



# 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:** Charlottesville City Schools  
**STATE OF ISSUE:** Virginia  
**POLICY EFFECTIVE DATE:** July 1, 2012  
**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**  
*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 and are limited to a maximum period of the current month plus six months.

**Premium Rate Change.** The Company has the right to change the premium rate 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. The Company will mail a notice of termination due to nonpayment of the premium to the Policyholder not less than 15 days prior to the end of 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.

In the event coverage is terminated due to nonpayment of premium by the Policyholder, the coverage will not be terminated by the Company with respect to Insured Persons, until the Policyholder has been provided written notice of termination, including a specific date, not less than 15 days from the date of such notice, by which coverage will terminate if overdue premium is not paid. Coverage will not terminate for at least 15 days after such notice has been mailed.

## **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 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

President

Secretary



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## NOTICE OF PROTECTION PROVIDED BY VIRGINIA LIFE, ACCIDENT AND SICKNESS INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or accident and sickness insurance company (including a health maintenance organization) licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
  - o \$300,000 in death benefits
  - o \$100,000 in cash surrender or withdrawal values
- Health Insurance
  - o \$500,000 for health benefit plans
  - o \$300,000 in disability income insurance benefits
  - o \$300,000 in long-term care insurance benefits
  - o \$100,000 in other types of accident and sickness insurance benefits
- Annuities
  - o \$250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$350,000, except for health benefit plans, for which the limit is increased to \$500,000.

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association's website at [www.valifega.org](http://www.valifega.org) or contact:

Virginia Life, Accident and Sickness Insurance  
Guaranty Association  
c/o DSH Consulting LLC  
P.O. Box 606  
534 Main Street  
Hampden, MA 01036-9998  
(571) 438-9408

State Corporation Commission  
Bureau of Insurance  
P. O. Box 1157  
Richmond, VA 23218-1157  
(804) 371-9741  
Toll Free: 1-877-310-6560  
<http://www.scc.virginia.gov/pages/Home>

**Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia law, then Virginia law will control.**

# 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?

### Why?

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.

### What?

The types of personal information we collect and share depend on the product or service you have with us. This information can include:

- Social Security number and transaction history
- medical information and insurance claim information
- assets and checking account information

When you are no longer our customer, we continue to share your information as described in this notice.

### How?

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.

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

### Questions?

Call 800-648-8624 or go to [www.fslins.com](http://www.fslins.com) or [www.ftj.com](http://www.ftj.com)

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	



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## Amendment to the Application for Vision Care Benefits

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

Group Name: Charlottesville City Schools

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

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Effective July 1, 2024 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: July 1, 2024 New Renewal Date: July 1, 2028

#### 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®

*Bryson Z. Jones*      *Bradford R. Jones*

President

Secretary



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## AMENDMENT TO THE APPLICATION FOR VISION CARE BENEFITS

### CURRENT GROUP INFORMATION (AS REFLECTED IN THE COMPANY'S RECORDS):

Group Name: Charlottesville City Schools  
DBA, if applicable: \_\_\_\_\_  
Policy Number: VC-19 Group Number: \_\_\_\_\_

EFFECTIVE July 1, 2020 THE APPLICATION FOR VISION CARE BENEFITS IS AMENDED AS NOTED BELOW:

NAME CHANGE (SAME TAX ID #):

New Group Name: \_\_\_\_\_  
DBA, if applicable: \_\_\_\_\_

CHANGE IN PRIMARY BUSINESS ADDRESS (SAME STATE):

New Street Address: \_\_\_\_\_  
P.O. Box: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

\* Except as required by state law.

CHANGE TO DEPENDENT AGE COVERAGE\*\*:

Dependent Children to be covered to Age\*\*  19  21  25  26\*\*\*  Other \_\_\_\_\_  
Dependent Children to be covered if Full-Time Student\*\*  Yes  No  
If "Yes", Dependent Full-Time Student Covered to\*\*  21  25  27  Other \_\_\_\_\_

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

\*\*\* Regardless of financial dependency, residency, student status, or marital status.

