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: State of Tennessee

POLICY EFFECTIVE DATE: January 1, 2023

POLICY ANNIVERSARY DATE: January 1 of the following year and each January 1 thereafter

Fidelity Security Life Insurance Company represents that the Member 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 Member.

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

Bryson T. Jones — President

Bradford R. James — 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 Member is responsible for any amounts due above the Allowance. The Allowance cannot be used to satisfy a Copayment.

Annual Enrollment means each year during a time period specified by the State, Employees and Retirees may:

1. elect enrollment in one of the vision insurance program options;
2. drop enrollment in the vision insurance program; and
3. add any eligible Dependents to vision coverage, remove any Dependents from vision coverage; or drop Dependent vision coverage entirely.

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 January 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 Member must pay to a Provider before benefits are payable for a covered Vision Examination or Vision Materials per Benefit Frequency.

Company means Fidelity Security Life Insurance Company

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 an individual who meets the following eligibility criteria based upon a Subscriber's eligibility. An individual cannot enroll as an Employee and as a Dependent under the same group plan (State, Local Education, or Local Government.) If both parents of a child qualify as eligible Employees, only one Employee (parent) can enroll Dependent children.

1. A legally married spouse; or
2. A child from birth to the last day of the month in which such child turns age 26 who meets at least one of the following criteria without consideration of factors such as financial dependency, marital status, enrollment in school, or residency:
    a. Subscriber's natural (biological) child, or
    b. Subscriber's adopted child (including a child placed for adoption in anticipation of adoption); or
3. A Subscriber or spouse's stepchild under the age of 26; or

4. An individual under age 26 who is placed with the Subscriber by a valid order of guardianship, custody, or conservatorship (or legally equivalent order) by a court of competent jurisdiction ("placement order").
   a. The Subscriber must provide certification upon enrollment and upon request that: (a) the placement order is in effect and has not expired by subsequent court order or by operation of law, and (b) the Subscriber will immediately notify Benefits Administration when the placement order terminates or expires.
   b. If a placement order terminates or expires due to the person attaining the legal age of majority, the person may remain an eligible Dependent until age 26 if the Subscriber certifies that the following requirements in (i), (ii) and (iii) are met:
      i. The Subscriber and the person have a relationship as set forth in 26 U.S.C. §125(d)(2), which includes the following relationships:
         (1) The person is a descendant of a son/daughter, stepson/stepdaughter of the Subscriber;
         (2) The person is a brother/sister, half-brother/half-sister, stepbrother/stepsister, son/daughter-in-law, brother/sister-in-law, or niece/nephew of the Subscriber; or
         (3) The person has the same principal place of abode as the Subscriber and is a Member of the Subscriber's household; and
      ii. The Subscriber provides over one-half of the person's financial support for the calendar year in which the Subscriber's taxable year begins; and
      iii. The person is a U.S. citizen, a U.S. national, or a resident of the U.S., Mexico, or Canada.
   c. Additional documents and certifications may be requested to establish that the person is an eligible Dependent.
5. Dependents over the age of 26 years who meet at least one of the criteria in 2 or 3 in this section and who are incapacitated (mentally or physically incapable of earning a living regardless of age, provided the Dependent is incapable of self-sustaining employment). This provision applies only when the incapacity existed before the Dependent's 26th birthday and they were already insured under this Policy. The child must meet the requirements for Dependent eligibility listed in this section. A request to continue coverage due to incapacity must be provided to State of Tennessee, Department of Finance and Administration, Division of Benefits Administration prior to the Dependent's 26th birthday. Annual proof may also be required. Approval is subject to review by the claims administrator. Coverage will not continue and will not be reinstated once the Dependent is no longer incapacitated.
6. Dependents not eligible for coverage:
   a. Children in the care, custody or guardianship of the Tennessee Department of Children's Services or equivalent placement agency, who are placed with the Subscriber for temporary or long-term foster care, but not including a person who is placed with the Subscriber for the purpose of adoption;
   b. Dependents not listed in the above definitions;
   c. Parents of the Employee/Retiree or spouse;
   d. Ex-spouse; and
   e. Live in companions who are not legally married to the Employee/Retiree.

