GROUP
EYE CARE
PLAN

UNITED TEACHERS OF ISLAND TREES WELFARE TRUST FUND

UNITED TEACHERS OF ISLAND TREES

Plan Number: 26-301528

Administered by:

Ameritas Life Insurance Corp. of New York

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 coverage or the termination of our arrangements with the providers, whichever comes first.

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SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

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

Benefit Class	Class Description
Class 4	Eligible Retiree Electing Vision

EYE CARE EXPENSE BENEFITS

Deductible Amount:	$0

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

DEFINITIONS

COMPANY refers to Ameritas Life Insurance Corp. of New York. The words "we", "us" and "our" refer to Company. Our Home Office address is 1350 Broadway, Suite 2201, New York, NY 10018.

PLANHOLDER refers to the Planholder stated on the face page of this document.

MEMBER refers to a person:

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

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

c. for whom the coverage has become effective.

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

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

DEPENDENT refers to:

a. a Member's spouse or Domestic Partner.

b. each child less than 26 years of age, for whom the Member, the Member's spouse, or the Member's Domestic Partner, 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 plan. Additionally, if the Planholder'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 Planholder's separate medical plans will be ineligible under this Plan as well.

c. each child age 26 or older who:

   i. is Totally Disabled as defined below; and

   ii. becomes Totally Disabled while covered 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 Member's Dependent as:

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

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

DEPENDENT UNIT refers to all of the people who are covered as the dependents of any one Member.

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

PLAN EFFECTIVE DATE refers to the date coverage under the plan becomes effective. The Plan Effective Date for the Planholder is July 1, 2017. The effective date of coverage for a Member is shown in the Planholder's records.

All coverage 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 Member.

CONDITIONS FOR 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 coverage on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Member."

If employment is the basis for membership, a member of the Eligible Class for Coverage is any eligible retiree electing vision working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Coverage is as defined by the Planholder.

Late Enrollees Have Limited Coverage For 2 Years are excluded from the Eligible Class for Coverage.

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

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

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

3. the day he or she first has a dependent. 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 covered to also cover his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Coverage is any eligible retiree electing vision working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Coverage is as defined by the Planholder.

Late Enrollees Have Limited Coverage For 2 Years are excluded from the Eligible Class for Dependent Coverage.

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

CONTRIBUTION REQUIREMENTS. Member Coverage: A Member is not required to contribute to the payment of his or her coverage fees.

Dependent Coverage: A Member is not required to contribute to the payment of coverage fees for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the plan, qualification will occur following the eligibility period of 12 month(s) of continuous active employment.

For persons who become Members after the Plan Effective Date of the plan, qualification will occur following the eligibility period of 12 month(s) of continuous active employment.

If employment is the basis for membership in the Eligible Class for Members, a Member 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 coverage.

EFFECTIVE DATE. Each Member has the option of being covered and covering his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the coverage fees. The Effective Date for each Member and his or her Dependents, will be the:

1. the date on which the Member qualifies for coverage, 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 coverage.

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the coverage, or any increase in coverage, is to take effect. If not, the coverage 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 coverage, or any increase in coverage, is to take effect. The coverage will not take effect until the day after he or she ceases to be totally disabled.

TERMINATION DATES

MEMBERS. The coverage for any Member, will automatically terminate on the **earliest of:**

1. the date the Member ceases to be a Member;
2. the last day of the period for which the Member has contributed, if required, to the payment of coverage fees; or
3. the date the plan is terminated.

DEPENDENTS. The coverage for all of a Member's dependents will automatically terminate on the **earliest of:**

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

The coverage for any Dependent will automatically terminate on 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 coverages may be continued. Contact your plan administrator for details.

EYE CARE COVERAGE

If a Member under this section incurs Covered Expenses, we will pay benefits as stated below.

COVERED EXPENSES. Covered Expenses include the lesser of:

a. the charge for the covered procedure furnished, or

b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Eye Care Services.

COVERED EXPENSES. Covered Expenses means the Eye Care expenses incurred by a Member for the procedures shown in the Schedule of Eye Care Services, up to the Maximum Covered Expense shown for each procedure and the Eye Care Maximum as shown in the Schedule of Benefits, if applicable. Such expenses will be Covered Expenses only to the extent that they are incurred for procedures done by a physician, optometrist, or optician. These expenses are subject to the "Limitations" below.

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

Benefit Period means the period from September 1 of any year through August 31 of the next year. But during the first year a person is covered, a benefit period means the period from his or her effective date through August 31 of the next year.

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

EXTENSION OF BENEFITS. Should a Member's coverage under this section terminate, we will pay Covered Expenses for frames or lenses which were ordered while coverage was in force, provided such frames or lenses are delivered within 30 days from the date the Member's coverage ceases.

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

1. vision examinations more than once in any 12 month period.

2. prescribed lenses more than once in any 12 month period.

3. frames more than once in any 12 month period.

4. contact lenses more than once in any 12 month period. When chosen, contact lenses shall be in lieu of any other lens or frame benefit during the 12 month period. When lenses are chosen, expenses for contact lenses are not Covered Expenses during the 12 month period.

5. examinations performed or frames or lenses ordered before the Member was covered under this section.

6. subject to Extension of Benefits, any examination performed or frame or lens ordered after the Member's coverage under this section ceases.

7. sub-normal vision aids; orthoptic or vision training or any associated testing.

8. non-prescription lenses.

9. replacement or repair of lost or broken lenses or frames except at normal intervals.

10. any eye examination or corrective eye-wear required by an employer as a condition of employment.

11. medical or surgical treatment of the eyes.

12. any service or supply not shown on the Schedule of Eye Care Procedures.

13. coated lenses; oversize lenses (exceeding 71 mm); photo-gray lenses; polished edges; UV-400 coating and facets, and tints other than solid.

SCHEDULE OF EYE CARE SERVICES

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

SERVICE	MAXIMUM COVERED EXPENSE
Vision Examination May consist of, but not limited to, the following: case history; external examination of the eye and adnexa; ophthalmoscopic examination; determination of refractive status; binocular balance testing; tonometry test for glaucoma, when indicated; gross visual fields, when indicated; color vision testing when indicated; summary finding; prescribing of lenses.	Up to $20.00
Contact Lens Exam	Up to $80.00
Materials	
Frame	Up to $100.00
Lenses	
Single Vision	Up to $30.00
Bifocal	Up to $50.00
Trifocal	Up to $150.00
No line bifocal or progressive power	Up to $150.00
Lenticular	Up to $150.00
Contact Lenses	Up to $150.00
Anti-Glare Coating	Up to $100.00

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 Planholder's name, Member's name, and plan number. If it was not reasonably possible to give written notice within the 30 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

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

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

TIME OF PAYMENT. We will pay all benefits 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 Member unless otherwise agreed upon through your authorization or Provider contracts.

FACILITY OF PAYMENT. If a Member or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Member, 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 Member 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 Member 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 Member 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 Planholder to obtain the Plan is a representation and not a warranty. No misrepresentation by the Planholder will be used to deny a claim or to deny the validity of the Plan unless:

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

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

The validity of the Plan will not be contested after it has been in force for one year, except for nonpayment of fees or fraudulent misrepresentations.

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