

**FIDELITY SECURITY LIFE INSURANCE COMPANY**  
**3130 Broadway • Kansas City, Missouri 64111-2406 • (800) 648-8624**

**Group Insurance Certificate Providing  
Limited Benefits for Vision Care  
Non-Participating**

This Certificate will take the place of any and all Certificates and Riders which may have been issued to You at a prior time under the Policy.

**GENERAL INFORMATION**

**About Your Insurance** - This Certificate explains the plan of insurance which is underwritten by Fidelity Security Life Insurance Company. Read it closely to become familiar with Your plan. An individual identification card will be issued to You containing the name of the Policyholder.

**Important Notice** - Benefits are payable only for expenses incurred while this insurance is in force. No agent has the right to change the Policy or to waive any part of it. The Policy under which this Certificate is issued may at any time be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice to any person who claims rights or benefits under the Policy. The insurance under the Policy does not take the place of nor does it affect any requirements for coverage by Workers' Compensation or a similar type of insurance. The benefits for Dependents which are described in this Certificate will be applicable to Your Dependents only if You make application to have Your Dependents insured.

**DEFINITIONS**

The following terms have specific meaning as used in the Policy.

**Covered Person** means: active full time employees of the State; all appointed or elected officials; employees eligible under the Policyholder's short and long term disability program remain eligible during the period of disability; eligible retirees as defined by the Policyholder and all other classifications of employees as defined by the Policyholder. A Local Unit Adoption Agreement and Binder for participation in State employee health plans by a Local Unit may contain different definitions for eligibility. Covered Person will also include Your Dependents, if enrolled.

**Dependent** means any of the following persons: 1) Your lawful spouse; 2) Each unmarried child from birth to the end of the calendar year in which the child turns age 19 who is primarily dependent upon You for support and maintenance; 3) Each unmarried child at least 19 years of age to age 23 who is primarily dependent upon You for support and maintenance and who is a full-time student; or 4) Each unmarried child at least 19 years of age: who is primarily dependent upon You for support and maintenance because the child is incapable of self-sustaining employment by reason of mental incapacity or physical handicap; who was so incapacitated and is a Covered Person under this Policy on his or her 19<sup>th</sup> birthday; and who has been continuously so incapacitated since his or her 19<sup>th</sup> birthday. Such child's coverage will continue if satisfactory evidence of such disability and dependency is received within 120 days after the end of the calendar year in which the maximum age is attained. Coverage for the child will continue until the employee discontinues coverage or the disability no longer exists. Child includes stepchild, foster child, legally adopted child, child legally placed in Your home for adoption, and child under Your legal guardianship. A full-time student is one who is enrolled at an educational institution. A Local Unit Adoption Agreement and Binder for participation in State employee health plans by a Local Unit may contain different definitions for eligibility.

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

**Policyholder** is named as the Policyholder on the face of the Policy.

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

**Vision Examination** means a comprehensive ophthalmological service as defined in the Current Procedural Technology (CPT) and the Documentation Guidelines listed under "Eyes-examination items". Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

**Vision Materials** means corrective lenses and/or frames or contact lenses.

**We, Our, Us** means Fidelity Security Life Insurance Company.

**You, Your, Yours** means the Covered Person covered under the Policy.

**DEFINITIONS  
(PPO and Non-PPO)**

**Preferred Agreement** means an agreement between the PPO and a Provider concerning the rates and reimbursement methods for services and supplies provided by such Provider.

**Non-Preferred Provider** means a Provider, located within the PPO Service Area, who has not signed a Preferred Agreement with the PPO.

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

**Preferred Provider Organization (“PPO”)** means a network of Providers and retail chain stores within the PPO Service Area who have signed Preferred Agreements with the Company.

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

**Low Vision Supplemental Testing** 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, travel vision, the workplace, television viewing, school requirements, and hobbies and interests. Preliminary tests may include assessment of ocular functions such as color vision and contrast sensitivity. Measurements will be taken of the person’s 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 determining the level of impairment. Visual fields may also be evaluated. A specialized refraction must be performed with each eye thoroughly examined. The eye care professional may prescribe various treatment options, including low vision aides, as well as assist the person with identifying other resources for vision and lifestyle rehabilitation.