Employee means a State Employee, Local Education Employee, or Local Government Employee as defined below.

State Employee means:

1. Any person employed by the employer, who is regularly scheduled to work at least 30 hours per week;
2. Any person who has received a seasonal appointment and who meets the requirements set forth in TCA 8-27-204(a)(3); and
3. All other individuals cited in state statute or approved as an exception by the State Insurance Committee.
   Note: Individuals in positions classified as temporary appointments or performing services on a contractual basis will not be considered to be Employees unless they otherwise meet the definition of an eligible Employee as defined in subsection 3.

Local Education Employee means an Employee of participating agency, who is:

1. A teacher as defined in TCA 8-34-101-(49);
2. An interim teacher whose salary is based on the local school system's schedule;
3. An Employee not defined in 1 or 2 in this section who is regularly scheduled to work at least 30 hours per week in a non-seasonal, non-temporary position;

4. A non-certified Employee who has completed 12 months of employment with a local education agency that participates in the local education insurance plan and works a minimum of 25 hours per week [a resolution passed by the school system's governing body authorizing the expanded 25 hour rule for the local education agency must be sent to the Policyholder - Benefits Administration before enrollment]; or
5. Any other individual deemed eligible by applicable federal law, state law, or action of the Local Education Insurance Committee.

Local Government Employee means:

1. An Employee of participating agency who is:
   a. scheduled to work at least 30 hours per week in a non-seasonal, non-temporary position;
   b. a Member of the chief legislative body of the county or municipal government (defined as only those elected officials who have the authority to pass local legislation); or
   c. a utility board Member appointed or elected pursuant to TCA 7-82-307, but only during their term of service.
2. An Employee who is a county official, as defined in TCA 8-34-101(9)(A), regardless of whether the county participates in the local government plan, pursuant to TCA 8-27-704(a).
3. Any other individual as deemed eligible by applicable federal law, state law, or action of the Local Government Insurance Committee.

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.

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

Low Vision means a severe visual loss that is not correctable with standard lenses and:

1. when the best-corrected acuity is 20/200 or less in the better eye with best conventional spectacle or contact lenses prescription; or
2. when there can be a demonstrated constriction of the peripheral fields in the better eye to 10 degrees or less from the fixation point or the widest diameter subtends an angle less than 20 degrees in the better eye.

Low Vision Aids are classified as follows:

1. *Spectacle-mounted magnifiers* - A magnifying lens is mounted in spectacles (this type of system is called a microscope) or on a special headband. This allows use of both hands to complete the close-up task, such as reading;
2. *Handheld or spectacle-mounted telescopes* - These miniature telescopes are useful for seeing longer distances, such as across the room to watch television, and can also be modified for near (reading) tasks;
3. *Handheld and stand magnifiers* - These magnifiers can serve as supplements to other specialized systems and are convenient for short-term reading of such things as price tags, labels and instrument dials. Both types of magnifiers can be equipped with lights; or
4. *Video magnification* - Table-top (closed-circuit television) or head-mounted systems enlarge reading material on a video display. Some systems can be used for distance viewing tasks. These are portable systems and can be used with a computer or Computer Display. Image brightness, image size, contrast, foreground/background color and illumination can be customized.

Low Vision Supplemental Examination means diagnostic evaluation beyond the Comprehensive Eye Examination and includes a history of functional difficulties that involves such things as reading, activities in the kitchen, glare problems, mobility, the workplace, television viewing, school requirements, hobbies and interests. Preliminary tests may include assessment of ocular functions such as color vision and contrast sensitivity. Measurements will be taken for visual acuity using special low vision test charts, which include a larger range of letters or numbers to more accurately determine a starting point for assessing the level of impairment. Visual fields may also be evaluated. A specialized Refraction must be performed with each eye thoroughly examined. The Provider may prescribe various treatment options, including Low Vision Aids, as well as assist with identifying other resources for vision and lifestyle rehabilitation.

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.

Member means an Employee, Retiree or Dependent who meets the eligibility requirements as shown in this Certificate and whose coverage under the Policy is in force and has not ended.

