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-19

POLICYHOLDER: Washington State Health Care Authority
School Employees Benefit Board (SEBB) Program

POLICY RENEWAL DATE: January 1, 2026

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

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.

TABLE OF CONTENTS

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.

Annual Open Enrollment means a period of time defined by HCA when a subscriber may change to another health plan offered by the SEBB Program and make certain other account changes for an effective date beginning January 1 of the following year.

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 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.

Continuation Coverage means the temporary continuation of SEBB benefits available to enrollees under the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Uniformed Services Employment and Reemployment Rights Act (USERRA), or SEBB policies, such as unpaid leave.

Dependent means a spouse, state-registered domestic partner or child of the Insured who meets the eligibility requirements as shown in the Eligibility and Enrollment section, and whose coverage under the Policy is in force and has not ended.

Employer Group means an employee organization representing school employees and a tribal school obtaining school employee benefits through a contractual agreement with HCA to participate in SEBB benefit plans.

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.

Health Care Authority (HCA) means the Washington State agency that administers the PEBB and SEBB Programs.

Insured means an employee of a K12 school district, educational service district or charter school within Washington, an employee of an Employer Group, a School Board Member, and a Continuation Coverage enrollee, who meets the eligibility requirements as shown in the Eligibility and Enrollment section, 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 Preferred Provider Organization (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 Policy issued to the Policyholder providing "vision coverage."

Policyholder means the group named as the Policyholder in the face page of the Policy.

PPO Service Area means the geographical area where the PPO is located. The PPO Service Area includes all counties in the state of Washington. In addition, the PPO Service Area is national and includes In-Network Providers in all 50 states and the District of Columbia.

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.

Premium Surcharge means a payment required by the Policyholder from a subscriber, in addition to the subscriber's medical premium contribution, due to an enrollee's tobacco use or an enrolled subscriber's spouse or state registered Domestic Partner choosing not to enroll in their employer-based group medical when:

1. the spouse's or state registered Domestic Partner's share of the medical premium is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered Domestic Partner in the Public Employees Benefits Board (PEBB) Uniform Medical Plan (UMP) Classic; and
2. the benefits have an actuarial value of at least ninety-five percent of the actuarial value of PEBB UMP Classic benefits.

Provider means a person licensed by the state in which he, she or they are a resident to practice the healing arts or optometrist who is operating within the scope of his, her or their license for the service or treatment given. Provider also includes a dispensing optician.

Public Employees Benefits Board (PEBB) means a group of representatives, appointed by the governor, who approves insurance benefit plans for employees and their dependents, and establishes eligibility criteria for participation in insurance benefit plans.

Public Employee Benefits Board (PEBB) Program means the HCA program that administers PEBB benefit eligibility and enrollment.

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).

School Board Member means the board of directors of a school district or the board of directors of an educational service district who is self-paying for SEBB benefit plans.

School Employees Benefits Board (SEBB) means a group of representatives, appointed by the governor, who designs and approves insurance benefit plans for school employees and their dependents, and establishes eligibility criteria for participation in insurance benefit plans.

School Employees Benefits Board Organization or SEBB Organization means a K12 school district, educational service district or charter school established under Washington state statute that is required to participate in benefit plans provided by SEBB.

School Employees Benefits Board (SEBB) Program means the program within HCA that administers insurance and other benefits for eligible school employees, eligible school board members and eligible dependents.

Vision Examination means any eye or visual examination shown in the Schedule of Benefits.

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

The following definitions apply to the **ELIGIBILITY AND ENROLLMENT** section:

Enrollee means an eligible school employee, an eligible School Board Member, a Continuation Coverage subscriber or a Dependent who meets all eligibility requirements and is enrolled in SEBB benefits, and for whom applicable premium payments have been made.

Subscriber means an eligible school employee, an eligible School Board Member, or a Continuation Coverage enrollee who has been determined eligible by the SEBB Program, SEBB Organization or Employer Group, is enrolled in SEBB benefits, and is the individual to whom the SEBB Program and contracted vendors will issue all notices, information, requests, and premium bills on behalf of an enrollee.

ELIGIBILITY AND ENROLLMENT

In these sections, we may refer to an Insured as "school employees" or "subscribers" and may refer to Insured Persons as "enrollees." Additionally, "health plan" is used to refer to a plan offering medical, vision, or dental coverage, or a combination developed by the School Employees Benefits Board (SEBB) and provided by a contracted vendor or self-insured plans administered by the Health Care Authority (HCA).

