A STOCK COMPANY
LINCOLN, NEBRASKA

GROUP EYE CARE INSURANCE POLICY

The Policyholder    SCOTTS BLUFF COUNTY
Policy Number       10-35391
State of Delivery   Nebraska
Plan Effective Date July 1, 2010
Plan Change Effective Date July 1, 2012
Premium Due Date 1st of each month.
Renewal Date        July 1

Ameritas Life Insurance Corp. agrees to pay, with respect to each Insured Person, the group insurance benefits provided in this policy.

This policy is issued to the Policyholder in consideration of the Policyholder's application and the payment of premiums, as provided herein.

This policy is delivered in and governed by the laws of the state of delivery.

AMERITAS LIFE INSURANCE CORP.

[Signatures]
Corporate Secretary
President
Notice of Grievance Procedures

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

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

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

In Writing: Nebraska Department of Insurance
Terminal Building, Suite 400
941 “O” Street
Lincoln, NE 68508

By phone: 402-471-2201 or
877-564-7323 - Consumer Affairs Hotline

You also have the right to ask your insurer to assist you in filing a grievance, review its decisions involving your requests for service, or your requests to have your claims paid. Additionally, upon request and free of charge you are entitled to receive reasonable access to, and copies of all documents, records and other information relevant to your claim, including the clinical basis for any adverse determinations, such as criteria, standards, or clinical indicators.

I. Definitions

“Adverse Determination” means a determination by a health carrier that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the health carrier’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested health care service is therefore denied, reduced or terminated.

“Covered Person” means the policyholder, enrollee, claimant or their representatives, provider, agent or other entity which expresses a grievance or complaint involving the activities of the company or any persons involved in the solicitation, sale, service, execution of any transaction, or disposition of any funds of the policyholder.

“Grievance” means a written complaint on behalf of an insured person submitted by an insured person or a person, including, but not limited to, a provider, authorized in writing to act on behalf of the insured person regarding:

(a) the availability, delivery, or quality of health care services, including a complaint regarding an adverse determination;

(b) claims payment, handling, or reimbursement for health care services;

(c) matters pertaining to the contractual relationship between a covered person and the insurer.

II. Levels of Review

You may ask your insurer to review its decisions involving your requests for service or your requests to have your claims paid. In general, the following levels of review will be available to you:
First Level Grievance Review - for written grievances, including those resulting from adverse determinations
Second Level Grievance Review - following first-level reviews if not resolved

A. First Level Grievance Review

A written grievance concerning any matter, including an adverse determination may be submitted by a covered person. A written decision to the covered person will be provided within 15 working days after receiving a grievance and all information necessary for the insurer’s review of the grievance. The person or persons reviewing the grievance will not be the same person or persons who made the initial determination denying a claim or handling the matter that is the subject of the grievance. If a decision cannot be made within 15 working days due to circumstances beyond the insurer’s control, the insurer may take up to an additional 15 working days to issue a written decision.

The time requirements for responding to a request for a standard review of an adverse determination is only 15 working days.

B. Second Level Grievance Review

In any case where the first level grievance review process does not resolve a difference of opinion between the insurer and the covered person, a written grievance may be submitted and the insurer will review it as a second level grievance.

A second level grievance review panel shall be established to give those covered persons who are dissatisfied with the first level grievance review decision the option to request a second level review. A majority of the panel shall be comprised of persons who were not previously involved in the grievance. A health carrier shall provide that the majority of the persons reviewing a grievance involving an adverse determination are health care professionals who have appropriate expertise.

The review panel shall schedule and hold a review meeting within forty-five working days after receiving a request from a covered person for a second-level review. In those situations where the covered person cannot appear in person, the insurer shall offer the covered person the opportunity to communicate with the review panel by conference call or other available technology.

Upon the request of a covered person, an insurer shall provide to the covered person all relevant information that is not confidential or privileged. A covered person has the right to attend the second level review, present his or her case to the review panel, submit supporting material both before and at the review meeting, ask questions of any representative and be assisted or represented by a person of his or her choice.

