VIRGINIA
IMPORTANT INFORMATION REGARDING YOUR INSURANCE

Ameritas Life Insurance Corp. is subject to regulation in the Commonwealth by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

This notice contains important information about how to file complaints, grievances or appeals with us. Please read this and the Explanation of Benefits (EOB) that is sent in response to a claim or request for a pre-treatment estimate of benefits. The EOB will have information specific to that benefit determination.

WHO TO CONTACT

If you need to contact us about your insurance, please use the following address:

Complaint Officer
Quality Control
P.O. Box 82657
Lincoln, NE 68501-2657
1- 877-897-4328(Toll-Free)
402-309-2579 (FAX)

You may call us between the hours of 8:00 a.m. to 7:00 p.m. ET Monday through Friday. After hours, you may leave a message and we will return your call. Dental Consultants are available for discussions with treating providers 40 hours per week during typical working hours.

If you have been unable to contact us or if you need additional help, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

In writing:	Life and Health Division Bureau of Insurance P.O. Box 1157 Richmond, VA 23218
Richmond area:	804-371-9741
Toll-free:	1-800-552-7945
Out-of-State:	1-877-310-6560

Since this coverage includes an option to seek services from a participating provider (PPO), both the Virginia Department of Health and the Virginia Bureau of Insurance are available to assist you.

If you have any questions regarding an appeal, or grievance concerning the health care services that you have been provided, that have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance.

Contacting the Managed Care Ombudsman at the Bureau of Insurance:

In writing:	Office of the Managed Care Ombudsman Bureau of Insurance P.O. Box 1157 Richmond, VA 23218
Toll-free:	1-877-310-6560
In Richmond area:	804-371-9032
Email:	ombudsman@scc.Virginia.gov
Web Page:	Information regarding the ombudsman may be found by accessing the state corporation commission's web page at: www.scc.virginia.gov

Contacting The Office of Licensure and Certification (OLC)

In writing:	Virginia Department of Health 9960 Mayland Drive, Suite 401 Henrico, VA 23233
Toll-free:	1-800-955-1819
Richmond metro area:	804-367-2106
Fax:	804-527-4503
Email:	mchip@vdh.virginia.gov
Web Page:	Information regarding The Office of Licensure and Certification may be found by accessing the Department of Health's web page at www.vdh.virginia.gov/olc.

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HOW GRIEVANCES AND APPEALS ARE HANDLED

If you wish to file a complaint, grievance or appeal, please review the information below:

I. Definitions

"Adverse Decision" means a determination by us that a dental service is not medically necessary and reimbursement for the service is either denied or reduced.

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

"Grievance" means a complaint on behalf of an insured person submitted by a covered 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 covered services;
(b) benefits or claims payment, handling, or reimbursement for covered services;
(c) matters pertaining to the contractual relationship between a covered person and the insurer.

II. Grievance and Appeal Procedures

A. Requesting an Appeal or Filing a Grievance

At any time, you may file a grievance about the matters defined above. You cannot be disenrolled or penalized in any way because a grievance or complaint was filed.

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting us, or any of the regulatory agencies, use the contact information above and include your identification and/or policy number.

B. Internal Reviews

For situations or issues other than an adverse decision, the grievance will be reviewed by all appropriate internal parties. We will respond to a grievance within 30 days and will provide a written letter of our final decision no later than 60 days from the date of receipt of the grievance.

For those situations which meet the definition of an adverse decision, and we receive a request for reconsideration of this decision, we will notify you and the provider within 10 working days following the request for reconsideration. If the decision is upheld, and you request a formal appeal, we will provide a written letter of our final decision no later than 60 working days after receiving the required documentation.

For a formal appeal of an adverse decision, the case will be reviewed by a peer of the treating provider who was primarily responsible for the care under review. The licensed provider who renders the final decision on an appeal will not have participated in the adverse decision, or any prior reconsideration, and will not be employed

by or a director of the company.

You have the right to participate via a teleconference call or in person during the review process in order to present additional information regarding an appeal of an adverse decision.

C. Expedited Reviews

Requests for reconsideration or appeal of prospective pre-treatment estimates related to urgent care will be reviewed within 1 business day of the request and receipt of all information necessary to make the determination. We will provide our decision by telephone or e-mail and send written confirmation within 24 hours of the decision.