The following Eligibility and Enrollment information is provided by SEBB.

Eligibility for Subscribers and Dependents
School Employee Eligibility. The school employee's SEBB Organization will inform the school employee in writing whether or not they are eligible for SEBB benefits upon employment and whenever their eligibility status changes. The written notice will include information about the school employee's right to appeal eligibility and enrollment decisions.

A school employee of an Employer Group should contact their payroll or benefits office for eligibility criteria.

School employees have the right to appeal eligibility and enrollment decisions. Information about a school employee's right to an appeal can be found in the "Appeal Rights."

Continuation Coverage Eligibility. The SEBB Program determines whether subscribers are eligible for SEBB continuation coverage (COBRA or unpaid leave) upon receipt of the subscriber's election to enroll. If the subscriber requests to enroll and is not eligible, the SEBB Program will notify the subscriber of the right to appeal. Information about appeals can be found under "Appeal Rights."

School Board Member Eligibility. The SEBB Program determines whether a School Board Member is eligible to self-pay coverage upon receipt of their election to enroll. If a School Board Member requests to enroll and is not eligible, the SEBB Program will notify the School Board Member of their right to appeal. Information about appeals can be found under "Appeal rights."

Dependent Eligibility. The following are eligible as dependents:

1. Legal spouse.
2. State-registered domestic partner and substantially equivalent legal unions as defined in Washington state statute. Individuals in a state-registered domestic partnership are treated the same as a legal spouse, except when in conflict with Federal law.
3. Children, through the last day of the month in which their 26th birthday occurred, regardless of their marital status, student status, or eligibility for coverage under another plan. It also includes children age 26 or older with a disability as described in subsection (g) "Children of any age with a developmental of physical disability." Children are defined as the subscriber's:
   a. Children based on establishment of a parent-child relationship, as described in Washington state statutes, except when parental rights have been terminated;
   b. Children of the subscriber's spouse, based on the spouse's establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild's relationship to a subscriber (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death;
   c. Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;
   d. Children of the subscriber's state-registered domestic partner, based on the state-registered domestic partner's establishment of a parent-child relationship, except when parental rights have been terminated. The child's relationship to the subscriber (and eligibility as a dependent) ends on the same date the subscriber's legal relationship with the state-registered domestic partner ends through divorce, annulment, dissolution, termination, or death;
   e. Children specified in a court order or divorce decree for whom the subscriber has a legal obligation to provide support or health care coverage;
   f. Extended dependent in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. Extended dependent child does not include a foster child unless the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption; and
   g. Children of any age with a developmental or physical disability that renders the child incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance provided such condition occurs before the age of 26. The following requirements apply to a dependent child with a disability:
      - The subscriber must provide proof of the disability and dependency within 60 days of the child's attainment of age 26;
      - The subscriber must notify the SEBB Program in writing when the child is no longer eligible under this subsection;
      - A child with a developmental or physical disability who becomes self-supporting is not eligible under this subsection as of the last day of the month in which they become capable of self- support;
      - A child with a developmental or physical disability age 26 and older who becomes capable of self-support does not regain eligibility under this subsection if they later become incapable of self-support; and
      - The SEBB Program (with input from the medical plan if enrolled in medical) will periodically verify the eligibility of a dependent child with a disability beginning at age 26, but no more frequently than annually after the two-year period following the child's 26th birthday. Verification will require renewed proof of disability and dependence from the subscriber.

Enrollment for Subscribers and Dependents
For all subscribers and dependents:

- To enroll at any time other than during the initial enrollment period, see "Making changes."
- Any dependents enrolled in vision coverage will be enrolled in the same vision plan as the subscriber.

School Employee Enrollment. A school employee is required to enroll in a vision plan unless otherwise described in SEBB Program rules.

A school employee must use Benefits 24/7, the SEBB Program's online enrollment system, or submit a *School Employee Enrollment/Change* form and any supporting documents to their SEBB Organization or Employer Group when they become newly eligible or regain eligibility for SEBB benefits. The online enrollment must be completed or the form must be received no later than 31 days after the date the school employee becomes eligible or regains eligibility.