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 State of Tennessee.

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 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).

Retiree, with eligibility for the State of Tennessee Group Vision Insurance Program, means a State Retiree, Local Education Retiree, or Local Government Retiree as shown below.

State Retiree means an individual who:
Meets the requirements set forth in TCA 8-27-205 or 8-27-208.

Local Education Retiree means an individual who:
Meets the requirements set forth in TCA 8-27-305

Local Government Retiree means an individual who:
Meets the requirements set forth in TCA 8-27-705

Subscriber means an Employee or Retiree who meets the eligibility requirements as shown in this Certificate, makes the enrollment elections, and whose coverage under the Policy is in force and has not ended.

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.

PARTICIPATION REQUIREMENTS

An agency must be participating in the State of Tennessee Sponsored Group Health Plan in order to qualify for participation in the State of Tennessee Voluntary Group Vision Insurance Program. Employees and Dependents of Employees ARE NOT required to participate in a state-sponsored group basic health plan as a condition of participating in the State Group Vision Insurance Program. Retirees and Dependents of Retirees ARE required to participate in a state-sponsored group basic health plan as a condition of participating in the State Group Vision Insurance Program. An Employee or Retiree's participation in the State Group Vision Insurance Program is required for participation of eligible Dependents, EXCEPT when Dependents are allowed to remain enrolled in a state-sponsored group basic health plan after the Retiree is no longer eligible for a state-sponsored group basic health plan and the State Group Vision Insurance Program due to reaching the age for Medicare or following the Retiree's death. Participation by those enrolled in the State Group Vision Insurance Program is on a calendar year basis, and enrollment may only be dropped by the participants during the Annual Enrollment Period for the beginning of the next calendar year or due to a special qualifying event. Only Members who lose eligibility under this plan or become newly eligible for other coverage may cancel.

EFFECTIVE DATES

Effective Date of Subscriber's Insurance. The Subscriber's insurance will be effective as follows, unless the enrollment is the result of a Special Enrollment:

1. State
   (1) Newly Hired Employee (including Employees coming from the Local Education or Local Government Plans, or from Higher Education Institutions, or Employees moving between Higher Education Institutions): the first day of the month following the hire date and completion of one calendar month of employment with the new Employer.
   (2) Seasonal Employee Hired Prior to July 1, 2015: the first day of the month following the date the Employer certifies that the Employee has met the requirements of TCA 8-27-204(a)(3) and the employee submits a completed enrollment form to Policyholder.
   (3) Existing Employee with at Least One Calendar Month of Employment Followed by gaining eligibility for coverage: the first day of the month following gaining eligibility for coverage (including part-time to full-time employment and emergency appointment to permanent appointment) and the employee's submission of a completed enrollment form to Policyholder.
2. Local Education
   (1) Newly Hired Employee (including Employees moving between LEAs, or coming from LGAs, the State Plans, or Higher Education Institutions): the first day of the first month following the eligibility date.
   (2) Existing Employee gaining eligibility for coverage: the first day of the month after gaining eligibility for coverage (including part-time to full-time employment, interim teachers accepting permanent teaching positions, and non-certified employees accepting certified positions) and the employee's submission of a completed enrollment form to Policyholder.
3. Local Government
   (1) Newly Hired Employee (including Employees moving between LGAs, or coming from LEAs, the State, or Higher Education Institutions): the first day of the month following the eligibility date.
   (2) Existing Employee gaining eligibility for coverage: the first day of the month after gaining eligibility for coverage (including part-time to full-time employment) and the employee's submission of a completed enrollment form to Policyholder.

Effective Date of Dependents' Insurance. Coverage for Dependents becomes effective the same date as the Subscriber's effective date, unless the enrollment is the result of a Special Enrollment or an Annual Enrollment. For an Annual Enrollment, the effective date is the first date of a calendar year following enrollment during the Policyholder's Annual Enrollment.