The review panel shall issue a written decision to the covered person within 5 business days of completing the review meeting. Upon concurrence of the covered person, a copy of the decision shall be forwarded to the insurance department.

C. Written Decision

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

1. the names, titles and qualifying credentials of the persons participating in the first level grievance review process;
2. a statement of the reviewer’s understanding of the grievance;
3. the decision stated in clear terms and the contract basis or medical rationale supporting the decision, a reference to the evidence or documentation used as a basis for the decision; and
4. for first level reviews, a description of the process to obtain a second level grievance review and the time frame for review.
5. notice of the covered person’s right to contact the Nebraska Department of Insurance.
Notice of Availability for Second Level Grievance Review

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

Correspondence concerning this claim determination should be mailed to:

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

Please read this notice carefully. This notice contains important information about how to file a second level grievance with your insurer following the first level review just completed.

You always have the right to contact the Nebraska Department of Insurance if you have a question or concern regarding your coverage under this contract. The Nebraska Department may be contacted:

In Writing: Nebraska Department of Insurance
Terminal Building, Suite 400
941 “O” Street
Lincoln, NE 68508

By Phone:
402-471-2201
877-564-7323 – Consumer Affairs Hotline

Definitions

The term “adverse determination” means a determination by a health carrier that a health care service has been reviewed and based upon the information provided, does not meet the health carrier’s requirements and the requested health care service is denied, reduced or terminated. Therefore, the term “adverse determination” refers to claims subject to consultant review.

“Covered Person” means the policyholder, enrollee, claimant or their representatives, provider, agent or other entity which expresses a grievance or complaint involving the activities of the company or any persons involved in the solicitation, sale, service, execution of any transaction, or disposition of any funds of the policyholder.

“Grievance” means a written complaint on behalf of an insured person submitted by an insured person or a person, including, but not limited to, a provider, authorized in writing to act on behalf of the insured person regarding:

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

Availability of Second Level Grievance Review

In any case where the first level grievance review process does not resolve a difference of opinion between the insurer and the covered person, a written grievance may be submitted and the insurer will review it as a second level grievance.

A second level grievance review panel shall be established to give those covered persons who are dissatisfied with the first level grievance review decision the option to request a second level review. A majority of the panel shall be comprised of persons who were not previously involved in the grievance. A health carrier shall provide that
the majority of the persons reviewing a grievance involving an adverse determination are health care professionals who have appropriate expertise.

Upon the request of a covered person, an insurer shall provide to the covered person all relevant information that is not confidential or privileged. A covered person has the right to attend the second level review, present his or her case to the review panel, submit supporting material both before and at the review meeting, ask questions of any representative and be assisted or represented by a person of his or her choice.

The review panel shall schedule and hold a review meeting within forty-five working days after receiving a request from a covered person for a second-level review. In those situations where the covered person cannot appear in person, the insurer shall offer the covered person the opportunity to communicate with the review panel by conference call or other available technology.

If you and/or your representative plan to participate in person or by phone, please contact us:

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

Review Panel meetings will be held at 475 Fallbrook Blvd., Lincoln, NE 68521.

The review panel shall issue a written decision to the covered person within 5 business days of completing the review meeting.

Written Decision

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

• Names, titles and qualifying credentials of person(s) acting as the reviewer or reviewers participating in the grievance review process;
• A statement of the reviewer's understanding of the covered person's grievance;
• The reviewers' decision in clear terms explaining the contract basis and/or coding in sufficient detail for the covered person to respond further to Ameritas' position, a reference to the evidence or documentation used as the basis for the decision;
• In cases involving an adverse determination, the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; and,
• Notice of the covered person’s right to contact the Nebraska Department of Insurance.
Nebraska - IMPORTANT INFORMATION

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

Your Rights

- You have the right to receive considerate and respectful care, with recognition of your personal dignity regardless of race, color, religion, sex, age, physical or mental handicap or national origin.
- You have the right to participate with your network provider in decision-making regarding your eye care.
- You have the right to know your costs in advance for routine and emergency care.
- You have the right to tell us when something goes wrong.
- Start with your provider. He/she is your primary contact.
- If you have a problem that cannot be resolved with your provider, call our eyecare claims department for assistance at 800-877-7195.