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**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 RENEWAL DATE:**

Original Renewal Date: \_\_\_\_\_  
New Renewal Date: \_\_\_\_\_

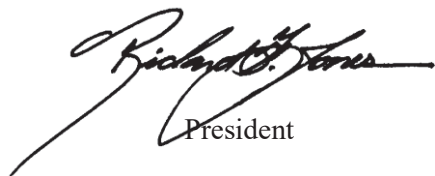
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**CHANGE IN GROUP SIZE (FLORIDA POLICYHOLDERS ONLY):**

Original Number of Full-time Employees: \_\_\_\_\_  
New Number of Full-time Employees: \_\_\_\_\_

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FIDELITY SECURITY LIFE INSURANCE COMPANY

  
President

  
Secretary



**Charlottesville City Schools**

EyeMed Access Plan H, Fixed Fee  
Voluntary  
Option 1

*EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company*

Version 7

Vision Care Services	Member Cost In-Network	Out-of-Network Reimbursement*
Exam with Dilatation as Necessary	\$10 Copay	\$35
Retinal Imaging Benefit	Up to \$39	N/A
Exam Options: Standard Contact Lens Fit and Follow-Up: Premium Contact Lens Fit and Follow-Up:	Up to \$55 10% off Retail Price	N/A N/A
Frames: Any available frame at provider location	\$0 Copay; \$130 Allowance, 20% off balance over \$130	\$65
Standard Plastic Lenses Single Vision Bifocal Trifocal Lenticular Standard Progressive Lens Premium Progressive Lens	\$10 Copay \$10 Copay \$10 Copay \$10 Copay \$65 Copay \$65 Copay, 80% of Charge less \$120 Allowance	\$25 \$40 \$55 \$55 \$40 \$40
Lens Options: UV Treatment Tint (Solid and Gradient) Standard Plastic Scratch Coating Standard Polycarbonate - Adults Standard Polycarbonate - Kids under 19 Standard Anti-Reflective Coating Polarized  Other Add-Ons	\$15 \$15 \$15 \$40 \$40 \$45 20% off Retail Price  20% off Retail Price	N/A N/A N/A N/A N/A N/A N/A N/A
Contact Lenses (Contact lens allowance includes materials only) Conventional Disposable Medically Necessary Laser Vision Correction Lasik or PRK from U.S. Laser Network	\$0 Copay; \$135 allowance, 15% off balance over \$135 \$0 Copay; \$135 allowance, plus balance over \$135 \$0 Copay, Paid-in-Full  15% off Retail Price or 5% off promotional price	\$108 \$108 \$210  N/A
Amplifon Hearing Health Care	Hearing Health Care from Amplifon Hearing Health Care Network Members receive a 40% discount off hearing exams and a low price guarantee on discounted hearing aids.	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency: Examination Lenses or Contact Lenses Frame	Once every 12 months Once every 12 months Once every 12 months	
Monthly Rate Subscriber Subscriber + Spouse Subscriber + Child(ren) Subscriber + Family	\$9.27 \$17.48 \$18.41 \$27.00	

All plans are based on a 48-month contract term and 48-month rate guarantee.

Premium 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

\* Member Reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider. 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

**Additional Discounts:**

Member receives a 20% discount on items not covered by the plan at network Providers. 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. Services or materials provided by any other group benefit plan providing vision care may not be covered.

Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.

After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com). The contact lens benefit allowance is not applicable to this service.

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

Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group

Rates are valid for groups domiciled in the State of VA.

Fees quoted will be valid until the 7/1/2020 plan implementation date. Date quoted: 3/18/2020.

Rates assume Employer contribution of 20% or less for employees and dependents

Insured Plans are underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York

Policy number VC-19/VC-20, form number M-9083

**Plan Exclusions:**

- 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures;
- 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear
- 4) 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;
- 5) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals;
- 8) 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; 9) Services or materials provided by any other group benefit plan providing vision care;
- 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

If Charlottesville City Schools has chosen this benefit design, sign here:

*Rene Hoover*  
Signature

4/13/2020  
Date

TC7



Underwritten by Fidelity Security Life Insurance Company

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Policy No.