If the school employee does enroll online or return the form by the deadline, the school employee will be enrolled in the Metropolitan Life Vision Plan. Dependents cannot be enrolled until the SEBB Program's next Annual Open Enrollment or when a qualifying event occurs that creates a special open enrollment for enrolling a dependent. See "Special Open Enrollment Changes."

Continuation Coverage Enrollment. A subscriber enrolling in SEBB Continuation Coverage (COBRA or Unpaid Leave) may enroll by using Benefits 24/7 or by submitting the *SEBB Continuation Coverage (COBRA/Unpaid Leave) Election/Change* form and any supporting documents to the SEBB Program. The online enrollment must be completed or the SEBB Program must receive the election form no later than 60 days from the date the enrollee's SEBB health plan coverage ended or from the postmark date on the *SEBB Continuation Coverage Election Notice* sent by the SEBB Program, whichever is later.

Premiums and applicable Premium Surcharges must be made directly to HCA. The first premium payment and applicable Premium Surcharges are due to HCA no later than 45 days after the election period ends as described above. For more information, see "Options for Continuing SEBB Vision Coverage" and the *SEBB Continuation Coverage Election Notice* sent by the SEBB Program.

School Board Member Enrollment. A School Board Member is required to enroll in a vision plan.

A newly elected School Board Member may enroll and self-pay premiums by submitting the *SEBB School Board Member Election/Change* form and any supporting documents to the SEBB Program. The SEBB Program must receive the form no later than 60 days from the beginning of their elected or appointed term.

Premiums and applicable Premium Surcharges must be made directly to HCA. The first premium payment and applicable Premium Surcharges are due to HCA no later than 45 days after the election period ends as described above.

A School Board Member may renew their participation at the start of each subsequent term as a School Board Member. If a School Board Member is reelected for a new term consecutive from their previous term, they will not be required to make new elections.

Dependent Enrollment. To enroll an eligible dependent, the subscriber must include the dependent's information online using Benefits 24/7 or on the applicable enrollment form and provide the required document(s) as proof of the dependent's eligibility. The dependent will not be enrolled in SEBB health plan coverage if the SEBB Program, the SEBB Organization or the Employer Group is unable to verify their eligibility within the SEBB Program enrollment timelines.

Dual Enrollment. A subscriber and their dependents may be enrolled in only one SEBB vision plan. A school employee or their dependent who is eligible to enroll in both SEBB Program and PEBB Program is limited to a single enrollment in a vision plan in the SEBB or PEBB Program. For example:

- A child who is an eligible dependent under two parents working for the same or different SEBB Organizations may be enrolled as a dependent under both parents enrolled in SEBB Program benefits may be enrolled as a dependent under both parents but is limited to a single enrollment in SEBB vision; or
- A child who is an eligible dependent of a school employee in the SEBB Program and an employee in the PEBB Program may only be enrolled as a dependent under one parent in either the SEBB or PEBB Program.

Medicare Eligibility and Enrollment

School Employee and Dependent. If a school employee or their dependent becomes eligible for Medicare, they should contact the nearest Social Security Administration office to ask about the advantages of immediate or deferred Medicare enrollment.

Continuation Coverage Subscriber, a School Board Member or Their Dependents. If a Continuation Coverage subscriber, a School Board Member or their dependent becomes eligible for Medicare when they are turning age 65 but not getting Social Security benefits, Federal regulations allow a seven-month initial enrollment period to enroll in Medicare. If they do not enroll within three months before the month they turn age 65, enrollment in Medicare may be delayed. If enrollment in Medicare does not occur when the subscriber or their dependent is first eligible, a late enrollment penalty may apply.

A SEBB Continuation Coverage (COBRA) subscriber must notify the SEBB Program in writing within 30 days if, after electing SEBB Continuation Coverage (COBRA), a subscriber or their dependent becomes eligible for Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage. If a subscriber or their dependent enrolls in SEBB Continuation Coverage (COBRA) and then becomes eligible for Medicare, their enrollment in SEBB Continuation Coverage (COBRA) will be terminated the last day of the month prior to the month their Medicare coverage begins. This may cause the SEBB Continuation Coverage (COBRA) to be terminated early, before the subscriber has used all the months they would otherwise be entitled to. A subscriber or their dependents who are already enrolled in Medicare when they enroll in SEBB Continuation Coverage (COBRA) will not have their coverage terminated early.

When Vision Coverage Begins

School Employees and Dependents. For a newly eligible school employee and their eligible dependents, vision coverage begins the first day of the month following the date the school employee becomes eligible.

