



# FIDELITY SECURITY LIFE INSURANCE COMPANY®

3130 Broadway  
Kansas City, Missouri 64111-2406  
Phone 800-648-8624  
A STOCK COMPANY  
(Herein Called "the Company")

**POLICY NUMBER:** VC-146  
**POLICYHOLDER:** University of Kentucky  
**STATE OF ISSUE:** Kentucky  
**POLICY EFFECTIVE DATE:** July 1, 2011  
**POLICY ANNIVERSARY DATE:** July 1 of the following year and each July 1 thereafter

Fidelity Security Life Insurance Company agrees to pay the benefits provided by the Policy in accordance with its terms and conditions.

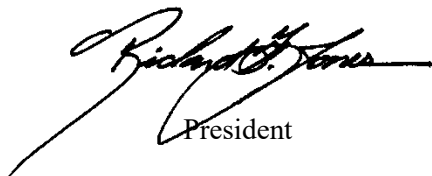
The Policy is issued in consideration of the Policyholder's application (a copy of which is attached) and receipt by the Company of the premiums.

All periods of time under the Policy begin and end at 12:01 A.M. Local Time at the Policyholder's business address.

The Policy may be modified by mutual agreement between the Policyholder and the Company.

The Policy is issued by Fidelity Security Life Insurance Company at Kansas City, Missouri on the Policy Effective Date.

FIDELITY SECURITY LIFE INSURANCE COMPANY

  
President

  
Secretary

**GROUP VISION INSURANCE POLICY**  
**THIS IS A LIMITED BENEFIT POLICY**  
**This Policy is a legal contract between the Policyholder and the Company.**

*Please read the Policy carefully.*

## PREMIUMS

Premiums are payable in advance by the Policyholder. The first premium is due on the effective date of the Policy. Subsequent premiums are due on the first day of each calendar month thereafter.

The required premium due on each premium due date is the sum of the premiums for all Insureds and their Dependents covered under the Policy. The premiums due will be determined by applying the premium rates then in effect for each plan provided by the Policy to the number of Insured Persons. All premiums are payable to the Company at the Company's home office or to any of the Company's authorized agents.

The premium due may be adjusted due to a change in insurance as requested by the Policyholder or as required by the Company as follows:

1. if an amount of insurance is added or increased during a calendar month, premiums will be increased as of the date the change becomes effective, unless otherwise mutually agreed;
2. if an amount of insurance is deleted or decreased during a calendar month, premium will cease or be decreased at the end of the calendar month in which the deletion or decrease occurred, unless otherwise mutually agreed;
3. if the Policyholder's contribution percentage is changed, premium will be adjusted at the end of the calendar month in which the change occurred, unless otherwise mutually agreed; or
4. if the number of eligible employees increases or decreases by more than 10% premium will be adjusted at the end of the calendar month in which the increase or decrease occurred, unless otherwise mutually agreed.

If premiums are due the Company or premium refunds are due the Policyholder as a result of clerical error or delay in the reporting of dates and/or data to the Company, all premiums or refunds will be calculated at the current rate of premium payment.

**Premium Rate Change.** The Company has the right to change the premium rate on any Policy Anniversary Date on or after the fourth Policy Anniversary Date. The Company will provide written notice at least 31 days before the date of change.

**Grace Period.** A grace period of 31 days will be allowed to the Policyholder for the payment of each premium due after the first premium. The Policy will remain in force during the grace period. If the required premium is not paid by the end of the 31-day period, the Policy will terminate. The Policyholder will be required to pay premium for the grace period.

**Return of Premium.** The Company reserves the right to rescind the coverage for one or all Insureds due to misrepresentation or fraud on the Policyholder's application or an Insured's enrollment form, if such misrepresentation materially affected the acceptance of the risk.

If, on the date coverage is rescinded, no claims have been paid under the Policy, the Company will return all premiums paid for such coverage to the Policyholder.

If, on the date coverage is rescinded, claims have been paid under the Policy, the Company reserves the right to deduct from the premiums to be returned to the Policyholder an amount equal to the amount of such claims paid.

## **TERMINATION OF POLICY**

The Policyholder or the Company may terminate or cancel the Policy on the earliest of the following:

1. any date on or after the fourth Policy Anniversary Date the Company requests termination. Written notice must be provided to the Policyholder at least 31 days prior to termination;
2. any date on or after the date the Company receives the Policyholder's written request for termination;
3. the date the number of persons covered under the Policy does not meet the minimum participation requirements of 10;
4. the date the required premium has not been paid, except as provided in the Grace Period provision; or
5. the date 100% of the eligible employees are not covered when a contribution is not required by the employee.

The Policyholder is responsible for notifying the Insured of the termination of the Policy.

Termination of the insurance of any Insured Person will be without prejudice to any claim originating before the date of termination.

## **CERTIFICATE**

The Company will furnish the Certificate to the Policyholder for the Insured which will set forth the essential features of the insurance coverage.

## **ADDITIONAL INSUREDS**

Insured Persons may be added at any time if they meet the eligibility requirements stated in the Policyholder's application, complete an enrollment form, if required, and pay any required premium.

## **INCORPORATION PROVISION**

The provisions of the attached Certificate and all Rider(s) issued with the Policy or to amend the Policy after the Policy Effective Date are made a part of the Policy.



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## Amendment to the Application for Vision Care Benefits

### Current Group Information (as reflected in the Company's records):

Group Name: University of Kentucky

DBA, (if applicable): \_\_\_\_\_

Policy Number: VC-19 Group Number: 1011431/1011432/1011433/1011434

Effective 7-1-21 the Application for Vision Care Benefits is amended as noted below:

#### Change in Policy Number:

Original Policy Number: VC-19 New Policy Number: VC-146

#### Change in Renewal Date:

Original Renewal Date: 7-1-21 New Renewal Date: 7-1-25

#### Name Change (Same Tax ID#):

New Group Name: \_\_\_\_\_

DBA, if applicable: \_\_\_\_\_

#### Change in Primary Business Address (same state):

New Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

#### Change to Coverage for Domestic Partners:

Are Domestic Partners to be covered under this Plan\*?  Yes  No Same Sex\*?  Yes  No Opposite Sex\*?  Yes  No

\* Unless state law has different requirements.

#### Change to Dependent Age Coverage:

Dependent Children to be covered to Age\*\*  19  21  25  26\*\*\*  Other \_\_\_\_\_

Dependent Children who are full-time students covered to age\*\*:  23  25  27  Other \_\_\_\_\_

\*\*Unless state law has different requirements.