**Low Vision Aides** are classified as follows:

*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.

*Hand held 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.

*Hand-held and stand magnifiers* – These can serve as supplements to other specialized systems. They are convenient for short term reading such things as price tags, labels, and instrument dials. Both types can be equipped with lights.

*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 views tasks. These are portable systems, and those that can be used with a computer or monitor. Image brightness, image size, contrast, and foreground/background color and illumination can be customized.

**EFFECTIVE DATES**

**Effective Date of employee's Insurance** - Your insurance will be effective as follows for enrollees whose contribution is collected: 1) biweekly through payroll deduction by the State Auditor, coverage shall commence on January 1, 2006, or thereafter four (4) days after the payroll deduction occurs; 2) through payroll deduction by a Local Unit of Government, coverage shall become effective the first day of the calendar month following the first premium payment, unless the Local Unit of Government establishes a different date; 3) through payroll deduction by a direct bill agency, coverage shall become effective the first day of the calendar month following the first premium payment, unless otherwise established.

**Effective Date of Dependent's Insurance** - Coverage for Dependents becomes effective on the later of: 1) the date Dependent Coverage is first included in Your coverage; or 2) the premium due date on or after the date the person first qualifies as Your Dependent. If an enrollment form is required, You must provide such form and agree to pay any premium contribution that may be required prior to coverage becoming effective.

**Newborn Children** - A Dependent child born while this Certificate is in force shall be covered from the moment of birth for 31 days. In order to continue coverage beyond this 31-day period, You must send Us notice and agree to pay any premium contributions that may be required by the Policyholder within this 31-day period.

**Adopted Children** - A Dependent child placed with You for adoption while the Certificate is in force will be covered from the date of placement for 31 days. In order to continue coverage beyond this 31-day period, You must send in notice and agree to pay any premium contributions that may be required by the Policyholder within this 31-day 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. The coverage is effective upon the earlier of: a) the date of placement for the purpose of adoption; or b) the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption.

**SCHEDULE OF BENEFITS**

Covered Persons have the right to obtain vision care from the Provider of their choice. However, payment of the Benefit varies depending on the type of Provider chosen. Benefits are payable as shown in the following Schedule:

<u>Benefit</u>	<u>Preferred Provider</u>	<u>Non-Preferred Provider</u>
Vision Examination:	\$10 copayment	up to \$35
Contact Lens Fit and Two Follow-up Visits:		
Standard	\$55 copayment	up to \$35
Premium	N/A	up to \$35
Vision Materials:		
<i>Lenses</i>		
Single	\$25 copayment	up to \$25
Bifocal	\$25 copayment	up to \$40
Trifocal	\$25 copayment	up to \$55
<i>Frames</i>	\$0 copayment up to \$110 allowance	up to \$35
<i>Contact Lenses</i>		
Conventional	\$0 copayment up to \$105 allowance	up to \$95
Disposable	\$0 copayment, up to \$105 allowance	up to \$95
Medically Necessary	\$0 copayment	up to \$165
<i>Lens Options</i>		
Basic Polycarbonate	\$20 copayment	N/A
Low Vision	\$0 Copayment \$1,000 lifetime maximum	\$0 Copayment \$1,000 lifetime maximum

**Benefit Period:**

- 12 month benefit period for Vision Examination and Contact Lens Fit and two Follow-up visits
- 24 month benefit period for Frame
- 12 month benefit period for Lenses/Lens Options OR 12 month benefit period for Contact Lenses

Non-Preferred Provider expenses do not apply toward Preferred Provider expenses and Preferred Provider expenses do not apply toward Non-Preferred Provider expenses.

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.

**Benefit Period for Vision Examination** is shown in the Schedule of Benefits and begins on the later of the Covered Person's Effective Date or last date a Vision Examination was performed on the Covered Person.