Special Enrollment Provisions means that, without regard to the dates or circumstances on which an individual would otherwise be able to enroll in one of the Programs, current Employees/Retirees and Dependents as defined are permitted to enroll in coverage under one or more of these Programs if the Employee or Dependent meets the following conditions of a Special Qualifying Event (SQE), as stated in Section 1 or 2 below:

1. Loss of Eligibility for Other Coverage.
   a. An individual, otherwise eligible to enroll in a specific benefit Program, may be enrolled through this Special Enrollment provision provided that they:
      i. Declined coverage in a specific benefit Program when it was previously offered during their initial eligibility period, or during a subsequent annual enrollment period;
      ii. Had specific benefit coverage under any group vision insurance plan at the time a specific Program coverage was previously offered; and
      iii. Experience a loss of eligibility for other specific vision insurance coverage for reasons including the following (but not for a failure to pay premiums or termination for cause):
         (1) Death;
         (2) Divorce;
         (3) Legal separation;
         (4) Cessation of dependent status;
         (5) Termination of employment (voluntary and non-voluntary);
         (6) Employer's discontinuation of contribution to insurance coverage (total contribution, not partial);
         (7) Reduction in number of work hours of employment;
         (8) Spouse maintaining coverage that has reached their lifetime maximum (if legally permitted); or
         (9) Loss of TennCare or Children's Health Insurance Program (CHIP) coverage other than non-payment of premium, or expiration of COBRA coverage.
   b. If an Employee/Retiree satisfies all three requirements of 1.a above, the Employee/Retiree and all Dependents of the Employee/Retiree are eligible for special enrollment to the specific benefit Program.
   c. If a Dependent satisfies all three requirements of 1.a above, only that Dependent, the Employee/Retiree, and other Dependents satisfying the requirements of 1.a above are eligible for special enrollment to the specific benefit Program.
   d. All Special Enrollments for Loss of Eligibility for Coverage must be submitted to and received by the Employee's agency benefits coordinator or State of Tennessee Benefits Administration within sixty (60) days of the loss of eligibility for other coverage
   e. The effective date of coverage for a Special Enrollment for Loss of Coverage will be the first day of the first calendar month after the date the ABC/BA receives the request for special enrollment.
   f. Substantiation of Loss of Coverage. If requesting special enrollment based on loss of eligibility for other coverage, the Employee/Retiree must submit appropriate documentation to substantiate all of the following:
      (a) That the Employee/Retiree or Dependent was covered for any other group vision insurance plan at the time they declined the offer of specific coverage from This Program; and
      (b) That the Employee/Retiree experienced an event resulting in the Employee/Retiree or Dependent's loss of eligibility for the specific coverage under the other group vision insurance plan, and the date of the Employee/Retiree or Dependent's loss of eligibility.

2. Acquisition of New Dependents.
    a. When an Employee/Retiree acquires a new Dependent by marriage, birth, adoption, placement for adoption or legal guardianship, the Employee/Retiree, Spouse, and any Dependent may be enrolled in the vision insurance program by Special Enrollment.
    b. All Special Enrollment applications based upon the acquisition of a new Dependent must be submitted to and received by ABC/BA within thirty (30) days of the acquisition date
    c. The effective date of coverage for a Special Enrollment for acquiring a new Dependent will be the first day of the first calendar month after the date the ABC/BA receives the request for special enrollment.
    d. Substantiation of Acquiring a New Dependent. If requesting enrollment based on acquiring a new Dependent, the Employee must submit appropriate documentation as listed on the enrollment application to substantiate the following:
        i. The date of birth of a child; or
        ii. The date of the adoption or the order placing the child in custody for adoption; or
        iii. The date of guardianship, custody or conservatorship specified by the order granting same; or
        iv. The date of marriage.