Application for Vision Care Benefits

I. EMPLOYER INFORMATION

Employer Name: Charlottesville City Schools

Tax ID #: 54-~~10~~-6001203

DBA Name (if other than above): \_\_\_\_\_

Business Address: 1562 Dairy Rd

City: Charlottesville

State: VA Zip: 22903

Mailing Address (if other than above): \_\_\_\_\_

City: \_\_\_\_\_

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

Principal Contact: Debra Oden

Title: Coordinator Budget / Benefits

Phone Number: 434-245-2949

Fax Number: 434-245-2957

E mail address: Debra.oden@ccs.k12-va.us

Type of Business:  Proprietorship  Corporation  Partnership  Other (Specify): \_\_\_\_\_

Service Area:  National (US, does not include Puerto Rico)  State Specific (list): \_\_\_\_\_

If any subsidiary or affiliated companies are to be insured or any Employees are working at a location other than the address above, please explain:

Will this plan replace any existing coverage?  Yes  No

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

Name: \_\_\_\_\_ Address: \_\_\_\_\_

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

Effective date of existing coverage: \_\_\_\_\_

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

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

Are Domestic Partners covered under this plan?  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

Employer's Premium Contribution for: Employees: \_\_\_\_\_ Dependents: \_\_\_\_\_

Employee's Premium Contribution for: Employees: 100% Dependents: 100%

Are Employee and Dependent premiums being paid through a Section 125 Plan?  Yes  No Pretax basis

Are Employee and Dependent premiums being collected by payroll deduction?  Yes  No

Premium received with application: N/A

NUMBER OF PARTICIPANTS

Total number of employees: to be determined

Total number of dependents: to be determined

Premiums shall be payable in advance at the rates set forth in the Schedule of Premiums, included on the attached proposal page.

IV. ELIGIBILITY INFORMATION

Number of Full-time Employees: app. 720 Number Applying: to be determined

Eligibility Reporting Contact (produces the eligibility file): Penny Glazebrook

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

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

E-mail: \_\_\_\_\_ Phone: (434) 245-2942 Fax: ( ) \_\_\_\_\_

Eligibility Authorization Contact (Benefits Administrator or Third Party Administrator responsible for verifying vision elections for members)

Name: Penny Glazebrook Phone: (434) 245-2942

Days/Hours of Availability: \_\_\_\_\_ E-mail: penny.glazebrook@ccs.k12.va.us

PROBATIONARY PERIOD

For New Employees.  30 days  60 days  90 days  180 days  Other \_\_\_\_\_

Probationary Period is waived for present Employees:  Yes  No

Number of Employees who have not yet completed the probationary period: \_\_\_\_\_

\* Eligible at the first of the month after hire date

V. EFFECTIVE DATE

1. This plan will become effective at 12.01 a.m. Standard Time at the employer's address herein, on the first day of September, 2006, provided that 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 members, according to the membership layout guidelines. It is understood and agreed that EyeMed may rely on this information to provide services to individuals designated as eligible.
  - C. A check for the first month's remittance is received.
2. This plan will be effective through ~~September~~ 2010 (48 months) and the premium is based on the information provided. August 31st

The Employer hereby makes application to Fidelity Security Life Insurance Company for Vision Care Benefits. The Employer agrees to maintain and furnish any records necessary to administer the plan, and to forward premiums monthly in advance.

The Employer certifies that all the information shown on this application and any attachments are correct and complete and understands that the Insurance Company intends to rely on this information in determining whether or not the enrolling Employees may become insured. It is further understood and agreed that **NO INSURANCE WILL BECOME EFFECTIVE UNTIL APPROVED BY THE INSURANCE COMPANY**; and that no field representative of the Insurance Company has the authority to modify any conditions of application, or policies, by making any promise or representation. It is understood that the insurance as to any Employee will not become effective on the date insurance should otherwise become effective if he is not at work on such date performing all duties of his occupation and otherwise meets the requirements of the Insurance Company.