Exceptions:

1. Vision coverage begins on the school employee's first day of work when their first day of work is on or after September 1, but not later than the first day of school for the current school year as established by the SEBB Organization.
2. When a school employee establishes eligibility toward SEBB benefits at any time in the month of August, vision coverage begins on September 1 only if the school employee is also determined to be eligible for the school year that begins on September 1.

For a school employee regaining eligibility, including following a period of leave as described in SEBB Program rules, and their eligible dependents, vision coverage begins the first day of the month following the school employee's return to work if the school employee is anticipated to be eligible for the employer contribution.

Note: When a school employee who is called to active duty in the uniformed services under the Uniformed Services Employment and Reemployment Rights Act (USERRA) loses eligibility for the employer contribution toward SEBB benefits, they regain eligibility for the employer contribution toward SEBB benefits the day they return from active duty. Vision coverage begins the first day of the month in which the school employee returns from active duty.

Continuation Coverage Subscribers and Dependents. For a continuation coverage subscriber and their eligible dependents enrolling when newly eligible due to a qualifying event, vision coverage begins the first day of the month following the day they lost eligibility for SEBB vision plan coverage.

School Board Members and Dependents. For a newly elected or appointed School Board Member and their eligible dependents, vision coverage begins the first day of the month following the day the SEBB Program receives the required form.

All Subscribers and Dependents. For a subscriber or their eligible dependents enrolling during the SEBB Program's Annual Open Enrollment, vision coverage begins January 1 of the following year.

For a subscriber or their eligible dependents enrolling during a special open enrollment, vision coverage begins the first day of the month following the event date or the date the online enrollment election using Benefits 24/7 or the required form is received, whichever is later. If that day is the first of the month, vision coverage begins on that day.

If the special open enrollment is due to the birth or adoption of a child, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, vision coverage will begin as follows:

- For a school employee, vision coverage will begin the first day of the month in which the event occurs;
- For a newly born child, vision coverage will begin the date of birth;
- For a newly adopted child, vision coverage will begin on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier; or
- For a spouse or state-registered domestic partnership of a subscriber, vision coverage will begin the first day of the month in which the event occurs.

If the special open enrollment is due to enrollment of an extended dependent or a dependent child with a disability, vision coverage will begin the first day of the month following the event date or eligibility certification, whichever is later.

Making Changes

Removing a Dependent Who is no Longer Eligible. A subscriber must provide notice to remove a dependent who is no longer eligible due to divorce, annulment, dissolution, or a qualifying event of a dependent ceasing to be eligible as a dependent child, as described under "Dependent Eligibility.". The notice must be received within 60 days of the last day of the month the dependent no longer meets the eligibility criteria.

A school employee must provide notice online using Benefits 24/7 or by submitting a written request to their SEBB Organization or Employer Group.

All other subscribers must provide notice online using Benefits 24/7 or by submitting written request to the SEBB Program.

Consequences for not submitting notice within 60 days may include, but are not limited to:

- The dependent may lose eligibility to continue SEBB vision coverage under one of the Continuation Coverage options described in "Options for Continuing SEBB Vision Coverage";
- The subscriber may be billed for claims paid by the vision plan for services that were rendered after the dependent lost eligibility;
- The subscriber may not be able to recover subscriber-paid insurance premiums for the dependent that lost eligibility; and
- The subscriber may be responsible for premiums paid by the state for the dependent's vision plan coverage after the dependent lost eligibility.

Voluntary Termination for Continuation Coverage Subscribers or School Board Members. A Continuation Coverage subscriber or a School Board Member may voluntarily terminate enrollment in a vision plan at any time by submitting a request online using Benefits 24/7 or in writing to the SEBB Program. Enrollment in the vision plan will be terminated the last day of the month in which the request was received online or by the SEBB Program, or on the last day of the month specified in the termination request, whichever is later. If the request is received on the first day of the month, vision plan enrollment will be terminated on the last day of the previous month.

Note: A School Board Member must be enrolled in all SEBB health plan coverage, including SEBB medical, SEBB dental, and SEBB vision. A School Board Member who voluntarily terminates enrollment in a vision plan also terminates all other health plan enrollment.

Making Changes During Annual Open Enrollment and Special Open Enrollment. A subscriber may make certain changes to their enrollment during the Annual Open Enrollment or when a specific life event creates a special open enrollment period.