**Benefit Period for Contact Lens Fit and two Follow-Up Visits** is shown in the Schedule of Benefits and begins on the later of the Cover Person’s Effective Date or last date a Vision Examination was performed on the Covered Person.

**Benefit Period for Vision Materials** is shown in the Schedule of Benefits and begins on the later of the Covered Person's Effective Date or last date Vision Materials were provided to the Covered Person.

**Vision Examination Benefit** - A Covered Person is eligible for one Vision Examination in each successive Benefit Period.

**Vision Materials Benefit** - If a Vision Examination results in a Covered Person needing corrective Vision Materials for their visual health and welfare, those Vision Materials prescribed by Providers will be supplied, subject to certain limitations and exclusions of the Policy, as follows:

- \* Lenses - Up to two lenses provided one time in each successive Benefit Period.
- \* Frame - One frame provided one time in each successive Benefit Period.
- \* Contact Lenses - Contact lenses provided in lieu of eyeglass lenses, one time in each successive Benefit Period. Contact Lens Fit and Follow-up includes contact fit and two follow-up visits once a Vision Exam has been completed. Standard Contact Lens Fitting means spherical clear contact lenses in conventional wear and planned replacement (examples include but not limited to: disposable, frequent replacement, etc.). Premium Contact Lens Fitting means all lens designs, materials and specialty fittings other than Standard Contact Lenses (examples include toric, multifocal, etc.)
- \* Low Vision – Provided to Covered Persons who have severe visual problems that are not correctable with regular lenses. Severe visual problem is defined when the best-corrected acuity is 20/200 or less in the better eye with best conventional spectacle or contact lens prescription or 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.

#### LIMITATION

**Vision Examination and Vision Materials** - Fees charged by a Provider for services other than Vision Examination or covered Vision Materials must be paid in full by the Covered Person to the Provider. Such fees or materials are not covered under this Policy.

Benefit allowances provide no remaining balance for future use within the same Benefit Period.

#### EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from: 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 corrective eye wear, required by an Employer as a condition of employment and safety eyewear, unless specifically covered under the Policy; 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; 6) Non-prescription sun glasses; 7) Two pair of glasses in lieu of bifocals.

Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Period when Vision Materials would next become available.

#### TERMINATION OF INSURANCE

**For all Covered Persons** - All Covered Persons' insurance will end automatically on the earliest of the following dates: a) The date the Policy ends; b) The last day of the period for which premiums have been paid for the following: i) the withdrawal of deduction authorization for employee and/or dependents coverage; ii) the date premiums are due, payable and unpaid, subject to Section XXXVIII of the Contract identified below, and as a result of clerical or inadvertent error; iii) termination of employment; iv) the death of an employee.

**For Dependents** - A Dependent's insurance will automatically stop on the earlier of: a) the date Your coverage ends; b) the end of the month in which the Dependent ceases to be Your Dependent; c) the end of the last period for which any required contribution has been made.

A Dependent Child will not cease to be a Dependent solely because of age if the child is: a) not capable of self-sustaining employment due to mental incapacity or physical handicap that began before the age limit was reached; and b) mainly dependent on You for support.

Proof of such incapacity and dependency must be furnished to the Company within 120 days after the child reaches the termination age.

We may require the same proof again, but We will not ask for it more than once a year after this coverage has been continued for two (2) years. This continued coverage will end: a) on the date the Policy ends; b) the date the incapacity or dependency ends; c) the last day of the month for which required premium for the child is paid; or d) 60 days after the date we request proof which is not given to Us.

#### CLAIMS

**Notice of Claim.** Written notice of claim must be given: (a) within 30 days after a covered loss begins; or (b) as soon as reasonably possible after that. This notice may be given to Us at Our Home Office or to Our Administrator. Notice should include the Covered Person's name and the Policy and Certificate numbers.

