre-Service Grievances:</td>
<td>In writing, within 15 calendar days of receipt of Your Grievance.</td>
</tr>
<tr>
<td>(A request for a service or a treatment that has not yet been provided.)</td>
<td></td>
</tr>
<tr>
<td>Post-Service Grievances:</td>
<td>In writing, within 30 calendar days of receipt of Your Grievance.</td>
</tr>
<tr>
<td>(A claim for a service or a treatment that has already been provided.)</td>
<td></td>
</tr>
<tr>
<td>All other Grievances</td>
<td>45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of Your Grievance.</td>
</tr>
<tr>
<td>(That are not in relation to a claim or request for a service or treatment.)</td>
<td></td>
</tr>
</tbody>
</table>

D. Grievance Appeals.
If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at 877-897-4328 or the number on Your ID card, in person, or in writing. You have up to 60 business days from receipt of the Grievance information to file an Appeal.

When We receive Your Appeal, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:
Expedited/Urgent Grievances: The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.

Pre-Service Grievances: 15 calendar days of receipt of Your Appeal.
(A request for a service or a treatment that has not yet been provided.)

Post-Service Grievances: 30 calendar days of receipt of Your Appeal.
(A claim for a service or a treatment that has already been provided.)

All other Grievances 30 calendar days of receipt of Your Appeal.
(That are not in relation to a claim or request for a service or treatment.)

E. Assistance.
If You remain dissatisfied with Our Appeal determination, or at any other time You are dissatisfied, You may:

Call the New York State Department of Financial Services at
1-800-342-3736 or write them at:
New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
www.dfs.ny.gov

If You need assistance filing a Grievance or Appeal, You may also contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400; or e-mail cha@cssny.org
www.communityhealthadvocates.org
SECTION X
Utilization Review

A. Utilization Review.
We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call 877-897-4328 or the number on your ID card. The toll-free number is available at least 40 hours a week with an after hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, call 877-897-4328 or visit Our website at www.ameritas.com

B. Preauthorization Reviews
We do not require Preauthorization Reviews under this Policy. If we do in the future:

1. Non-Urgent Preauthorization Reviews. If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

   If We need additional information, We will request it within three (3) business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

2. Urgent Preauthorization Reviews. With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone and in writing within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period.

C. Concurrent Reviews.

1. Non-Urgent Concurrent Reviews. Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee), by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee), by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within 15 calendar days of the end of the 45-day period.
2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) within the earlier of 72 hours or of one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if We do not receive the information, within 48 hours of the end of the 48-hour period.

D. **Retrospective Reviews.**

If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period.

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

E. **Retrospective Review of Preauthorized Services.**

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

F. **Reconsideration.**

If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization benefit estimates the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

G. **Utilization Review Internal Appeals.**

You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment

NY Grievance Rev. 11-17 C/B
will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform
You of any additional information needed before a decision can be made. If only a portion of the additional
information is received, We will request the missing information, in writing, within five business days of receipt
of the partial information. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the
clinical peer reviewer who made the initial adverse determination and who is (1) a Physician or (2) a health care
professional in the same or similar specialty as the Provider who typically manages the disease or condition at
issue.

H. Standard Appeal.
Preauthorization Appeal. If Your Appeal relates to a Preauthorization request, We will decide the Appeal
within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to
You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the
determination is made, but no later than 30 calendar days after receipt of the Appeal request.

Retrospective Appeal. If Your Appeal relates to a retrospective claim, We will decide the Appeal within 60
calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or
Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is
made, but no later than 60 calendar days after receipt of the Appeal request.

Expedited Appeal. An Appeal of a review of continued or extended health care services, additional services
rendered in the course of continued treatment, home health care services following discharge from an inpatient
Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be
handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited
Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one
(1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange
information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt
of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal.

If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal appeal or
an external appeal.

Our failure to render a determination of Your Appeal within 60 calendar days of receipt of the necessary
information for a standard Appeal or within two (2) business days of receipt of the necessary information for an
expedited Appeal will be deemed a reversal of the initial adverse determination.