\*\*\*Dependent Children covered to age 26 regardless of financial dependency, residency, student status or marital status.

#### New Rates, Benefits, Network or Plans:

A. New Rates Please refer to the attached proposal page.

B. New Benefits Please refer to the attached proposal page.

C. New Network Please refer to the attached proposal page.

D. New Plan Please refer to the attached proposal page.

**Change in Group Size (Florida, Michigan, Missouri, Washington policyholders only):**

Original Number of Eligible Employees/Members: \_\_\_\_\_ New Number of Eligible Employees/Members: \_\_\_\_\_

FIDELITY SECURITY LIFE INSURANCE COMPANY®

  
President

  
Secretary



**Application for Vision Care Benefits**

Underwritten by Fidelity Security Life Insurance Company  
Kansas City, Missouri

**I. GROUP INFORMATION**

Group Name: University of Kentucky Tax ID: 61-600-1218  
DBA Name (if other than above): \_\_\_\_\_  
Business Address: 112 Scovell Hall City: Lexington State: KY Zip: 40506-0064  
Mailing Address: 112 Scovell Hall City: Lexington State: KY Zip: 40506-0064  
Primary Contact: Joey Payne Title: Director of Employee Benefits  
Phone Number: 859 257-9185 Fax Number: 859 323-1095  
E-mail Address: joey.payne@uky.edu  
Type of Business:  Proprietorship  Corporation  Other (Specify): governmental university  
Service Area:  National (United States does not include Puerto Rico)  State Specific (List) \_\_\_\_\_

**PLEASE NOTE THE FOLLOWING TYPE BUSINESSES REQUIRE PRIOR CARRIER APPROVAL:**

MEWA  PEO  Trust  Union

If any subsidiary or affiliated companies are to be insured or any Employees/Members are working at a location other than the address above, please explain: KCTCS, these employees were previously part of UK and have a legislated right to participate in UK benefit plans.

Billing Contact Name: Lora Dials Phone: 859 257-6604  
Billing Address: 375 Peterson Service Building City: Lexington State: KY Zip: 40506-0005

If you have subsidiaries, affiliated companies, or divisions who use another name and will be covered by this plan, AND require separate billing invoices, please attach the following information on a separate sheet of paper signed by you: • Name • Address • Billing Contact & Phone Number

Will this plan replace any existing coverage?  Yes  No

If "Yes," indicate name and address of existing insurer:

Name: EyeMed Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Effective date of existing coverage: \_\_\_\_\_

Termination date of existing coverage (if applicable): \_\_\_\_\_

If "Yes," are any Employees/Members on COBRA continuation?  Yes  No How many? \_\_\_\_\_

Do you intend to offer Employees/Members COBRA continuation?  Yes  No

**II. PLAN SELECTION**

Please refer to the attached proposal page. Services are provided by EyeMed Vision Care.

III. **PREMIUMS**

Contribution towards premium:  Yes  No

Group's Premium Contribution for\*: Employees/Members: \_\_\_% Dependents: \_\_\_%

Employee's/Member's Premium Contribution for: Employees/Members: 100% Dependents: 100%

Are Employee/Member and Dependent premiums paid through a Section 125 Plan?  Yes  No

Are Employee/Member and Dependent premiums collected via payroll deduction?  Yes  No

Premiums shall be payable at the rates included on the attached proposal page.

*\*If the Group's contribution percentage is changed or the number of eligible Employees/Members increases or decreases, premium may be adjusted as allowed under the Policy. The premium may be adjusted at the end of the calendar month in which the change occurred.*

IV. **ELIGIBILITY**

Number of Employees/Members: 17,000 Number Applying: \_\_\_\_\_

Number of Dependents: 14,000 Number of Retirees: 3,700

Are Domestic Partners covered under this Plan?  Yes  No

Same Sex\*\*?  Yes  No Opposite Sex\*\*?  Yes  No

Dependent Children Covered to Age\*\*  19  21  25  Other 26

Dependent Children Covered if Full-Time Student\*\*  Yes  No

If "Yes", Dependent Full-Time Student Covered to\*\*  21  25  27  Other \_\_\_\_\_

\*Except as required by state law.

\*\*Unless state law has different requirements for Dependent Child status.

Eligibility Reporting Contact (produces the eligibility file): Bront Davis

Address (if different from group): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail Address: bront.davis@uky.edu Phone: 859 257-2372 Fax: 859 323-1095

Eligibility Authorization Contact (Benefits Administrator or Third Party Administrator responsible for verifying vision election for Employees/Members):

Name: Donna Henry Phone: 859 257-8830

Days/Hours of Availability: 8-5 E-mail Address: dkhenr2@email.uky.edu

**PROBATIONARY PERIOD**

For New Employees/Members:  30 days  60 days  90 days  180 days  Other 1st day of month following hire date.

Probationary Period is waived for present Employees/Members:  Yes  No

Number of Employees/Members who have not yet completed the probationary period: 0

V. **EFFECTIVE DATE**

This plan will become effective at 12:01 a.m. Local Time at the Group's address herein, on the first day of July, 2011, provided all of the following have been completed prior to this effective date:

- A. This application has been received and accepted by the Company (must be submitted 30 days in advance of the effective date).

- B. EyeMed has been furnished a working file of all eligible Employees/Members, according to the layout guidelines. It is understood and agreed that EyeMed may rely on this information to provide services to individuals designated as eligible.

The Group hereby makes application to Fidelity Security Life Insurance Company for Vision Care Benefits. The Group agrees to maintain and furnish any records necessary to administer this plan and to forward premiums monthly.

All the information shown on this application and any attachments are correct and complete as of the date this application is signed. All statements by the Group shall be deemed to be representations and not warranties. The Group understands that the Company intends to rely on this information in determining whether or not the enrolling Employees/Members and their Dependents may become insured. It is further understood and agreed that **NO INSURANCE WILL BECOME EFFECTIVE UNTIL APPROVED BY THE COMPANY**, and that no field representative of the Company has the authority to modify any conditions of the application or the Policy by making any promise or representation. It is understood that the insurance as to any Employee/Member will not become effective on the date insurance should otherwise become effective if he or she is not at work on such date performing all duties of his or her occupation and otherwise meets the requirements of the Company.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Dated at: UK this 17 day of July, 2011

Signed for the Group: [Signature] Title: Director of Employee Benefits

VI. **EMPLOYEE/MEMBER ID CARDS**

Group will be receiving ID cards:  Yes  No

Company Name: University of Kentucky

(Maximum of 30 characters, including punctuation, spacing and any code.)