Dated at: \_\_\_\_\_ this 28 day of August 2006.

Signed for the Employer: Dotty Odew Title: Board Budget/Benefits

Member ID Cards

Group will be receiving EyeMed ID cards:  Yes

Company Name as you want it to appear on the ID card. (Can only be 30 characters including punctuation, spacing & any code)

Charlottesville City Schools

Delivery of ID cards

All EyeMed ID cards mailed directly to employees' home address

**EMPLOYER INFORMATION**

- If your group is located in California, and you have members outside of the state of California, please indicate the other states: \_\_\_\_\_
- All other states, if you have members in the state of California, please indicate the total number of members. \_\_\_\_\_

• Billing Contact Name Penny Glazebrook Phone: (434) 245-2942  
 • Billing Address: 1562 Dairy Rd City: Charlottesville State: VA Zip: 22903

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:

- Name
- Address
- Billing Contact and Phone Number

**WRITING BROKER'S CERTIFYING STATEMENT**

I certify that I have accurately recorded on this application the information supplied by the proposed policyholder(s).

Firm Name (print): Wachovia Insurance Services Tax ID Number: 56-1882208

Broker Name (print): Gregory K. Snow

Address 9020 Stony Point Pkwy City: Richmond State: VA Zip: 23235  
Suite 200

Phone # 804-267-3175 Fax # 804-330-1386

Primary Contact: Greg Snow Secondary Contact: Julie Smith

Title: Senior Consultant Title: Associate Consultant

Email: Greg.Snow@wachovia.com Email: Julie.H.Smith@wachovia.com

Broker Signature: X [Signature]

**PLEASE CHECK ONE OF THE FOLLOWING:**

I have been appointed by Fidelity Security Life (FSL). FSL Agent No.: \_\_\_\_\_  
The commission schedule is attached.

- I have not been appointed by FSL.  
My broker application package is attached:
- FSL agent data sheet
  - FSL agent commission agreement
  - License copy

NOTE: Broker commission will not be paid until appointment has been completed





**CHARLOTTEVILLE CITY SCHOOLS**

Benefit presented is for a September 1, 2006 effective date.

Member Copy:  
Exam \$10.00  
Lens \$10.00

Frequency:  
Exam Once per 12 mths  
Frame Once per 24 mths  
Lenses or Contacts Once per 12 mths

Monthly Fee:  
Employee Only \$6.89  
Employee + Spouse \$12.59  
Employee + Child(ren) \$13.68  
Employee + Family \$20.05

*CWW*

**Rate Contribution Level Definition:**  
The rates presented assume 100% employee contribution for employees and dependents.

**Rate Terms and Conditions:**  
Benefit presented has a 48-month policy term and rate guarantee.

Pricing includes broker commissions.

Rates are valid based on group domiciled in the state of VIRGINIA and group size of 501 - 2000 eligible employees.

Fees quoted are valid until the stated effective date

[www.eyemedvisioncare.com](http://www.eyemedvisioncare.com)

**EYEMED ACCESS PLAN H BENEFIT DESIGN SUMMARY**

Eyemed Vision Care in conjunction with Fidelity Security Life Insurance Company Vision Care Services

	Member Cost	Out-of-Network
Exam with Dilation as Necessary:	\$10 Copay	Up to \$35
Exam Options:		
Standard*	Up to \$65	N/A
Premium**	10% off retail price	N/A
Frames (any available frame at provider location):	\$0 Copay, \$100 allowance for a frame plus 20% off balance over \$100	Up to \$45
Standard Plastic Lenses:		
Single Vision	\$10 Copay	Up to \$26
Bifocal	\$10 Copay	Up to \$40
Trifocal	\$10 Copay	Up to \$55
Lens Options (paid by the member):		
Tint (Solid and Gradient)	\$15	N/A
UV Coating	\$15	N/A
Standard Scratch-Resistance	\$15	N/A
Standard Polycarbonate	\$40	N/A
Standard Anti-Reflective	\$45	N/A
Standard Progressive (Add-on to Bifocal)	\$65	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lenses: (allowance for materials only)		
Conventional	\$0 Copay, \$115 allowance, 15% discount off balance over \$115	\$82
Disposables	\$0 Copay, \$115 allowance, plus balance over \$115	\$82
Medically Necessary	\$0 Copay, Paid in full	\$200