I. Appeal Assistance.
If You need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or email cha@cssny.org
www.communityhealthadvocates.org
SECTION XI

External Appeal

A. Your Right to an External Appeal.

In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two (2) requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under this Policy; and
- In general, You must have received a final adverse determination through Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through Our internal Appeal process if:
  - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
  - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
  - We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

B. Your Right to Appeal A Determination that A Service Is Not Medically Necessary.

If We have denied coverage on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph “A” above.

C. Your Right to Appeal A Determination that A Service is Experimental or Investigational.

If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph “A” above and Your attending Physician must certify that Your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; or
2. There does not exist a more beneficial standard service or procedure covered by Us; or
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one (1) of the following:

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation. Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.
D. The External Appeal Process.

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited external appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment, We will provide coverage subject to the other terms and conditions of this Policy. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the cost of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be Covered under this Policy for non-investigational treatments provided in the clinical trial.

The External Appeal Agent’s decision is binding on both You and Us. The External Appeal Agent’s decision is admissible in any court proceeding.

We may charge You a fee of $25 for each external appeal, not to exceed $75 in a single Plan Year. The external appeal application will explain how to submit the fee. We will waive the fee if We determine that paying the fee would be a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to You.
E. Your Responsibilities.

It is Your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.
SECTION XII

Coordination of Benefits

This section applies when You also have group dental coverage with another plan. When You receive a Covered Service, We will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

A. Definitions.

1. “Allowable expense” is the necessary, reasonable, and customary item of expense for eye care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

2. “Plan” is other group dental coverage with which We will coordinate benefits. The term “plan” includes:
   - Group eye care benefits and blanket or group remittance eye care benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
   - Eye care benefits coverage, in group and individual automobile “no-fault” and traditional liability “fault” type contracts.
   - Eye care benefits coverage of a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

3. “Primary plan” is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

4. “Secondary plan” is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

B. Rules to Determine Order of Payment.

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.

2. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.

3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

4. If a child is covered by both parents’ plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child’s dental care expenses:
• The plan of the parent who has custody will be primary;
• If the parent with custody has remarried, and the child is also covered as a child under the step-parent’s plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third; and
• If a court decree between the parents says which parent is responsible for the child’s eye care expenses, then that parent’s plan will be primary if that plan has actual knowledge of the decree.

5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

C. Effects of Coordination.
When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

D. Right to Receive and Release Necessary Information.
We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give Us any needed information for coordination purposes, in the time frame requested.

E. Our Right to Recover Overpayment.
If We made a payment as a primary plan, You agree to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help Us recover any overpayment.

F. Coordination with “Always Excess,” “Always Secondary,” or “Non-Complying” Plans.
We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

1. If this Certificate is primary, as defined in this section, We will pay benefits first.

2. If this Certificate is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer.

3. If We request information from a non-complying plan and do not receive it within 30 days, We will calculate the amount We should pay on the assumption that the non-complying plan and this Certificate provide identical benefits. When the information is received, We will make any necessary adjustments.
SECTION XIII

Termination of Coverage

Coverage under this Certificate will automatically be terminated on the first of the following to apply:

1. The Policyholder, and/or Student, has failed to pay Premiums within 30 days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.

2. The date on which the Student ceases to meet the eligibility requirements as defined by the Policyholder.

3. Upon the Student's death, coverage will terminate unless the Student has coverage for Dependents. If the Student has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium has been paid.

4. For Spouses in cases of divorce, the date of the divorce.

5. For Children, until the end of the month in which the Child turns 19 years of age. For a Child who is a student at an accredited institution of learning, until the end of the month in which the Child turns 24 years of age.

6. For all other Dependents, the date in which the Dependent ceases to be eligible.

7. The end of the month during which the Policyholder Student provides written notice to Us; requesting termination of coverage, or on such later date requested for such termination by the notice.

8. If the Student has performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing on his/her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us; to the Student. However, if the Student makes an intentional misrepresentation of material fact in writing on his or her enrollment application We will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to one year; Your enrollment under the Certificate.

9. The date that the Policyholder's Policy is terminated. If We terminate and/or decide to stop offering a particular class of policies, without regard to claims experience or health related status, to which this Certificate belongs, We will provide the Policyholder and Students at least 30 days prior written notice.

10. If We elect to terminate or cease offering student accident and health insurance coverage in this state. We will provide written notice to the Policyholder and Student at least 180 days prior to when the coverage will cease.