Mid-Year Cancellation means that Members may only cancel coverage during the annual enrollment period for the beginning of the next calendar year unless there is a loss of eligibility under the State Group Vision Insurance Program or due to a qualifying event. Only persons who lose eligibility under this plan or become newly eligible for other coverage may cancel. A Subscriber requesting to cancel vision coverage for themselves or their Dependents must complete an Insurance Cancel Request Application and submit the application and the required documentation noted on the application within 60 days of a qualifying event. Purchase of a private policy, voluntary cancellation of other coverage, and financial hardship do not qualify as reasons to cancel coverage. The following are qualifying events for Cancellation Requests:
1. Marriage, divorce, legal separation, annulment
2. Birth, adoption, placement for adoption
3. Death of spouse, dependent
4. New employment, return from unpaid leave, change from part-time to full-time employment (spouse or dependent)
5. Entitlement to Medicare, Medicaid, TRICARE
6. Court decree or order
7. Open enrollment
8. A change in place of residence or workplace that is out of the national service area (i.e., move out of the U.S.)

Transfer from Prior Contract means that Members enrolled under the prior vision insurance contract with the State as of December 31, 2022, will be automatically enrolled under the new vision insurance contract with the State with no break in coverage if premium payments were current and the Member did not make a change effective January 1, 2023. Benefit frequencies and other limitations under this vision insurance contract will not incorporate Member's experience under the prior vision insurance contract.

BENEFITS

Benefits are payable for each Member 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 Member.

Out-of-Network Provider Benefits. The Member 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 Member 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, except as provided in the Low Vision Aids benefit;
13. services rendered after the date a Member ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Member 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 pursuant to the terms of the contract between the State of Tennessee and the Company (contract no. 73804).

For All Subscribers. The Subscribers' 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;
3. the last day of the month in which the Subscriber separates from active employment with the Policyholder for Central State Government Employees;
4. the last day of the month following the month of the Subscriber's separation from active employment with the Policyholder for non-Central State Government Employees (Higher Education, Local Education, and Local Government Employees);
5. the date of the Subscriber's enrollment in the State of Tennessee's Sponsored Group Health Insurance Plan for Retirees terminates; or
6. the date the Subscriber is no longer eligible for insurance.

For Dependents. An enrolled Dependent's insurance will cease on the earlier of:

1. the date the Subscriber's coverage ends;
2. the end of the month in which the enrolled Dependent ceases to be an eligible Dependent as defined in the Policyholder's application;
3. the date the enrolled Dependent's enrollment in the State of Tennessee's Sponsored Group Basic Health Insurance Plan for Retirees and Dependents terminates; or
4. the end of the last period for which any required premium contribution has been made.

For an incapacitated Dependent child, the Company may ask for proof of the eligible Dependent child's incapacity and dependency within 31 days of 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.

Survivor means that for a:

1. *Survivor in Current Plan* – Upon the Subscriber's death, surviving Dependents covered under this vision plan on the date of a Subscriber's death may continue their enrollment in this vision plan with one of the two options listed below.
    a. Deceased Subscriber was eligible for continuation of coverage as a Retiree at time of death - Dependents may elect COBRA or Retiree continuation of vision elections in effect for them on the date of Subscriber's death; or
    b. Deceased Subscriber was not eligible for continuation of coverage as a Retiree at time of death – Dependents may elect COBRA continuation for vision elections in effect for them on the date of Subscriber's death.
2. *Survivor with New Agency Joining Plan* – Upon a new agency joining the State Group Insurance Plan (SGIP), surviving Dependents of deceased Employees or Retirees may enroll in this vision plan if the following criteria is satisfied.
    - The new agency opts to offer the SGIP vision plan to its Employees,
    - Surviving Dependents were enrolled in COBRA or the new agency's regular vision plan and the agency's medical plan in the month prior to the new agency joining the SGIP,
    - Surviving Dependents choose to enroll in the SGIP medical and vision insurance programs, and
    - The deceased Employee or Retiree was eligible to receive a pension from the Tennessee Consolidated Retirement System (TCRS) (note: this does not apply to COBRA participants)

PREMIUMS

The Company provides insurance coverage in return for premium payment. Premiums are payable to the Company by the Policyholder on behalf of the Members. The Member's first premium is due on the Member'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 according to the terms of the Company's contract with the State of Tennessee (contract no. 73804).

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 Subscriber's intent to terminate coverage.

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 Member 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 Member will be deemed as notice to the Company.