Annual Open Enrollment Changes
A school employees may make the following changes to their enrollment during the SEBB Program's Annual Open Enrollment period:

- Enroll or remove eligible dependents
- Change their vision plan

A school employee must submit the election change online using Benefits 24/7 or submit the required *School Employee Enrollment/Change* form and any supporting documents to their SEBB Organization or Employer Group. The change must be completed online, or the forms received, no later than the last day of the Annual Open Enrollment.

All other subscribers may make the following changes to their enrollment during the SEBB Program's Annual Open Enrollment period:

- Enroll in or terminate enrollment in a vision plan
- Enroll or remove eligible dependents
- Change their vision plan

They must submit the election change online using Benefits 24/7 or submit the required *SEBB Continuation Coverage (COBRA/Unpaid Leave) Election/Change* or *SEBB School Board Member Election/Change* form (as appropriate) and any supporting documents to the SEBB Program. The change must be completed online, or the forms received, no later than the last day of the Annual Open Enrollment period.

The change will be effective January 1 of the following year, except when a subscriber chooses to terminate enrollment or remove an eligible dependent, then the change will be effective December 31.

Special Open Enrollment Changes
A subscriber may change their enrollment outside of the Annual Open Enrollment period if a qualifying event creates a special open enrollment period. However, the change in enrollment must be allowable under Internal Revenue Code (IRC) and Treasury Regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, their dependent, or both.

A special open enrollment event must be other than a school employee gaining initial eligibility or regaining eligibility for SEBB benefits.

A special open enrollment may allow a subscriber to make the following changes:

- Enroll in or change their vision plan
- Enroll or remove eligible dependents

To request a special open enrollment change:

- the school employee must make the change online using Benefits 24/7 or submit the required *SEBB Employee Enrollment/Change* form and any supporting documents to their SEBB Organization or Employer Group.
- All other subscribers must make the change online using Benefits 24/7 or submit the required *SEBB Continuation Coverage (COBRA/Unpaid Leave) Election/Change*, or *SEBB School Board Member Election/Change* form (as appropriate) and any supporting documents to the SEBB Program.

The change must be completed online, or the forms must be received, no later than 60 days after the event that creates the special open enrollment. In many instances, the date the change is received online or the date the form is received affects the effective date of the change in enrollment. Submitting the requested change sooner may avoid a delay in the enrollment or change. In addition, the SEBB Program, SEBB Organization or the Employer Group will require the subscriber to provide proof of a dependent's eligibility, evidence of the event that created the special open enrollment, or both.

Exception. If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the subscriber should complete the request online or notify their SEBB Organization, their Employer Group or the SEBB Program by submitting the required forms as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the request must be received online or the required forms must be received no later than 60 days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption. Coverage for a newly born child will include coverage for a Vision Examination or Vision Materials due to injury, sickness, congenital defects, birth abnormalities and premature birth.

Special Open Enrollment Events that Allow for a Change in Health Plans. A subscriber may not change their health plan during a special open enrollment if their state-registered Domestic Partner or state-registered Domestic Partner's child is not a tax dependent.

Any of the following events may create a special open enrollment:

1. Subscriber gains a new dependent due to:
   a. Marriage or registering a state-registered domestic partnership;
   b. Birth, adoption or when assuming a legal obligation for total or partial support in anticipation of adoption; or
   c. A child becoming eligible as an extended dependent through legal custody or legal guardianship;
2. Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan;
4. Subscriber has a change in employment location that affects medical plan availability. If the subscriber changes employment locations and their current medical plan is no longer available, the subscriber must select a new medical plan. If the subscriber has one or more new medical plans available, the subscriber may select to enroll in a newly available plan;
5. Subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan. "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in the Treasury Regulation;
6. Subscriber or their dependent has a change in residence that affects health plan availability. If the subscriber has a change in residence and their current medical plan is no longer available, the subscriber must select a new medical plan;
7. A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent);
8. Subscriber or their dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the subscriber or their dependent loses eligibility for coverage under Medicaid or CHIP;
9. Subscriber or their dependent becomes eligible for state premium assistance subsidy for SEBB health plan coverage from Medicaid or CHIP;
10. Subscriber or their dependent enrolls in coverage under Medicare, or the subscriber or their dependent loses eligibility for coverage under Medicare. If the subscriber's current medical plan becomes unavailable due to the subscriber's or their dependent's enrollment in Medicare, the subscriber must select a new medical plan;