Delivery of ID cards mailed directly to Employee's/Member's home address.

**ATTENTION: THE DEPARTMENT OF INSURANCE REQUIRES THAT ONLY THE BROKER AND/OR GENERAL AGENT WHO SOLD THE PRODUCT AND HOLDS A VALID LIFE AND HEALTH LICENSE MAY COMPLETE THE CERTIFYING STATEMENT.**

**WRITING BROKER'S CERTIFYING STATEMENT**

I certify that I have accurately recorded on this application the information supplied by the applicant and I am properly licensed in the state in which the Group is domiciled.

Firm Name (print): The MPM Group, LLC Tax ID No.: 75-3052829

Broker Name (print): Dale E. Baldwin SS#: [REDACTED]

Address: 1010 Monarch Street, Suite 220 City: Lexington State: KY Zip: 40513

Phone: (859) 224-4973 Fax: (859) 224-1266

Primary Contact: Dale Baldwin Title: Manager E-mail Address: debaldwin@mpm.com

Secondary Contact: Nicole Jordan Title: Office Manager E-mail Address: nmjordan@mpm.com

Commission checks payable to:  Firm  Broker

Broker Signature: [Signature]



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**WRITING GENERAL AGENT'S CERTIFYING STATEMENT**

I certify that I have accurately recorded on this application the information supplied by the applicant and I am properly licensed in the state in which the Group is domiciled.

Firm Name (print): \_\_\_\_\_ Tax ID No.: \_\_\_\_\_

General Agent Name (print): \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Primary Contact: \_\_\_\_\_ Title: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Secondary Contact: \_\_\_\_\_ Title: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Commission checks payable to:  Firm  General Agent

General Agent's Signature: ► \_\_\_\_\_

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VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
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**EXAM SERVICES**

<i>Exam at PLUS Providers</i>	<i>\$0 copay</i>	Up to \$40
Exam	\$10 copay	Up to \$40

**FRAME**

<i>Any available frame at PLUS Providers</i>	<i>\$0 copay; 20% off balance over \$180 allowance</i>	Up to \$55
Frame	\$0 copay; 20% off balance over \$130 allowance	Up to \$55

**CONTACT LENSES**

*(Contact Lens allowance includes materials only)*

Contacts - Conventional	\$0 copay; 15% off balance over \$130 allowance	Up to \$100
Contacts - Disposable	\$0 copay; 100% of balance over \$130 allowance	Up to \$100
Contacts - Medically Necessary	\$0 copay; paid-in-full	Up to \$200

**STANDARD PLASTIC LENSES**

Single Vision	\$10 copay	Up to \$40
Bifocal	\$10 copay	Up to \$60
Trifocal	\$10 copay	Up to \$80
Progressive - Standard	\$75 copay	Up to \$60
Progressive - Premium Tier 1	\$95 copay	Up to \$60
Progressive - Premium Tier 2	\$105 copay	Up to \$60
Progressive - Premium Tier 3	\$120 copay	Up to \$60
Progressive - Premium Tier 4	\$75 copay, 20% off retail price less \$120 allowance	Up to \$60

**LENS OPTIONS**

Polycarbonate - Std < 19 years of age	\$0 copay	Up to \$30
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Proposed Benefits

EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company

- Option Essential
- Exam & Materials
- Insight Network
- Fully Insured
- Employee Paid
- Funded Benefits

Frequency

**Examination**  
Once every plan year

**Lenses (in lieu of contacts)**  
Once every plan year

**Contacts (in lieu of lenses)**  
Once every plan year

**Frame**  
Once every other plan year

Terms

**Contract Term**  
48 months

**Rate Guarantee**  
48 months

**MONTHLY RATES**

Subscriber	\$8.50
Subscriber + Spouse	\$16.00
Subscriber + Child(ren)	\$15.20
Subscriber + Family	\$21.40

Monthly Rate is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies. The Plan reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866-939-3633.

**PLAN DETAILS**

Quote for group situated in the State of KY and will be valid until the 07/01/2021 implementation date. Date Quoted 09/29/2020. Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group. Percentage discounts are not part of the insurance benefit. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-146, form number M-9184.

**PLAN EXCLUSIONS/LIMITATIONS**

No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state.

By signing below, the Group agrees to receive all documents and correspondence electronically and that the Group can access the internet or the email address provided. The Group understands that the Group may revoke this authorization or request specific paper documents without revoking this authorization by contacting EyeMed by mail, email, or telephone. If University of Kentucky has chosen this benefit design, attach this document to the group application and sign here

2-12-21

Signature  
P201603 TC - 15

Date

Q-00019911 – QL-0000034063

# Saving our members some extra green

We're committed to keeping money in our members' pockets.

That's why we offer our members additional discounts above the proposed plan benefits.

## ADDITIONAL DISCOUNTS

### VISION CARE SERVICES

### IN-NETWORK MEMBER COST

#### DISCOUNTED EXAM SERVICES

Retinal Imaging

Up to \$39

#### CONTACT LENS FIT AND FOLLOW-UP

*(Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)*

Fit and Follow-up - Standard

Up to \$40

Fit and Follow-up - Premium

10% off retail price

#### DISCOUNTED LENS OPTIONS

Anti Reflective Coating - Standard

\$45

Anti Reflective Coating - Premium Tier 1

\$57

Anti Reflective Coating - Premium Tier 2

\$68

Anti Reflective Coating - Premium Tier 3

20% off retail price

Photochromic - Non-Glass

\$75

Polycarbonate - Standard

\$40

Scratch Coating - Standard Plastic

\$15

Tint - Solid or Gradient

\$15

UV Treatment

\$15

#### OTHER ADD-ON SERVICES AND MATERIALS

20% off retail price

### Savings for Members

#### 40% off

additional pairs of glasses and a 15% discount on conventional lenses once funded benefit is used – an industry exclusive

#### 20% off

any item not covered by the plan, including non-prescription sunglasses

#### Lasik

Lasik or PRK from US Laser Network  
15% off retail price or 5% off promotional price

#### Hearing Care

Amplifon Hearing Health Care Network  
40% off hearing exams and a low price guarantee on discounted hearing aids

#### DISCOUNT DETAILS

Member receives a 20% discount on items not covered by the plan at EyeMed In-Network locations. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products. The Plan reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Service and amounts listed above are subject to change at any time.