11. The Policyholder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

12. The Policyholder has failed to comply with a material plan provision relating to participation rules. We will provide written notice to the Policyholder and Student at least 30 days prior to when the coverage will cease.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.
SECTION XIV

Extension of Benefits

Upon termination of insurance, whether due to termination of eligibility, or termination of the Certificate, an extension of benefits shall be provided for a period of no less than 30 days for completion of a dental procedure that was started before Your coverage ended.
SECTION XV
Temporary Suspension Rights for Armed Forces' Members

If You, the Student, are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government, and
2. Your service ends during the Plan Year for which this Certificate is effective.

You must make a written request to Us to have Your coverage suspended during a period of active duty. Your unearned Premium will be refunded during the period of such suspension.

Upon completion of active duty, Your coverage may be resumed as long as You:

1. Make written application to Us; and
2. Remit the Premium within 60 days of the termination of active duty.

The right of resumption extends to coverage of Your Dependents. For coverage that was suspended while on active duty, coverage will be retroactive to the date on which active duty terminated.
SECTION XVI
General Provisions

1. Agreements between Us and Participating Providers.
Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Certificate does not require any Provider to accept a Member as a patient. We do not guarantee a Member’s admission to any Participating Provider or any dental benefits program.

2. Assignment.
You cannot assign any benefits or monies due under this Certificate to any person, corporation, or other organization. Any assignment of benefits by You will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Certificate or Your right to collect money from Us for those services. However, You may request Us to make payment for services directly to Your Provider instead of You.

3. Choice of Law.
This Certificate shall be governed by the laws of the State of New York.

Clerical error, whether by the Policyholder or Us, with respect to this Certificate, or any other documentation issued by Us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

5. Conformity with Law.
Any term of this Certificate which is in conflict with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

6. Continuation of Benefit Limitations.
Some of the benefits in this Certificate may be limited to a specific number of visits, a benefit maximum, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Subscriber.

7. Entire Agreement.
This Certificate, including any endorsements, riders and the attached applications, if any, constitutes the entire Certificate.

8. Fraud and Abusive Billing.
We have processes to review claims before and after payment to detect fraud and abusive billing. Members seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

9. Furnishing Information and Audit.
All persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with certain information over the telephone for reasons such as the following: to determine the level of care You need; so that We may certify care authorized by Your Provider, or make decisions regarding the Medical Necessity of Your
care. The Policyholder will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to enrollment at the Policyholder's New York office.

10. Identification Cards.
Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits, Your Premiums must be paid in full at the time that the services are sought to be received.

11. Incontestability.
No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be deemed representations and not warranties.

12. Independent Contractors.
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. Participating Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Participating Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You, Your covered Spouse or Children while receiving care from any Participating Provider or in any Participating Provider's facility.

We will give the Policyholder, and the Policyholder will give You; ID cards, Certificates riders and other necessary materials.

You can request additional information about Your coverage under this Certificate. Upon Your request, We will provide the following information.

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.
- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- A copy of Our clinical review criteria, and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or utilization review guidelines.
- Written application procedures and minimum qualification requirements for Providers.

15. Notice.
Any notice that We give You under this Certificate will be mailed to Your address as it appears in Our records or to the address of the Policyholder. You agree to provide your Policyholder and Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. Mail, first class, postage prepaid to: Ameritas Life Insurance Corp. of New York
P.O. Box 82595
Lincoln NE 68501-2595

We will give any refund of Premiums, if due, to the Policyholder.
On occasion a payment will be made to You when You are not Covered, for a service that is not covered, or which is more than is proper. When this happens We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

18. Reinstatement after Default.
If the Student defaults in making any payment under this Policy, the subsequent acceptance of payment by Us or by one of Our authorized agents or brokers shall reinstate the Policy, but with respect to sickness and injury, only to Cover such sickness as may be first manifested more than 10 days after the date of such acceptance.

We may develop or adopt standards that describe in more detail when We will or will not make payments under this Certificate. Those standards will not be contrary to the descriptions in this Certificate. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Certificate.

20. Right to Offset.
If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

The unenforceability or invalidity of any provision of this Certificate shall not affect the validity and enforceability of the remainder of this Certificate.