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

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

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

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

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

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

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

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

Your Responsibilities

- Read the details of your Certificate.
- Provide information to your provider that he/she needs to know to provide appropriate care.
- Feel free to call us to address any concerns you may have.
- Let your provider know whether you understand the treatment plan he/she recommends and follow the treatment plan and instructions for care.
• Pay any coinsurance due as soon as possible for the care received so your provider can continue to serve you.

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

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

OUR PRACTICES

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

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

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

The Quality Management Program addresses the following:

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

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

Utilization Review Program. Generally, utilization review involves a set of criteria designed to monitor the use of, or evaluate the medical necessity and appropriateness of health care services. We have established a utilization review program to ensure that any criteria used to evaluate the medical necessity of a health care service are clearly documented and include procedures for applying such criteria based on the needs of the individual patients. This criteria was developed with involvement of dental consultants who are all licensed dentists. The program is reviewed on an annual basis to ensure that the guidelines are current with dental technology, evidence-based research and any dental trends.

All claims will be processed within at most 30 calendar days of obtaining all the necessary information. Our standard turn-around times are generally below 10 working days for claim review. For all claims submissions, you and your provider will receive an explanation of benefits which details how each submitted procedure was reimbursed and/or the reason for denial.

When a claim has been denied or partially denied based on medical necessity, this is considered an adverse determination. These decisions are reviewed by qualified and appropriately licensed health
professionals and only after receiving and reviewing any relevant clinical information necessary to make the decision.

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

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

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

To access details about non-insurance discounts and third-party service providers, you may contact our customer connections team or your plan administrator.

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

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

<table>
<thead>
<tr>
<th>Benefit Class</th>
<th>Class Description</th>
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<tbody>
<tr>
<td>Class 1</td>
<td>All Eligible Employees</td>
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EYE CARE EXPENSE BENEFITS

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

Deductible Amount:
- Exams - Each Benefit Period $10
- Frames and Lenses - Each Benefit Period $25

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

LASER VISION CORRECTION EXPENSE BENEFITS

Coinsurance Percentage: 100%

*Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.*
Ameritas Life Insurance Corp.
Laser Vision Correction Benefit Rider

This Laser Vision Correction Benefit Rider is attached to and made a part of Group Policy Number 10-35391 issued to SCOTTS BLUFF COUNTY and each Certificate of Insurance issued under such Policy. It is hereby agreed that the Policy and each Certificate issued thereunder has been amended to provide benefits for the Covered Procedures as described below.

BENEFITS

If an Insured undergoes or receives a Covered Procedure rendered by a Provider, we will pay benefits as stated below. The Insured has the freedom of choice to receive laser vision correction treatment from any Provider.

Benefit Amount Payable For Covered Procedures Per Insured Person (Lifetime Maximum Benefit per Eye):

For Covered Procedures, we will pay the lesser of the Provider’s actual charge or the following benefit amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

<table>
<thead>
<tr>
<th>Benefit Period</th>
<th>1st Benefit Period</th>
<th>2nd Benefit Period</th>
<th>3rd Benefit Period</th>
<th>4th + Benefit Period</th>
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<tr>
<td></td>
<td>$175 per eye</td>
<td>$175 per eye</td>
<td>$350 per eye</td>
<td>$350 per eye</td>
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</table>

Exclusions and Limitations

- No benefit will be payable for any HCPCS Level II codes not listed below in the definition of Covered Procedures.
- No benefit will be payable for any Insured under the age of 18.
- No benefit will be payable in the first 12 months that a person is insured if the person is a Late Entrant. After this 12 month waiting period, the Maximum Amount Payable per Insured Person will begin at the 1st Benefit Period as shown in the above schedule.
- Each Insured Person is eligible for only one Covered Procedure benefit payment per eye. No benefit will be payable for multiple laser vision correction treatments on the same eye.