# University of Kentucky

## Proposed Benefits

EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company

- Option Enhanced
- Exam & Materials
- Insight Network
- Fully Insured
- Employee Paid
- Funded Benefits

## Frequency

- Examination**  
Once every plan year
- Lenses (in lieu of contacts)**  
Once every plan year
- Contacts (in lieu of lenses)**  
Once every plan year
- Frame**  
Once every plan year

## Terms

- Contract Term**  
48 months
- Rate Guarantee**  
48 months

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
<b>EXAM SERVICES</b>		
<i>Exam at PLUS Providers</i>	<i>\$0 copay</i>	Up to \$42
Exam	\$0 copay	Up to \$42
Fit and Follow-up - Standard	\$0 copay; contact lens fit and two follow-up visits	Up to \$40
Fit and Follow-up - Premium	\$0 copay; 10% off retail price, then apply \$40 allowance	Up to \$40
<b>FRAME</b>		
<i>Any available frame at PLUS Providers</i>	<i>\$0 copay; 20% off balance over \$210 allowance</i>	Up to \$80
Frame	\$0 copay; 20% off balance over \$160 allowance	Up to \$80
<b>CONTACT LENSES</b> <i>(Contact Lens allowance includes materials only)</i>		
Contacts - Conventional	\$0 copay; 15% off balance over \$160 allowance	Up to \$128
Contacts - Disposable	\$0 copay; 100% of balance over \$160 allowance	Up to \$128
Contacts - Medically Necessary	\$0 copay; paid-in-full	Up to \$210
<b>STANDARD PLASTIC LENSES</b>		
Single Vision	\$10 copay	Up to \$40
Bifocal	\$10 copay	Up to \$60
Trifocal	\$10 copay	Up to \$80
Progressive - Standard	\$10 copay	Up to \$83
Progressive - Premium Tier 1	\$30 copay	Up to \$83
Progressive - Premium Tier 2	\$40 copay	Up to \$83
Progressive - Premium Tier 3	\$55 copay	Up to \$83
Progressive - Premium Tier 4	\$10 copay, 20% off retail price less \$120 allowance	Up to \$83
<b>LENS OPTIONS</b>		
Anti Reflective Coating - Standard	\$0 copay	Up to \$34
Anti Reflective Coating - Premium Tier 1	\$12 copay	Up to \$34
Anti Reflective Coating - Premium Tier 2	\$23 copay	Up to \$34
Anti Reflective Coating - Premium Tier 3	\$0 copay; 20% off retail less \$45 Allowance	
Polycarbonate - Standard	\$0 copay	Up to \$30
Scratch Coating - Standard Plastic Tint - Solid or Gradient	\$0 copay	Up to \$12
UV Treatment	\$0 copay	Up to \$12
<b>Monthly Rates</b>		
Subscriber	\$21.40	
Subscriber + Spouse	\$40.00	
Subscriber + Child(ren)	\$38.00	
Subscriber + Family	\$53.60	

Monthly Rate is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies. The Plan reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866-939-3633.

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### PLAN EXCLUSIONS/LIMITATIONS

No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state.

By signing below, the Group agrees to receive all documents and correspondence electronically and that the Group can access the internet or the email address provided. The Group understands that the Group may revoke this authorization or request specific paper documents without revoking this authorization by contacting EyeMed by mail, email, or telephone. If University of Kentucky has chosen this benefit design, attach this document to the group application and sign here

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Signature  
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Date

Q-00019911 – QL-0000034064

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## ADDITIONAL DISCOUNTS

### VISION CARE SERVICES

### IN-NETWORK MEMBER COST

#### DISCOUNTED EXAM SERVICES

Retinal Imaging

Up to \$39

#### DISCOUNTED LENS OPTIONS

Photochromic - Non-Glass

\$75

#### OTHER ADD-ON SERVICES AND MATERIALS

20% off retail price

### \$avings for Members

#### 40% off

additional pairs of glasses and a 15% discount on conventional lenses once funded benefit is used – an industry exclusive

#### 20% off

any item not covered by the plan, including non-prescription sunglasses

#### Lasik

Lasik or PRK from US Laser Network  
15% off retail price or 5% off promotional price

#### Hearing Care

Amplifon Hearing Health Care Network  
40% off hearing exams and a low price guarantee on discounted hearing aids

#### DISCOUNT DETAILS

Member receives a 20% discount on items not covered by the plan at EyeMed In-Network locations. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products. The Plan reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Service and amounts listed above are subject to change at any time.

# FACTS

## WHAT DOES Fidelity Security Life Insurance Company, Fidelity Security Life Insurance Company of New York (NY Only) and Affiliates DO WITH YOUR PERSONAL INFORMATION?

<b>Why?</b>	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
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<b>What?</b>	<p>The types of personal information we collect and share depend on the product or service you have with us. This information can include:</p> <ul style="list-style-type: none"> <li>■ Social Security number and transaction history</li> <li>■ medical information and insurance claim information</li> <li>■ assets and checking account information</li> </ul> <p>When you are no longer our customer, we continue to share your information as described in this notice.</p>
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<b>How?</b>	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons Fidelity Security Life Insurance Company and Affiliates choose to share; and whether you can limit this sharing.
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Reasons we can share your personal information	Does Fidelity Security Life share?	Can you limit this sharing?
<b>For our everyday business purposes</b> – such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
<b>For our marketing purposes</b> – to offer our products and services to you	Yes	No
<b>For joint marketing with other financial companies</b>	Yes	No
<b>For our affiliates' everyday business purposes</b> – information about your transactions and experiences	Yes	No
<b>For our affiliates' everyday business purposes</b> – information about your creditworthiness	No	We don't share
<b>For our affiliates to market to you</b>	No	We don't share
<b>For nonaffiliates to market to you</b>	No	We don't share

<b>Questions?</b>	Call 800-648-8624 or go to <a href="http://www.fslins.com">www.fslins.com</a> or <a href="http://www.ftj.com">www.ftj.com</a>
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Who we are	
Who is providing this notice?	Fidelity Security Life Insurance Company and Affiliates including our Administrative, Insurance and Financial Service Providers.