Claim Forms. The Company will furnish claim forms to the Member within 15 days after notice of claim is received. If the Company does not provide the forms within that time, the Member 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 within 30 days, upon receipt of due written proof of loss.

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

Assignment. Benefits under the Policy may be assigned.

Right of Recovery. If payment for claims exceeds the amount for which the Member 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 Subscriber, within 18 months from the date the claim is paid.

Legal Actions. No Member can bring an action at law or in equity against the Company 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 Member resides, the limit is extended to meet the minimum time allowed by such law. Nothing in this document shall be construed to be a waiver of sovereign immunity by the State of Tennessee.

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 Insurance Obligation. The Policy, , including any endorsements and riders, this Certificate, the Policyholder's application, which is attached to the Policy when issued, constitutes the entire agreement between the Company and the Members. A copy of the Policy may be examined at the office of the Policyholder during normal business hours.

Amendments and Changes. No Member 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 Member, 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 agree 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 aa Member, in the absence of fraud, can be used in a contest after the Member's insurance has been in force for two years. No statement a Member makes can be used in a contest unless it is in writing and signed by the Member.

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

State of Tennessee – Basic Plan

BENEFIT FREQUENCY		
Vision Examinations		
Comprehensive Eye Examination	once every calendar year	Insured Person
Low Vision Supplemental Examination	once every 2 calendar years	Insured Person
Vision Materials		
Frame	once every 2 calendar years	Insured Person
Lenses and Lens Options	once every calendar year	Insured Person
Contact Lenses	once every calendar year	Insured Person
Low Vision Aids	once every 2 calendar years	Insured Person

BENEFIT	*In-Network Provider*	*Out-of-Network Provider* (Reimbursement up to)
Vision Examination		
Comprehensive Eye Examination	$10 Copayment	$40
Low Vision Supplemental Examination	$0 Copayment, up to $300 Allowance	$300
Vision Materials		
Frame	$0 Copayment, up to $105 Allowance	$55
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 and Lens Options.		
Conventional	$0 Copayment, up to $105 Allowance	$75
Disposable	$0 Copayment, up to $105 Allowance	$75
Medically Necessary	$0 Copayment, up to $155 Allowance	$80
Standard Plastic Lenses		
Single Vision	$20 Copayment	$55
Bifocal	$20 Copayment	$55
Trifocal	$20 Copayment	$55
Lenticular	$20 Copayment	$90
Progressive – Standard	$90 Copayment	$55
Progressive – Premium Tier 1	$110 Copayment	$55
Progressive – Premium Tier 2	$140 Copayment	$55
Progressive – Premium Tier 3	$200 Copayment	$55
Progressive – Premium Tier 4	$225 Copayment	$55
Lens Options		
Polycarbonate Lenses – Standard Dependent Children under 19 years of age	$0 Copayment	$10
Low Vision Aids	$0 Copayment, up to $300 Allowance	$300

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AMENDATORY RIDER REGARDING REPLACEMENT COVERAGE

The Policy/Certificate to which this Amendment Rider is attached is amended as follows:

The following applies when the Policy serves to replace similar coverage the Policyholder previously obtained through another plan or policy. In this provision, that other plan or policy is referred to as the prior plan. The Policyholder's coverage under the Policy will not be considered as replacement coverage unless the Policyholder's coverage under the Policy takes effect within 60 days after coverage under the prior plan ends.

In the absence of this provision, an Insured Person who was covered by the prior plan at the date of discontinuance might not qualify for coverage under the Policy because the person is not actively at work or is confined in a Hospital.

Each such person will be insured under the Policy if:

1. the person was insured under the prior plan, including coverage under the prior plan's extension of benefits provision, on the date the Policyholder's coverage with the prior plan ended;
2. the prior plan covered more than 15 people; and
3. the person is in a class of persons eligible for coverage under the Policy.

The benefits payable for the persons described above will be the benefits of the Policy less any amount payable under the prior plan pursuant to any extension of benefits provision.

The Policy, in applying any waiting periods, will give credit for the satisfaction or partial satisfaction of the same or similar provisions under the prior policy.

This Rider takes effect on the effective date of the Policy/Certificate to which it is attached. This Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the terms and conditions of the Policy/Certificate except as stated herein.