11. Subscriber or their dependent's current medical plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA); or
12. Subscriber or their dependent experiences a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the subscriber or their dependent. The subscriber may not change their health plan election because the subscriber's or dependent's physician stops participation with the subscriber's health plan unless the SEBB Program determines that a continuity of care issue exists. The SEBB Program will consider but not limit its consideration to the following:
    a. Active cancer treatment such as chemotherapy or radiation therapy;
    b. Treatment following a recent organ transplant;
    c. A scheduled surgery;
    d. Recent major surgery still within the postoperative period; or
    e. Treatment for a high-risk pregnancy; or
13. The SEBB Program determines that there has been a substantial decrease in providers available under a SEBB medical plan.

    NOTE: The plan cannot guarantee that any physician, hospital, or other provider will be available or remain under contract with the plan. An enrollee may not change vision plans simply because their provider or health care facility discontinues participation with this vision plan until the SEBB Program's next Annual Open Enrollment or when another qualifying event creates a special open enrollment for changing health plans, unless the SEBB Program determines that a continuity of care issue exists.

Special Open Enrollment Events that Allow Adding or Removing a Dependent
Any of the following events may create a special open enrollment:

1. Subscriber gains a new dependent due to:
    a. Marriage or registering a state-registered domestic partnership;
    b. Birth, adoption or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or
    c. A child becoming eligible as an extended dependent through legal custody or legal guardianship.
2. Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the HIPAA;
3. Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan;
4. Subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan. "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in the Treasury Regulation;
5. Subscriber or their dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the SEBB Program's Annual Open Enrollment;
6. Subscriber's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence resulted in the dependent losing their health insurance;
7. A court order requires the subscriber, or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent);
8. Subscriber or their dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the subscriber or their dependent loses eligibility for coverage under Medicaid or CHIP;
9. Subscriber or their dependent becomes eligible for a state premium assistance subsidy for SEBB health plan coverage from Medicaid or CHIP; or
10. Subscriber's dependent enrolls in Medicare or loses eligibility for Medicare.

When Vision Coverage Ends
Termination Dates. Vision coverage ends on the following dates:

1. On the last day of the month any enrollee ceases to be eligible. For a School Board Member, this includes when their elected or appointed term ends;
2. On the date a vision plan terminates or when the group policy ends. If that should occur, the subscriber will have the opportunity to enroll in another SEBB vision plan;
3. For a school employee and their dependents when the employment is terminated, vision coverage ends when:
   - the school employee resigns. If this is the case, vision coverage ends on the last day of the month in which a school employee's resignation is effective; or
   - The SEBB Organization or the Employer Group terminates the employment relationship. If this is the case, vision coverage ends on the last day of the month in which the employer-initiated termination is effective;

   Note: If the SEBB Organization or the Employer Group deducted the school employee's portion of the premium for SEBB insurance coverage after the school employee was no longer eligible for the employer contribution, vision coverage ends the last day of the month for which school employee premiums were deducted.
4. For a Continuation Coverage subscriber or a School Board Member who submits a request to terminate vision coverage, enrollment in vision coverage will be terminated the last day of the month in which the request was received online using Benefits 24/7 or by the SEBB Program, or on the last day of the month specified in the termination request, whichever is later. If the request is received on the first day of the month, vision coverage will be terminated on the last day of the previous month.

A subscriber will be responsible for payment of any services received after the date vision coverage ends as described above.

Final Premium Payments. Premium payments and applicable Premium Surcharges are not prorated during any month, for any reason, even if an enrollee dies or asks to terminate their vision plan before the end of the month.

If the monthly premium or applicable Premium Surcharges remain unpaid for 30 days, the account will be considered delinquent. A subscriber is allowed a grace period of 30 days from the date the monthly premiums or applicable Premium Surcharges become delinquent to pay the unpaid premium balance and applicable Premium Surcharges. If the subscriber's premium balance or applicable Premium Surcharges remain unpaid for 60 days from the original due date, the subscriber's vision coverage (including enrolled dependents) will be terminated retroactive to the last day of the month for which the monthly premiums and any applicable Premium Surcharges were paid.

Options for Continuing SEBB Vision Coverage
When vision coverage ends, the subscriber and their dependents covered by this vision plan may be eligible to continue SEBB vision coverage during temporary or permanent loss of eligibility.