What we do	
How does Fidelity Security Life Insurance Company and Affiliates protect my personal information?	<p>To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings.</p> <p>These physical, electronic and procedural safeguards were created to protect your information. We also limit employee access as appropriate.</p>
How does Fidelity Security Life Insurance Company and Affiliates collect my personal information?	<p>We collect your personal information, for example, when you</p> <ul style="list-style-type: none"> <li>■ apply for insurance or pay insurance premiums</li> <li>■ file an insurance claim or give us your contact information</li> <li>■ show your driver's license</li> </ul> <p>We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.</p>
Why can't I limit all sharing?	<p>Federal law gives you the right to limit only</p> <ul style="list-style-type: none"> <li>■ sharing for affiliates' everyday business purposes – information about your creditworthiness</li> <li>■ affiliates from using your information to market to you</li> <li>■ sharing for nonaffiliates to market to you</li> </ul> <p>State laws and individual companies may give you additional rights to limit sharing.</p>

Definitions	
Affiliates	<p>Companies related by common ownership or control. They can be financial and nonfinancial companies.</p> <ul style="list-style-type: none"> <li>■ <i>Our affiliates include Fidelity Security Life Insurance Company of New York, Forrest T. Jones &amp; Company, Inc., Forrest T. Jones Consulting Company and National Pension &amp; Group Consultants, Inc.</i></li> </ul>
Nonaffiliates	<p>Companies not related by common ownership or control. They can be financial and nonfinancial companies.</p> <ul style="list-style-type: none"> <li>■ <i>Fidelity Security Life Insurance Company does not share with nonaffiliates so they can market to you.</i></li> </ul>
Joint marketing	<p>A formal agreement between nonaffiliated financial companies that together market financial products or services to you.</p> <ul style="list-style-type: none"> <li>■ <i>Our joint marketing partners include insurance agencies, broker dealers and investment advisor firms.</i></li> </ul>

Other important information	



# FIDELITY SECURITY LIFE INSURANCE COMPANY®

3130 Broadway  
Kansas City, Missouri 64111-2406  
Phone 800-648-8624  
A STOCK COMPANY  
(Herein Called "the Company")

**POLICY NUMBER:** VC-146  
**POLICYHOLDER:** University of Kentucky  
**POLICY EFFECTIVE DATE:** July 1, 2011  
**POLICY ANNIVERSARY DATE:** July 1 of the following year and each July 1 thereafter

Fidelity Security Life Insurance Company represents that the Insured Person is insured for the benefits described in the following pages, subject to and in accordance with the terms and conditions of the Policy.

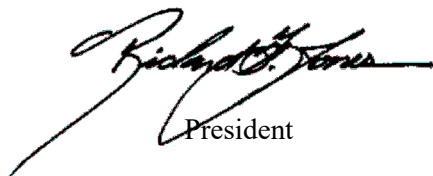
The Policy may be amended, changed, cancelled or discontinued without the consent of any Insured Person.

The Certificate explains the plan of insurance. An individual identification card will be issued to the Insured containing the group name, group number, and Insured's effective date. The Certificate replaces all certificates previously issued to the Insured under the Policy.

All periods of time under the Policy will begin and end at 12:01 A.M. Local Time at the Policyholder's business address.

The Policy is issued by Fidelity Security Life Insurance Company at Kansas City, Missouri on the Policy Effective Date.

FIDELITY SECURITY LIFE INSURANCE COMPANY

  
President

  
Secretary

**GROUP VISION INSURANCE CERTIFICATE**  
**THIS IS A LIMITED BENEFIT CERTIFICATE**  
*Please read the Certificate carefully.*

**THIS PLAN IS NOT MEDICARE SUPPLEMENT. If you are eligible for Medicare, please review "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare," available from the Company.**



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## DEFINITIONS

**Allowance** means the benefit amount shown in the Schedule of Benefits that is the maximum amount payable by the Company, subject to the expenses incurred. The Insured Person is responsible for any amounts due above the Allowance. The Allowance cannot be used to satisfy a Copayment.

**Benefit Frequency** means the period of time in which a benefit is payable as shown in the Schedule of Benefits.

The Benefit Frequency begins on July 1. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

**Copayment** or **Copay** means the designated amount, if any, shown in the Schedule of Benefits each Insured Person must pay to a Provider before benefits are payable for a covered Vision Examination or Vision Materials per Benefit Frequency.

**Comprehensive Eye Examination** means a general evaluation of the complete visual system. The examination includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields, basic sensorimotor examination and Refraction. It always includes initiation of diagnostic and treatment programs. It may include biomicroscopy, examination with cycloplegia or mydriasis and tonometry, as determined by the Provider. These services may be performed at different sessions, but comprise only one Comprehensive Eye Examination.

**Dependent** means any of the following persons whose coverage under the Policy is in force and has not ended:

1. the Insured's lawful spouse or Domestic Partner;
2. each child of the Insured or the Insured's spouse who is under 26 years of age;
3. each unmarried child at least 26 years of age who is primarily dependent upon the Insured or the Insured's spouse for support and maintenance because the child is incapable of self-sustaining employment by reason of mental incapacity or physical handicap.

Dependent includes a step-child, foster child, legally adopted child, child for whom the Insured is a party to a suit for adoption, child who has been placed in the Insured's home for adoption and child under the Insured's legal guardianship, if such child depends primarily on the Insured for support. Dependent will also include a child for whom the Insured is legally required to support due to court order or divorce decree.

**Domestic Partner** means a same-sex or an opposite-sex adult who is in a committed relationship with the Insured and the Insured and the Domestic Partner are mutually responsible for one another financially and otherwise. The term "spouse," wherever used, will include a Domestic Partner.

**Formulary** means a list, provided by the Company, of Vision Materials by tier, that are covered under the Policy as shown in the Schedule of Benefits.

**Insured** means an employee of the Policyholder who meets the eligibility requirements as shown in the Policyholder's application, and whose coverage under the Policy is in force and has not ended.

**Insured Person** means the Insured. Insured Person will also include the Insured's Dependents, if enrolled.

**In-Network Provider** means a Provider who has signed a Preferred Provider Agreement with the PPO.

**Medically Necessary Contact Lenses** means that adequate functional vision correction cannot be achieved with spectacles but can be achieved with contact lenses. Conditions that qualify for Medically Necessary Contact Lenses are:

1. Anisometropia of 3D in meridian powers;
2. High Ametropia exceeding -12D or +12D in meridian powers;
3. Keratoconus when vision is not correctable to 20/25 in either eye or both eyes using standard spectacle lenses; or
4. vision impairments, other than Keratoconus, when vision can be improved by two lines on the visual acuity chart when compared to best corrected standard spectacle lenses.

**Out-of-Area Provider** means an Out-of-Network Provider that is utilized by the Insured Person when there is no In-Network Provider within 30 minutes or 30 miles of the Insured Person's residence or place of employment.

**Out-of-Network Provider** means a Provider, located within the PPO Service Area, but is not an In-Network Provider.

**Policy** means the Vision Insurance Policy issued to the Policyholder.

**Policyholder** means the employer named as the Policyholder in the face page of the Policy.

**PPO Service Area** means the geographical area where the PPO is located.

**Preferred Provider Agreement** means the agreement between the PPO and a Provider who agrees to become an In-Network Provider. The Preferred Provider Agreement contains the rates and reimbursement methods for services and supplies furnished by an In-Network Provider.