22. Significant Change in Circumstances.
If We are unable to arrange for Covered Services as provided under this Certificate as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

23. Third Party Beneficiaries.
No third party beneficiaries are intended to be created by this Certificate and nothing in the Certificate shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Certificate. No other party can enforce this Certificate’s provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Certificate, or to bring an action or pursuit for the breach of any terms of this Certificate.

24. Time to Sue.
No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within 2 years from the date the claim was required to be filed.

25. Translation Services.
Translation services are available under this Certificate for non-English speaking Members. Please contact Us at 800-659-5556, the number on Your ID card, to access these services.

Translation services are available under this Certificate for non-English speaking Members. Please contact Us at 800-659-5556, the number on Your ID card, to access these services.
26. **Waiver.**
The waiver by any party of any breach of any provision of this Certificate will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

27. **Who May Change this Certificate.**
This Certificate may not be modified, amended, or changed, except in writing and signed by Our President or a person designated by the President. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Certificate in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the President or person designated by the President.

28. **Who Receives Payment under this Certificate.**
Payments under this Certificate for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You, the Subscriber or the Provider unless an assignment has been made.

29. **Workers’ Compensation Not Affected.**
The coverage provided under this Certificate is not in lieu of and does not affect any requirements for coverage by workers’ compensation insurance or law.

30. **Your Records and Reports.**
In order to provide Your coverage under this Certificate, it may be necessary for Us to obtain Your records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals, or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Certificate, You automatically give Us or Our designee permission to obtain and use Your records for those purposes and You authorize each and every Provider who renders services to You to:
- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a professional that We may engage to assist Us in reviewing a treatment or claim; and
- Permit copying of Your records by Us.

We agree to maintain Your information in accordance with state and federal confidentiality requirements. However, You automatically give Us permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Certificate, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.
SECTION XVI
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.

<table>
<thead>
<tr>
<th>Benefit Class</th>
<th>Class Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 2</td>
<td>All Eligible Students</td>
</tr>
</tbody>
</table>

**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 $10

*Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.*
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 12-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 covers claims for services submitted for payment within 120 days after the service is received. If it is not reasonably possible to submit a claim within the 120 days, it must be submitted as soon as reasonably possible.
### SCHEDULE OF EYE CARE SERVICES

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

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>PLAN MAXIMUM COVERED EXPENSE</th>
<th>Participating Provider</th>
<th>Non-Participating Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Exam</td>
<td>Covered in Full</td>
<td>Up to $35.00</td>
<td></td>
</tr>
<tr>
<td><em>(All lenses are per pair)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision Lenses</td>
<td>Covered in Full</td>
<td>Up to $25.00</td>
<td></td>
</tr>
<tr>
<td>Lined Bifocal Lenses</td>
<td>Covered in Full</td>
<td>Up to $40.00</td>
<td></td>
</tr>
<tr>
<td>Lined Trifocal Lenses</td>
<td>Covered in Full</td>
<td>Up to $55.00</td>
<td></td>
</tr>
<tr>
<td>Frame</td>
<td>Up to $100.00</td>
<td>Up to $45.00</td>
<td></td>
</tr>
<tr>
<td>Contact Lenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective</td>
<td>Up to $80.00</td>
<td>Up to $64.00</td>
<td></td>
</tr>
<tr>
<td>Medically Necessary</td>
<td>Covered in Full</td>
<td>Up to $200.00</td>
<td></td>
</tr>
<tr>
<td>Contact Lens</td>
<td>Covered in Full</td>
<td>Up to $55.00</td>
<td></td>
</tr>
<tr>
<td>Standard Fit and Follow-Up</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium Fit and Follow-Up</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Lens</td>
<td>Up to $55.00</td>
<td>Up to $55.00</td>
<td></td>
</tr>
</tbody>
</table>
Section XVII
Riders

N-I Disclosure NY Rev. 02-17
THIS DISCOUNT ACCESS IS NOT INSURANCE

Non-Insurance Products/Services

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

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

If you are traveling outside the United States and require emergency care for a service that would be covered under this Policy, you may contact AXA Assistance USA, Inc. for an appointment with a qualified provider. Such services would be considered as an out-of-network claim.

Pharmacy prescriptions are subject to a discount at CVS, Walgreens, Rite Aid and Walmart pharmacies. Access your prescription discount ID card by logging into your secure member account.