Definitions

Covered Procedures means only the following HCPCS Level II codes:

- S0800: Laser in Situ Keratomileusis (LASIK). This would encompass standard LASIK, Custom LASIK, LASIK, LASIK with Wavefront Technology, CustomVue LASIK, and LASIK with IntraLase technology.
- S0810: Photorefractive Keratectomy (PRK)

Benefit Period. Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31. Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a Benefit Period means the period from his or her effective date through December 31 of that year.

Provider. For the purposes of this benefit rider, a Provider refers to any person who is properly licensed under the laws of the state in which treatment is provided within the scope of the license.
This provision is effective on July 1, 2012

Ameritas Life Insurance Corp.

JoAnn M. Martin
President
PREMIUMS

TABLE OF MONTHLY PREMIUM RATES

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<td>$9.96 per Insured Person</td>
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<td>$12.20 Spouse Only</td>
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<tr>
<td>$10.34 Child(ren) Only</td>
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<td>$18.26 Spouse &amp; Child(ren)</td>
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<tr>
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<tr>
<td>$1.00 per Insured Person</td>
<td></td>
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<tr>
<td>$1.00 Spouse Only</td>
<td></td>
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<tr>
<td>$0.50 Child(ren) Only</td>
<td></td>
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<tr>
<td>$1.50 Spouse &amp; Child(ren)</td>
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</table>

PAYMENT OF PREMIUMS. The first premium will be due on the Policy Effective Date to cover the period from that date to the first Premium Due Date. Other premiums will be due on or before each Premium Due Date. Premiums are payable at our Home Office or at some other location to which we and the Policyholder agree.

PREMIUM DUE DATE. The Premium Due Date will be the first day of the month that falls on or after the Policy Effective Date. If we agree with the Policyholder to the payment of premiums on a basis other than monthly, the Premium Due Date will be fixed to match the correct basis. If there is a change in the method of payment or Premium Due Date, a pro-rata charge in the premium due will be made.

PREMIUM STATEMENTS. The premium due as of any Premium Due Date is the number of units in force on such date for each type of insurance multiplied by the rate shown in the Table of Premium Rates. A premium statement will be made as of the Premium Due Date showing the premium payable. If premiums are payable on other than a monthly basis, each statement will show any pro-rata premium charges and credits in the last premium period due to changes in the number of Insureds and in the amount of insurance for which people are insured. This is subject to the rules below.

SIMPLIFIED ACCOUNTING. The premium will start on the Premium Due Date falling on or after the date the insurance or the increase in the insurance is effective for: a) a person becoming insured; or b) an increase in the amount of insurance on any person. The premium will stop on the Premium Due Date falling on or after the date of termination of insurance or through the date of service of the last paid claim. There will be no pro-rata charges or credits for a partial month. If premiums are payable other than monthly, charges and credits will be figured as though the Premium Due Date is monthly.

We will be liable for the return of unearned premiums to the Policyholder only for the 3 months before the date we receive evidence that a return is due.

ADJUSTMENTS IN PREMIUM RATES. We may change the rates shown in the Table of Premium Rates by giving the Policyholder at least 30 days advance written notice. We may change the rates at any time the Schedule of Benefits, or any other terms and conditions of the policy, are changed. We will not change the rates
until the Renewal Date shown on the policy cover or more than once in any 12 month period thereafter, unless there is a change in the Schedule of Benefits or a change in any other terms and conditions in the policy.