\* Standard Contact Lens Filling - spherical over contact lenses in conventional wear and planned replacement (examples include but not limited to disposables, frequent replacement, etc.)  
\*\* Premium Contact Lens Filling - all lens designs, materials and specialty fillings other than Standard Contact Lenses (examples include toric, multifocal, etc.)

**Additional Value Added Savings**

Members receive a 20% discount on remaining balance at participating providers. This discount does not apply to Eyemed providers' professional services or disposable contact lenses. Members also receive a 40% discount on unlimited additional eyewear purchases (complete pairs) after initial benefit has been used. After initial purchase with above benefit, replacement contact lenses may be obtained via the internet at competitive prices and mailed directly to the member. Details are available at [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com).

Members also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization, please call: 1-877-6LASER6.

Benefits may not be combined with any discount, promotional offering or other group benefit plan. Allowances are one-time use benefits with no remaining balance available. Lost or broken materials are not covered.

**Underwriter**

Insured plans are underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri. Fidelity Security Life Insurance Company policy number VO-19 and VO-20; form number M-0034.

**Plan Limitations / Exclusions:**

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
- Services provided as a result of any Worker's Compensation law
- Antiheliotic lenses
- Services or materials provided by any other group benefit providing for vision care.
- Certain frame brands in which the manufacturer imposes a no discount policy.
- Contactive eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan
- Medical and/or surgical treatment of the eye, eyes, or supporting structures
- Two pair of glasses in lieu of bifocals.
- Plans non-prescription lenses and non-prescription sunglasses (except for 20% discount)

**Administration Services and Requirements for this Benefit**

- Membership data is required for all subscribers and dependents. Eyemed prefers to receive membership through our Online Group Management System. The group may submit membership electronically using Eyemed defined formats and processes. Group must provide a unique member ID for all members submitted, including dependents. Member IDs must remain consistent in all future membership data submissions.
- Group will receive monthly premium invoice including a printed membership roster. The invoice will be based on membership as of the 15th of the month. The group will automatically receive retro adjustments on the invoice for the previous 30 days. Payment is due based on the invoice amount and the invoice should be paid as billed. Each specific plan ID will receive one invoice and remit a single payment. Failure to pay invoice amount in 30 days can result in termination of the benefit and authorization of services to members.
- Eyemed can provide custom materials for enrollment events in an electronic or hard copy format. A completed and signed group application and signed benefit sheet are required before materials can be prepared. Please allow a business days for electronic and 10 business days for printed materials creation and delivery. Eyemed requires 15 business days notice for an enrollment event/health fair and representation is subject to defined Eyemed guidelines. Eyemed does not guarantee representation at the group's enrollment event or health fair.
- Utilization and/or claim reporting are available annually upon request using Eyemed standard reporting capabilities.
- Completed and signed Employer Group Application and signed Benefit Design Sheet are required 30 days prior to the effective date. Please note that late or incomplete applications may delay the effective date of the benefit. A minimum of 10 enrolled employees is required for implementation of the benefit.

Each Eyemed group quoted online by a broker/consultant through December 31, 2005, may qualify the broker/consultant for a monetary reward subject to the rules and regulations of the award plan.

If CHARLOTTEVILLE CITY SCHOOLS has chosen this benefit and agrees to the administrative services and requirements outlined above, please sign below and return this sheet with your completed application to your Eyemed sales representative.