**Preferred Provider Organization ("PPO")** means a network of Providers and retail chain stores within the PPO Service Area that have signed a Preferred Provider Agreement.

**Provider** means a licensed physician or optometrist who is operating within the scope of his or her license. Provider also includes a dispensing optician.

**Refraction** means a test performed by a Provider to determine the glasses or contact lens prescription due to a refractive error (for example, nearsightedness, farsightedness, astigmatism or presbyopia).

**Vision Examination** means any eye or visual examination covered under the Policy and shown in the Schedule of Benefits.

**Vision Materials** means those materials provided for visual health and welfare shown in the Schedule of Benefits.

## **EFFECTIVE DATES**

**Effective Date of Insured's Insurance.** The Insured's insurance will be effective as follows:

1. if the Policyholder does not require the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured becomes eligible;
2. if the Policyholder requires the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured becomes eligible, provided;
  - a. the Insured has given the Company the Insured's enrollment form (if required) on, prior to, or within 30 days of the date the Insured becomes eligible; and
  - b. the Insured has agreed to pay the required premium contributions; and
3. if the Insured fails to meet the requirements of 2 a) and 2 b) within 30 days after becoming eligible, the Insured's coverage will not become effective until the Company has verified that the Insured has met these requirements. The Insured will then be advised of the Insured's effective date.

**Effective Date of Dependents' Insurance.** Coverage for Dependents becomes effective on the later of:

1. the date Dependent coverage is first included in the Insured's coverage; or
2. the premium due date on or after the date the person first qualifies as the Insured's Dependent. If an enrollment form is required, the Insured must provide such form and agree to pay any premium contribution that may be required prior to coverage becoming effective.

If the Insured and the Insured's spouse are both Insureds, one Insured may request to be a Dependent spouse of the other. A Dependent child may not be covered by more than one Insured.

**Newborn Children.** A Dependent child born while the Insured's coverage is in force will be covered from the moment of birth for 31 days or a greater number of days, if elected by the Policyholder. To continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period.

**Adopted Children.** If a Dependent child is placed with the Insured for adoption while the Insured's coverage is in force, this child will be covered from the date of placement for 31 days or a greater number of days, if elected by the Policyholder. To continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period. If proper notice has been given, coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement.

## **BENEFITS**

Benefits are payable for each Insured Person as shown in the Schedule of Benefits for expenses incurred while this insurance is in force.

**In-Network Provider Benefits.** The Insured Person must pay any Copayment or any cost above the Allowance shown in the Schedule of Benefits at the time the covered service is provided. Benefits will be paid to the In-Network Provider who will file a claim with the Company on behalf of the Insured Person.

**Out-of-Network Provider Benefits.** The Insured Person must pay the Out-of-Network Provider the full cost at the time the covered service is provided and file a claim with the Company, unless the Out-of-Network Provider allows assignment of benefits. The Company will pay the Out-of-Network benefits up to the maximum dollar amount shown in the Schedule of Benefits.

**Out-of-Area.** An Insured Person who does not have access to an In-Network Provider within 30 minutes or 30 miles of the Insured Person's residence or place of employment may receive services from an Out-of-Area Provider. The Insured Person must pay the full cost at the time the covered service is provided and file a claim with the Company, unless the Out-of-Area Provider allows assignment of benefits. The Company will pay up to the In-Network Provider Allowance(s) and any cost above the In-Network Provider Copayments as shown in the Schedule of Benefits.

## **LIMITATIONS**

Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy.

Allowances provide no remaining balance for future use within the same Benefit Frequency.

## EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from:

1. medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures;
2. Refraction, when not provided as part of a Comprehensive Eye Examination;
3. services provided to an Insured Person who is eligible for benefits as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
4. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
5. any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment;
6. safety eyewear;
7. solutions, cleaning products or frame cases;
8. non-prescription sunglasses;
9. plano (non-prescription) lenses;
10. plano (non-prescription) contact lenses;
11. two pair of glasses in lieu of bifocals;
12. electronic vision devices;
13. services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or
14. lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.

## TERMINATION OF INSURANCE

The Policyholder or the Company may terminate or cancel the Policy as shown in the Policy.

**For All Insureds.** The Insureds' insurance will cease on the earlier of:

1. the date the Policy ends;
2. the end of the last period for which any required premium contribution agreed to in writing has been made, subject to the Grace Period provision;
3. the date the Insured is no longer eligible for insurance; or
4. the date the Insured's employment with the Policyholder ends. The Policyholder may, at the Policyholder's option, continue insurance for individuals whose employment has ended, if the Policyholder:
  - a. does so without individual selection between Insureds; and
  - b. continues to pay any premium contribution for those individuals.

**For Dependents.** A Dependent's insurance will cease on the earlier of:

1. the date the Insured's coverage ends;
2. the date the Dependent ceases to be an eligible Dependent as defined in the Policyholder's application; or
3. the end of the last period for which any required premium contribution has been made.

A Dependent child will not cease to be a Dependent solely because of age if the child is:

1. not capable of self-sustaining employment due to mental incapacity or physical handicap that began before the age limit was reached; and
2. mainly dependent on the Insured for support.

The Company may ask for proof of the eligible Dependent child's incapacity and dependency two months prior to the date the Dependent child would otherwise cease to be covered.

The Company may require the same proof again, but will not request it more than once a year after this coverage has been continued for two years. This continued coverage will end on the earlier of:

1. on the date the Policy ends;
2. on the date the incapacity or dependency ends;
3. on the end of the last period for which any required premium contribution for the Dependent child has been made; or
4. 60 days following the date the Company requests proof and such proof is not provided to the Company.

## PREMIUMS

The Company provides insurance coverage in return for premium payment. Premiums are payable to the Company by the Policyholder on behalf of the Insured Person. The Insured Person's first premium is due on the Insured Person's Effective Date. Premiums must be paid to the Company on or before the due date. The initial premium rates are shown in the Policyholder's application.

**Premium Changes.** The Company has the right to change the premium rates on any premium due date as allowed in the Policy. The Company will provide written notice to the Policyholder at least 31 days before the date of the change. The premium rates also may be changed at any time the terms of the Policy are changed.

**Grace Period.** The Policy has a 31-day grace period for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. Coverage will terminate at the end of the grace period if all premiums due are not paid. The Company will require payment of all premiums for the period this coverage continues in force, including the premiums for the grace period. The grace period will not apply if the Company receives written notice of the Policyholder's or the Insured's intent to terminate coverage.