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President   Secretary

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DOMESTIC PARTNER COVERAGE BENEFIT RIDER
For California Residents Only

If the Policy/Certificate provides coverage for a Dependent spouse of an Insured, and if the Policy/Certificate contains existing domestic partner language, the following definition applies only to the extent the existing language does not meet the minimum requirements of California law:

The term "spouse" or "Spouse" is defined as follows:
Spouse means:
1. a person to whom you are legally married; or
2. the Insured's Domestic Partner. "Domestic Partner" means an individual recognized as such under California state law.

The following provision is added:

Termination of Coverage for Domestic Partner. When a domestic partnership is terminated, coverage will cease for the dependent Domestic Partner on the date any one of the following occurs:

1. six months after the filing of a Notice of Termination of Domestic Partnership with the California Secretary of State; or
2. the domestic partnership is ended through dissolution, nullity, or legal separation the same as in a marriage.

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

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AMENDMENT RIDER

For North Carolina Residents Only

By attachment of this Rider, the Policy/Certificate is amended by the following:

ACCESS TO PREFERRED PROVIDERS

1. If you are unable to locate an In-Network Provider in your area, please contact us at the EyeMed Customer Care Center at (866-939-3633) or go to the EyeMed website at eyemedvisioncare.com/locator and, EyeMed, on our behalf, will provide a list of potential providers from which you can choose.

2. If you believe that no providers are within the driving distance standard or if you are unable to obtain an appointment within the appointment wait-time standard, please contact the EyeMed Customer Care Center for assistance to locate a provider and/or schedule an appointment. If it is determined that no In-Network Provider is available within these established standards and you obtain services from an Out-of-Network Provider, we will review and pay the eligible claims submitted as if you had visited an In-Network Provider. You may review the established accessibility standards for driving distance and appointment wait-times for this coverage in the Out-of-Network Claim Form found at the EyeMed website https://eyemed.com/resource/blob/15642/7cfe717302c35ac9d6e54e5420dbba11/eyemed-out-of-network-claim-form-data.pdf or visit eyemed.com and enter 'out of network claim form' in the search bar.

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

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NOTICE

If we at Fidelity Security Life Insurance Company fail to provide you with reasonable and adequate service, please contact:

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

FIDELITY SECURITY LIFE INSURANCE COMPANY

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NOTICE CONCERNING COVERAGE UNDER THE TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of Tennessee who purchase life insurance, annuities, or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. **This summary does not cover all provisions of the law or describe all of the conditions and limitations relating to coverage. This summary does not in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.**

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, an annuity, or if they are insured under a group insurance contract issued by an insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guaranty Association if:

(1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);

(2) the insurer was not authorized to do business in this state;

(3) their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

(2) any policy of reinsurance (unless an assumption certificate was issued);

(3) interest rate yields that exceed an average rate;

(4) dividends;

(5) credits given in connection with the administration of a policy by a group contractholder;

(6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);

(7) unallocated annuity contracts (which give rights to group contractholders, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For any one insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

- $300,000 for policies and contracts of all types, except as described in the next point
- $500,000 for basic hospital, medical and surgical insurance and major medical insurance issued by companies that become insolvent after January 1, 2010

Within these overall limits, the Guaranty Association cannot guarantee payment of benefits greater than the following:

- life insurance death benefits – $300,000
- life insurance cash surrender value – $100,000
- present value of annuity benefits for companies insolvent before July 1, 2009 – $100,000
- present value of annuity benefits for companies insolvent after June 30, 2009 – $250,000
- health insurance benefits for companies declared insolvent before January 1, 2010 – $100,000
- health insurance benefits for companies declared insolvent on or after January 1, 2010:
  - $100,000 for limited benefits and supplemental health coverages
  - $300,000 for disability
  - $300,000 for long-term care insurance
  - $500,000 for basic hospital, medical and surgical insurance or major medical insurance

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The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

Tennessee Life and Health Guaranty Association
150 3rd Avenue South, Suite 1600
Nashville, TN 37201

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37243

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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.