Notwithstanding the above, the Company reserves the right to change any one or more of the rates prior to the Renewal Date or more than once in any 12 month period thereafter upon the occurrence of one or both of the following:

1. We determine that the average number of dependent children for each Insured with Dependent coverage exceeds 4.0; and/or

2. We determine that the number of Insureds is less than 80% of the number of Insureds covered under the Policy as of either (i) the Plan Effective Date, if during the period of time between the Plan Effective Date and the Renewal Date, or (ii) the most recent 12 month anniversary of the Renewal Date.

Should either or both of the above occur and should we elect to change rates as a result, we agree to notify the Policyholder of the corresponding rate changes at least 30 days in advance of the Premium Due Date for which the rate change shall be effective. The right to change rates as well as the timing of such changes in the above two limited situations shall at all times be subject to applicable state laws and regulations.

RENEWAL DATE refers to the date each calendar year that the coverage issued under the group policy is considered for renewal. The Renewal Date(s) are shown on the policy cover.
DEFINITIONS

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

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

INSURED refers to a person:

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

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

c. for whom the insurance has become effective.

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

DEPENDENT refers to:

a. an Insured's spouse.

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

i. natural born children;

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

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

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

c. each child age 26 or older who:

i. is Totally Disabled as defined below; and

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

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

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and

2. Chiefly dependent upon the Insured for support and maintenance.

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

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

LATE ENTRANT refers to any person:

a. whose Effective Date of insurance is more than 31 days from the date the person becomes eligible for insurance; or

b. who has elected to become insured again after canceling a premium contribution agreement.

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

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

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

ELIGIBILITY

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

If employment is the basis for membership, a member of the Eligible Class for Insurance is any full time active employee working at least 32 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

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

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

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

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any full time active employee working at least 32 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

SECTION 125. This policy is provided as part of the Employer's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this policy.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Annual Election Period. The first Annual Election Period will be in June 2010 and those who elect to
participate in this program at that time will have their insurance become effective on July 1, 2010. Each Annual election Period thereafter will be in December for a January 1 effective date.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NON-PARTICIPATING PROVIDER
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 may be 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 unless otherwise required by state regulation.

EXTENSION OF BENEFITS
If your policy terminates, we will pay claims for eye care services and supplies that you received or ordered prior to your policy's termination. You will have six months following the date of service to submit your claim.

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

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

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

**EXCLUSIONS**
This plan does not cover:

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits,
- Plano lenses (lenses with refractive correction of less than plus or minus .50 diopter) except as specifically allowed in the frames benefit section below,
- Services or materials that are cosmetic, including Plano contact lenses to change eye color and artistically painted Contact Lenses,
- Two pairs of glasses in lieu of Bifocals,
- Replacement of Spectacle Lenses, Frames, and/or contact lenses furnished under this plan that are lost or damaged, except at the normal intervals when services are otherwise available,
- Orthoptics or vision training and any associated supplemental testing,
- Medical or surgical treatment of the eyes,
- Contact lens modification, polishing or cleaning,
- The refitting of Contact Lenses after the initial 90-day fitting period,
- Contact Lens insurance policies or service contracts,
- Additional office visits associated with contact lens pathology,
- Local, state and/or federal taxes, except where law requires us to pay.
SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for which benefits payable under this section. You must first pay a Deductible for certain services as indicated on the Schedule of Benefits in the - Eye Care Expense Benefits section.