*[Signature]*  
Signature



# 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:** Charlottesville City Schools  
**POLICY EFFECTIVE DATE:** July 1, 2012  
**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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SCHEDULE OF BENEFITS..... Attached (1A)

## 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 the later of the Insured Person's effective date or last date services were provided to the Insured Person. 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;
2. each child of the Insured or the Insured's spouse who is under 26 years of age;
3. each child at least 26 years of age who is primarily dependent upon the Insured or the Insured's spouse or Domestic Partner for support and maintenance because the child is incapable of self-sustaining employment by reason of intellectual disability or physical handicap.

Coverage for a Dependent child who is enrolled as a full-time student and is unable, due to a medical condition, to continue as a full-time student will continue: a) for a period of 12 months from the date the child ceases to be a full-time student; or b) the date the child no longer qualifies as a Dependent, whichever occurs first, provided the child's treating physician certifies to the Company at the time the child withdraws as a full-time student that the child's absence is medically necessary.

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. A full-time student is one who is actively attending at least the minimum number of hours of class a week the school considers as full-time status.

**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-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.

## 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 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.

In the event coverage is terminated due to nonpayment of premium by the Policyholder, the coverage will not be terminated by the Company with respect to Insured Persons, until the Policyholder has been provided written notice of termination, including a specific date, not less than 15 days from the date of such notice, by which coverage will terminate if overdue premium is not paid. Coverage will not terminate for at least 15 days after such notice has been mailed.

**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, subject to the Grace Period provision.

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 an intellectual disability 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. The Company will mail a notice of termination due to nonpayment of the premium to the Policyholder not less than 15 days prior to the end of the grace period. The Policyholder will be liable to the Company for the pro rata premium for the time the Policy was in force during the grace period.

## 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.

**Physical Examination and Autopsy.** The Company, at the Company's expense, will have the right and opportunity to examine any Insured Person for whom a claim is pending when and as often as it may reasonably be required during the pendency of a claim. The Company, at the Company's expense, will have the right to make an autopsy in case of death, unless it is forbidden by law.

**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.

**Claims Experience; Disclosure.** The Company, upon request, will provide the Policyholder with a complete record of the Policyholder's claims experience incurred under the Policy. This record will include all claims incurred for the lesser of: 1) the



period of time since the Policy was issued or issued for delivery; or 2) the period of time since the Policy was last renewed, reissued or extended, if already issued. This record will be made available promptly to the Policyholder upon request made but not less than 30 days prior to the date upon which the premiums or contractual terms of the Policy may be amended. Nothing in this provision shall require the disclosure of personal or privileged information about an individual that is protected from disclosure under any applicable federal or state law or regulation.

## **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 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

Charlottesville City Schools

<b><i>BENEFIT FREQUENCY</i></b>		
<b><u>Vision Examination</u></b>	once every 12 months	Insured Person
<b><u>Vision Materials</u></b>		
Frame	once every 12 months	Insured Person
Lenses	once every 12 months	Insured Person
Contact Lenses	once every 12 months	Insured Person

<b><i>BENEFIT</i></b>	<b><i><u>In-Network Provider</u></i></b>	<b><i><u>Out-of-Network Provider</u></i> <i>(Reimbursement up to)</i></b>
<b><u>Vision Examination</u></b>		
Comprehensive Eye Examination	\$10 Copayment	\$35
<b><u>Vision Materials</u></b>		
Frame	\$0 Copayment up to \$130 Allowance	\$65
Contact Lenses Only one of the following Contact Lenses benefits may be used for the Contact Lenses benefit. Contact Lenses are in lieu of Lenses, Frame.		
Conventional	\$0 Copayment up to \$135 Allowance	\$108
Disposable	\$0 Copayment up to \$135 Allowance	\$108
Medically Necessary	Paid in Full	\$210
<b><u>Standard Plastic Lenses</u></b>		
Single Vision	\$10 Copayment	\$25
Bifocal	\$10 Copayment	\$40
Trifocal	\$10 Copayment	\$55
Lenticular	\$10 Copayment	\$55
Progressive – Standard	\$65 Copayment	\$40
Progressive – Premium	\$65 Copayment up to \$120 Allowance	\$40



# FIDELITY SECURITY LIFE INSURANCE COMPANY®

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

## COMMONWEALTH OF VIRGINIA

### IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number:

Fidelity Security Life Insurance Company  
3130 Broadway  
P.O. Box 418131  
Kansas City, Missouri 64141-8131  
(800) 648-8624

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Commonwealth of Virginia  
Bureau of Insurance  
1300 East Main Street  
P.O. Box 1157  
Richmond, Virginia 23218  
(804) 371-9691 (Local)  
(800) 552-7945 (In-state)  
(877) 310-6560 (National Toll-free)

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company, or the Bureau of Insurance, have your policy number available.