**Claim Forms.** When We receive notice of claim, We will send the claimant forms for filing proof of loss within 15 days. If claim forms are not supplied within this 15 day period, a claimant may submit proof in writing, setting forth the nature and extent of the loss.

**Proof of Loss.** Proof of loss must be furnished to Us within 90 days after the date of loss. We will not deny or reduce a claim if it was not reasonably possible to give Us proof within the time allowed. In any event, the Covered Person must give Us proof within one (1) year after it is due unless he is legally incapacitated.

**Time of Payment of Claims.** Immediately after receiving written proof of loss, we will pay all benefits then due a Covered Person.

**Payment of Claims.** All claims will be paid to You, unless We have the obligation to pay the facility or Provider directly. However, in the event a benefit becomes payable to Your estate, We may pay such benefit, up to an amount equal to \$1,000, to any relative by blood or connection by marriage who We deem to be equitably entitled thereto. Payment made in good faith fully discharges Us to the extent of any payments made.

**Legal Actions.** No legal actions may be brought to recover under the Policy within 60 days after written proof of loss has been furnished as required.

**Claim Appeal Procedure.** If We partially or fully deny a claim for benefits submitted by a Covered Person and he or she disagrees or does not understand the reasons for this denial, the Covered Person may appeal this decision, and they have the right to: 1) Request a review of the denial; 2) Review pertinent plan documents; and 3) Submit in writing, any data, documents or comments which are relevant to Our review of this denial.

The Covered Person's appeal must be submitted in writing within 180 days of receiving written notice of denial. We will review all information and send written notification within 60 days of the Covered Person's request.

#### GENERAL PROVISIONS

**Entire Contract.** The Policy is a legal contract between the Policyholder and Us. The consideration for this contract is the application and the payment of premiums as set forth herein. The entire contract consists of the Contract for prepaid vision care and administrative services between the State of Indiana, Fidelity Security Life Insurance Company and EyeMed Vision Care, L.L.C effective January 1, 2006 (hereinafter "Contract") and this Policy, and this Certificate. Any statement made by the Policyholder or by a Covered Person in an application will be deemed a representation and not a warranty. No such statement will void the coverage or reduce the benefits or be used in defense to a claim unless it is in writing and a copy of the application is furnished the Covered Person.

**Modification of Policy.** The Policy may be modified at any time by agreement between the Policyholder and Us without consent of any employee. No modification will be valid unless approved by one of Our officers: (1) the President; (2) a Vice President; or (3) the Secretary. The approval must be endorsed on or attached to the Policy. No agent has authority to modify the Policy or waive any of the Policy's provisions to extend the time for premium payment by making any promise or representation.

**Incontestability.** The validity of the Policy shall not be contested, except for non-payment of premiums, after it has been in force for two (2) years after its date of issue. No statement made by You relating to: 1) Your insurability; or 2) The insurability of Your Dependents; shall be used in contesting the validity of the coverage of the person about whom the statement was made after coverage has been in force for a period of two (2) years. Any such statement must be contained in a written instrument signed by You, a copy of which has been furnished to You.

**Fraud.** If You or the Policyholder commits fraud pertaining to an employee against Us, as determined by a court of competent jurisdiction, Your coverage will end automatically without notice.

**Misstatement of Age.** If a Covered Person's age has been misstated, the benefits will be those which the premium paid would have bought for the correct age.

**Assignment of Benefits.** You may assign Your benefits. However, an assignment is not binding until We have received and acknowledged in writing the original or copy of the assignment before payment of the benefit. We do not guarantee the legal validity or effect of such assignment.

**Grace Period.** A grace period of 31 days will be allowed for the payment of each premium due after the first premium. Coverage will continue in force during the grace period to allow the State an opportunity to cure pursuant to Section XXXVIII of the Contract. If the premium is not paid within the grace period and, the State fails to cure, coverage will terminate as of the premium due date. The grace period will not apply if the Covered Person gives written notice to Us of his or her intent not to continue this coverage.

FIDELITY SECURITY LIFE INSURANCE COMPANY

  
President

  
Secretary