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>WHEN COVERED</th>
<th>PLAN MAXIMUM COVERED EXPENSE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Participating Provider</td>
<td>Non-Participating Provider</td>
</tr>
<tr>
<td><strong>Vision Examination(s)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Exam</td>
<td>Once every 12 months</td>
<td>Covered in Full</td>
<td>Up to $ 52.00</td>
</tr>
<tr>
<td><strong>Complete Pair of Spectacles</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>Once every 12 months</td>
<td>Covered in Full</td>
<td>Up to $ 55.00</td>
</tr>
<tr>
<td>Lined Bifocal</td>
<td>Once every 12 months</td>
<td>Covered in Full</td>
<td>Up to $ 75.00</td>
</tr>
<tr>
<td>Lined Trifocal</td>
<td>Once every 12 months</td>
<td>Covered in Full</td>
<td>Up to $ 95.00</td>
</tr>
<tr>
<td>Lenticular</td>
<td>Once every 12 months</td>
<td>Covered in Full</td>
<td>Up to $125.00</td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Frame&lt;sup&gt;®&lt;/sup&gt;</td>
<td>Once every 24 months</td>
<td>Up to $130.00</td>
<td>Up to $ 70.00</td>
</tr>
<tr>
<td><strong>Contact Lenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective</td>
<td>Once every 12 months</td>
<td>Up to $130.00</td>
<td>Up to $105.00</td>
</tr>
<tr>
<td>Medically Necessary</td>
<td>Once every 12 months</td>
<td>Covered in Full</td>
<td>Up to $210.00</td>
</tr>
<tr>
<td><strong>Low Vision</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(for severe visual problems not correctable with regular lenses, as determined by the treating provider)</td>
<td>Insureds can receive professional services for treatment of severe visual problems that are not correctable with regular lenses. The treating provider determines if an Insured’s condition meets the criteria for coverage of this benefit. Insureds may contact VSP’s Customer Care Division for details at (800-877-7195) for additional information.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>®</sup>Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Customer LASIK patients as determined by the VSP Participating Provider. Frame allowance may be applied towards non-prescription sunglasses, exhausting both frame and lens eligibility.
GENERAL PROVISIONS

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

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

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

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

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

PAYMENT OF BENEFITS. All benefits will be paid to the Insured unless otherwise agreed upon through your authorization or provider contracts.

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

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

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

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

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

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

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

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.
WORKER’S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen’s compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.
CONFORMITY WITH STATE AND FEDERAL LAW. Any provision of this policy which, on its effective date, is in conflict with the law of federal government or the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such law.

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

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

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

i. necessary to calculate premiums;

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

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

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

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

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

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

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

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

The Participation Requirements are as follows:

<table>
<thead>
<tr>
<th>Percentage of Members-</th>
<th>60%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Members-</td>
<td>87</td>
</tr>
</tbody>
</table>

TERMINATION OF THE POLICY. The Policyholder may terminate this policy as of any Premium Due Date by giving us written notice before that date.

We may terminate this policy on the earlier of:
1. any Premium Due Date if the participation of Insureds and/or Dependents does not meet the requirements in "Conditions For Insurance." Written notice of termination of insurance must be given to the Policyholder at least 45 days before the date of termination.

2. any Premium Due Date on or after the first policy year, for reasons other than lack of participation. Written notice of termination of insurance must be given to the Policyholder at least 60 days before the date of termination.

If any premium is not paid when due, this policy will automatically be terminated as of the Premium Due Date, except as stated below.

**GRACE PERIOD.** This policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, the policy will stay in force. If the Policyholder has not sent us a written request to terminate the policy and a premium is not paid by the end of the grace period, the policy will terminate at the end of the grace period. If the Policyholder gives us written notice of termination before the Premium Due Date, the policy will be terminated as of the date requested. The Policyholder will be liable for any unpaid premium for the time this policy was in force, including the grace period.

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

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

AMERITAS LIFE INSURANCE CORP.

by: SCOTTS BLUFF COUNTY

whose main office address is: 1825 10TH ST
GERING, NE  69341-2444

for Group Policy No. 10-35391

This group policy is hereby approved. Its terms are hereby accepted.

This Acceptance Application is made in duplicate. One is attached to the policy. The other part has been returned to the Company.

It is agreed that this application supersedes any previous application for the group policy.

SCOTTS BLUFF COUNTY

(Full or Corporate Name of Applicant)

Dated at_____________________________ By_______________________________
(Signature and Title)

On____________________, 20__ Witness____________________________________
(To be signed by Resident Agent where required by law)

This copy is to Remain Attached to the Policy