# FIDELITY SECURITY LIFE INSURANCE COMPANY®

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

## 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.



# FIDELITY SECURITY LIFE INSURANCE COMPANY®

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

## CONSUMER NOTICE

### Consumer Complaint

If you have a complaint related to quality of care, choice and accessibility of providers, or network adequacy, you may contact:

EyeMed Vision Care, LLC  
Attn: Quality Assurance Department  
4000 Luxottica Place  
Mason, Ohio 45040  
or you may call the toll free number at:  
1-877-226-1115

If you feel that your complaint has not been satisfactorily resolved, you may also contact:

Office of Licensure and Certification (OLC)  
Virginia Department of Health  
9960 Mayland Drive, Suite 401  
Henrico, Virginia 23233  
Phone Number: 1-804-367-2104 (Ask for MCHIP)  
Fax Number: 1-804-527-4503  
E-mail: [mchip@vdh.virginia.gov](mailto:mchip@vdh.virginia.gov)

or

Office of the Managed Care Ombudsman  
Bureau of Insurance  
P.O. Box 1157  
Richmond, VA 23218  
Or you may call: 1-877-310-6560  
In the Richmond metropolitan area, call: 804-371-9032  
Fax Number: 804-371-9944  
E-mail: [ombudsman@scc.virginia.gov](mailto:ombudsman@scc.virginia.gov)

### Referral and Authorization Requirements

Any services which cannot be obtained by a Preferred Provider within the PPO Service Area because: 1) due to their specialized nature, there is no Preferred Provider located within the PPO Service Area; 2) are provided by a Provider not in the PPO Service Area; and 3) are specifically authorized in advance by the Covered Person's Provider and approved by the Company shall be paid in accordance with the Schedule of Benefits, without further deductions, subject to all Policy maximums, limitations, conditions and exclusions, if applicable. To obtain authorization please contact EyeMed at:

EyeMed Vision Care, LLC  
Attn: Quality Assurance Department  
4000 Luxottica Place  
Mason, Ohio 45040  
or you may call the toll free number at:  
1-877-226-1115

## Questions

If you have any questions regarding a complaint concerning the services that you have been provided which have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance at:

Office of the Managed Care Ombudsman  
Bureau of Insurance  
P.O. Box 1157  
Richmond, VA 23218  
or you may call: 1-877-310-6560  
In the Richmond Metropolitan Area call: 804-371-9032  
Fax Number: 804-371-9944

E-mail: [ombudsman@scc.virginia.gov](mailto:ombudsman@scc.virginia.gov)

## Provider Directories

You may review an up to date provider list at any time by city, county, state or a certain mile radius from your location (distance at your choice) by visiting the EyeMed website at [www.discovereyemed.com](http://www.discovereyemed.com) or by contacting the EyeMed customer care center at (866) 939-3633. You may also request a hard copy of the provider directory through the contacts provided above.

## Provider Compensation

If you have questions regarding how your eye care provider is compensated, please contact the Claims Administrator, EyeMed, at:

First American Administrators, Inc.  
Attn: Provider Relations  
4000 Luxottica Place  
Mason, Ohio 45040  
or you may call the toll free number at:  
1-877-226-1115

This plan is subject to regulation 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.

## Emergency Services

Your plan covers Vision Examinations and/or Vision Materials. If you have an after-hours emergency for a Covered Benefit, please contact your EyeMed eye care provider the next day. If you have an eye-related emergency, please contact your medical care provider or go to the nearest medical facility.