**Unpaid Premium.** When a claim is paid during the grace period, any premium due and unpaid for the Insured Person will be deducted from the claim payment.

## CLAIMS

**Notice of Claim.** Written notice of claim must be given to the Company within 30 days after the occurrence or commencement of any loss covered by the Policy, or as soon as is reasonably possible. Notice given by or for the Insured Person to the Company at the Company's home office, to the Company's authorized administrator or to any of the Company's authorized agents with sufficient information to identify the Insured Person will be deemed as notice to the Company.

**Claim Forms.** The Company will furnish claim forms to the Insured Person within 15 days after notice of claim is received. If the Company does not provide the forms within that time, the Insured Person may send written proof of the occurrence, character and extent of loss for which the claim is made within the time stated in the Policy for filing proof of loss.

**Proof of Loss.** Written proof of loss must be furnished to the Company at the Company's home office within 90 days after the date of the loss. Failure to furnish proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within that time, if the proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted later than one year from the time proof is required.

**Time Payment of Claims.** Any benefit payable under the Policy will be paid immediately, but not more than 30 days, upon receipt of due written proof of loss.

**Payment of Claims.** All claims will be paid to the Insured, unless assigned. Any benefits payable on or after the Insured's death will be paid to the Insured's estate.

**Assignment.** Benefits under the Policy may be assigned.

**Right of Recovery.** If payment for claims exceeds the amount for which the Insured Person is eligible under any benefit provision or rider of the Policy, the Company has the right to recover the excess of such payment from the Provider or the Insured.

**Legal Actions.** No Insured Person can bring an action at law or in equity to recover on the Policy until more than 60 days after the date written proof of loss has been furnished according to the Policy. No such action may be brought after the expiration of three years after the time written proof of loss is required to be furnished. If the time limit of the Policy is less than allowed by the laws of the state where the Insured Person resides, the limit is extended to meet the minimum time allowed by such law.

**Claim Appeal Procedure.** If the Company partially or fully denies a claim for benefits submitted by an Insured Person and the Insured Person disagrees or does not understand the reasons for this denial, the Insured Person, an authorized person or a provider acting on behalf of the Insured Person may appeal this decision and such person has the right to: 1) request a review of the denial; 2) review pertinent plan documents; and 3) submit in writing any data, documents or comments which are relevant to the Company's review of this denial. The appeal must be submitted in writing within 60 days of receiving written notice of denial. The Company will review all information and send written notification within 30 days of the request.

## **GENERAL PROVISIONS**

**Clerical Error.** Clerical errors or delays in keeping records for the Policy will not deny insurance that would otherwise have been granted, nor extend insurance that otherwise would have ceased, and call for a fair adjustment of premium and benefits to correct the error.

**Conformity to Law.** Any provision of the Policy that is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

**Entire Contract.** The Policy, including any endorsements and riders, the Certificate, the Policyholder's application, which is attached to the Policy when issued, the Insured's individual enrollment form, if any, and the eligibility file, if any, are the entire contract between the parties. A copy of the Policy may be examined at the office of the Policyholder during normal business hours. All statements made by the Policyholder or an Insured will, in the absence of fraud, be deemed representations and not warranties, and no such statement will be used in defense to a claim hereunder unless it is contained in a written instrument signed by the Policyholder, the Insured, the Insured's beneficiary or personal representative, a copy of which has been furnished to the Policyholder, the Insured, the Insured's beneficiary or personal representative.

**Amendments and Changes.** No agent is authorized to alter or amend the Policy, or to waive any conditions or restrictions herein, or to extend the time for paying any premium. The Policy and the Certificate may be amended at any time by mutual agreement between the Policyholder and the Company without the consent of the Insured, but without prejudice to any loss incurred prior to the effective date of the amendment. No person except an Officer of the Company has authority on behalf of the Company to modify the Policy or to waive or lapse any of the Company's rights or requirements.

**Incontestability.** After the Policy has been in force for two years, it can only be contested for nonpayment of premiums. No statement made by an Insured Person can be used in a contest after the Insured Person's insurance has been in force for two years during the Insured Person's lifetime. No statement an Insured Person makes can be used in a contest unless it is in writing and signed by the Insured Person.

**Insurance Data.** The Policyholder must give the Company the names and ages of all individuals initially insured. The names of persons who later become eligible (whether or not the person becomes insured), and the names of those who cease to be eligible must also be given. The eligibility dates and any other necessary data must be given to the Company so that the premium can be determined.

The Company has the right to audit the Policyholder's books and records as the books and records relate to this insurance. The Company may authorize someone else to perform this audit. Any such inspection may be done at any reasonable time.

**Workers' Compensation.** The Policy is not a Workers' Compensation policy. The Policy does not satisfy any requirement for coverage by Workers' Compensation Insurance.



## SCHEDULE OF BENEFITS

University of Kentucky.  
ESSENTIAL OPTION

<b><i>BENEFIT FREQUENCY</i></b>		
<b><u>Vision Examinations</u></b>	once every 12 months	Insured Person
<b><u>Vision Materials</u></b>		
<b>Frame</b>	once every 24 months	Insured Person
<b>Lenses and Lens Options</b>	once every 12 months	Insured Person
<b>Contact Lenses</b>	once every 12 months	Insured Person

<b><i>BENEFIT</i></b>	<b><i>In-Network</i></b>		<b><i>Out-of-Network Provider</i></b> <b><i>(Reimbursement up to)</i></b>
	<b><i>Plus In-Network Provider</i></b>	<b><i>In-Network Provider</i></b>	
<b><u>Vision Examination</u></b>			
<b>Comprehensive Eye Examination</b>	\$0 Copayment	\$10 Copayment	\$40
<b><u>Vision Materials</u></b>			
<b>Frame</b>	\$0 Copayment up to \$180 Allowance	\$0 Copayment up to \$130 Allowance	\$55
<b>Contact Lenses</b> Only one of the following Contact Lenses benefits may be used for the Contact Lenses benefit. Contact Lenses are in lieu of Lenses.			
Conventional	\$0 Copayment up to \$130 Allowance	\$0 Copayment up to \$130 Allowance	\$100
Disposable	\$0 Copayment up to \$130 Allowance	\$0 Copayment up to \$130 Allowance	\$100
Medically Necessary	Paid in Full	Paid in Full	\$200
<b>Standard Plastic Lenses</b>			
Single Vision	\$10 Copayment	\$10 Copayment	\$40
Bifocal	\$10 Copayment	\$10 Copayment	\$60
Trifocal	\$10 Copayment	\$10 Copayment	\$80
Progressive – Standard	\$75 Copayment	\$75 Copayment	\$60
Progressive – Premium Tier 1	\$95 Copayment	\$95 Copayment	\$60
Progressive – Premium Tier 2	\$105 Copayment	\$105 Copayment	\$60
Progressive – Premium Tier 3	\$120 Copayment	\$120 Copayment	\$60
Progressive – Premium Tier 4	\$75 Copayment up to \$120 Allowance	\$75 Copayment up to \$120 Allowance	\$60
<b>Lens Options</b>			
Polycarbonate Lenses – Standard Dependent Children under 19 years of age	\$0 Copayment	\$0 Copayment	\$30

## SCHEDULE OF BENEFITS

University of Kentucky.  
ENHANCED OPTION

<b><i>BENEFIT FREQUENCY</i></b>		
<b><u>Vision Examinations</u></b>	once every plan year	Insured Person
<b><u>Vision Materials</u></b>	once every plan year	Insured Person

<b><i>BENEFIT</i></b>	<b><i>In-Network</i></b>		<b><i>Out-of-Network Provider</i></b> <b><i>(Reimbursement up to)</i></b>
	<b><i>Plus In-Network Provider</i></b>	<b><i>In-Network Provider</i></b>	
<b><u>Vision Examination</u></b>			
<b>Comprehensive Eye Examination</b>	\$0 Copayment	\$0 Copayment	\$42
<b>Contact Lenses Fit and Follow-Up</b> (One Fit and two Follow-Up visits) Contact Lenses Fit and Follow Up is available once a Comprehensive Eye Examination has been completed.			
Standard	\$0 Copayment	\$0 Copayment	\$40
Premium	\$0 Copayment up to \$40 Allowance	\$0 Copayment up to \$40 Allowance	\$40
<b><u>Vision Materials</u></b>			
<b>Frame</b>	\$0 Copayment up to \$210 Allowance	\$0 Copayment up to \$160 Allowance	\$80
<b>Contact Lenses</b> Only one of the following Contact Lenses benefits may be used for the Contact Lenses benefit. Contact Lenses are in lieu of Lenses and Lens Options.			
Conventional	\$0 Copayment up to \$160 Allowance	\$0 Copayment up to \$160 Allowance	\$128
Disposable	\$0 Copayment up to \$160 Allowance	\$0 Copayment up to \$160 Allowance	\$128
Medically Necessary	Paid in Full	Paid in Full	\$210
<b>Standard Plastic Lenses</b>			
Single Vision	\$10 Copayment	\$10 Copayment	\$40
Bifocal	\$10 Copayment	\$10 Copayment	\$60
Trifocal	\$10 Copayment	\$10 Copayment	\$80
Progressive – Standard	\$10 Copayment	\$10 Copayment	\$83
Progressive – Premium Tier 1	\$30 Copayment	\$30 Copayment	\$83
Progressive – Premium Tier 2	\$40 Copayment	\$40 Copayment	\$83

<b><i>BENEFIT</i></b>	<b><i>In-Network</i></b>		<b><i>Out-of-Network Provider</i></b> <b><i>(Reimbursement up to)</i></b>
	<b><i>Plus In-Network Provider</i></b>	<b><i>In-Network Provider</i></b>	
Progressive – Premium Tier 3	\$55 Copayment	\$55 Copayment	\$83
Progressive – Premium Tier 4	\$10 Copayment up to \$120 Allowance	\$10 Copayment up to \$120 Allowance	\$83
<b>Lens Options</b>			
Anti-Reflective Coating – Standard	\$0 Copayment	\$0 Copayment	\$34
Anti-Reflective Coating – Premium Tier 1	\$12 Copayment	\$12 Copayment	\$34
Anti-Reflective Coating – Premium Tier 2	\$23 Copayment	\$23 Copayment	\$34
Anti-Reflective Coating – Premium Tier 3	\$0 Copayment Up to \$45 Allowance	\$0 Copayment Up to \$45 Allowance	
Polycarbonate Lenses – Standard	\$0 Copayment	\$0 Copayment	\$30
Scratch Coating – Standard Plastic	\$0 Copayment	\$0 Copayment	\$12
Tint – Solid and Gradient	\$0 Copayment	\$0 Copayment	\$12
UV Treatment	\$0 Copayment	\$0 Copayment	\$12



# FIDELITY SECURITY LIFE INSURANCE COMPANY

3130 Broadway  
Kansas City, Missouri 64111-2406  
Phone 800-648-8624  
A STOCK COMPANY  
(Herein Called "the Company")

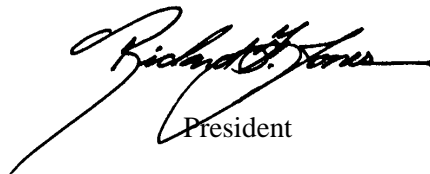
## AMENDMENT RIDER

By attachment of this Rider, the third paragraph of the **PREMIUMS** section in the Policy is amended to add the following:

5. if a government action, including fees, taxes and assessments, or change in law or regulation materially affects the Company's risk, premium may be adjusted and will be effective upon written notification from the Company at least 31 days before the date of change.

This Rider takes effect on the effective date of the Policy to which it is attached. This Rider terminates concurrently with the Policy to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Policy except as stated.

FIDELITY SECURITY LIFE INSURANCE COMPANY

  
Richard C. Jones  
President

  
Bradford R. Jones  
Secretary



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## NOTICE OF ADMINISTRATOR'S CAPACITY

**PLEASE READ:** This notice advises insured persons of the identity and relationship among the administrator, the policyholder and the insurer:

1. Fidelity Security Life Insurance Company (FSL) has, by agreement, arranged for First American Administrators, Inc. to provide administrative services for your insurance plan. As administrator, First American Administrators, Inc., is authorized to process claim payments, and perform other services, according to the terms of its agreement with the insurance company. First American Administrators, Inc. is not the insurance company or the policyholder.
2. The policyholder is the entity to whom the insurance policy has been issued. The policyholder is identified on either the face page or schedule page of the policy or certificate.
3. Fidelity Security Life Insurance Company is liable for the funds to pay your insurance claims.

As First American Administrators, Inc. is authorized to process claims for the insurance company, they will do so promptly. In the event there are delays in claims processing, you will have no greater rights to interest or other remedies against First American Administrators, Inc. than would otherwise be afforded to you by law.