There are three options the subscriber and their dependents may qualify for when coverage ends:

1. SEBB Continuation Coverage (COBRA)
2. SEBB Continuation Coverage (Unpaid Leave)
3. PEBB retiree insurance coverage

SEBB Continuation Coverage. The SEBB Program administers the following Continuation Coverage options that temporarily extend group insurance coverage when the enrollee's SEBB vision plan coverage ends due to a qualifying event.

- SEBB Continuation Coverage (COBRA) includes eligibility and administrative requirements under Federal COBRA laws and regulations. Some enrollees who are not qualified beneficiaries under Federal COBRA may also qualify for SEBB Continuation Coverage (COBRA).

- SEBB Continuation Coverage (Unpaid Leave) is an option created by the SEBB Program with wider eligibility criteria and qualifying event types than COBRA.

An enrollee who qualifies for both types of SEBB Continuation Coverage (COBRA and Unpaid Leave) may enroll in only one of the options. See "Continuation Coverage Enrollment." Refer to *SEBB Continuation Election Notice* sent by the SEBB Program for details.

Premium Payments for SEBB Continuation Coverage. If a subscriber enrolls in Continuation Coverage, the subscriber is responsible for timely payment of premiums and applicable Premium Surcharges.

PEBB Retiree Insurance Coverage
A retiring school employee or a dependent becoming eligible as a survivor is eligible to continue enrollment or defer enrollment in Public Employees Benefits Board (PEBB) insurance coverage if they meet procedural and substantive eligibility requirements. See the *PEBB Retiree Enrollment Guide* for details.

Transitional Continuation Coverage
Non-represented educational service (ESD) school employees and their dependents may gain temporary eligibility for SEBB benefits, on a self-pay basis, if they meet the following criteria:

1. A non-represented school employee and their dependents who are enrolled in medical, dental, or vision under a group plan offered by a SEBB Organization on December 31, 2023, who lose eligibility because the school employee is not eligible for SEBB benefits, may elect to continue existing enrollment in one or more of the following SEBB benefits: medical, dental, or vision coverage. These benefits will be provided for a maximum of 18 months.
2. A dependent of a SEBB eligible non-represented school employee of an ESD who is enrolled in medical, dental, or vision under a school employee's account on December 31, 2023, who loses eligibility because they are not an eligible dependent may continue existing enrollment for a maximum of 36 months.
3. A dependent of a non-represented school employee who is continuing medical, dental, or vision coverage through ESD on December 31, 2023, may elect to continue existing enrollment to finish out their remaining months, up to the maximum number of months authorized by Consolidated Omnibus Budget Reconciliation Act (COBRA) for a similar event, by enrolling in a medical, dental, or vision plan offered through the SEBB Program.

Family and Medical Leave Act of 1993
A school employee on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward SEBB benefits in accordance with the federal FMLA.

The SEBB Organization or the Employer Group determines if the school employee is eligible for leave and the duration of the leave under FMLA. The school employee must continue to pay their monthly premium contribution and applicable Premium Surcharge during this period.

If a school employee exhausts the period of leave approved under FMLA, they may continue SEBB insurance coverage by self-paying the monthly premium and applicable Premium Surcharges set by HCA, with no contribution from the SEBB Organization or Employer Group. See the "Options for Continuing SEBB Vision Coverage."

Paid Family and Medical Leave Act
A school employee on approved leave under the Washington state Paid Family and Medical Leave (PFML) Program may continue to receive the employer contribution toward SEBB benefits.

The Employment Security Department determines if the school employee is eligible for leave under PFML. The school employee must continue to pay their monthly premium contribution and applicable Premium Surcharges during this period.

If a school employee exhausts the period of leave approved under the PMFL, they may continue SEBB insurance coverage by self-paying the monthly premium and applicable Premium Surcharges set by HCA, with no contribution from the SEBB Organization or Employer Group. See the "Options for Continuing SEBB Vision Coverage."

General Provisions for Eligibility and Enrollment

Payment of Premiums During a Labor Dispute. Any school employee or dependent whose monthly premiums are paid in full or in part by the SEBB Organization or the Employer Group may pay premiums directly to HCA if the school employee's compensation is suspended or terminated directly or indirectly because of a strike, lockout, or any other labor dispute for a period not to exceed six months.

When the school employee's compensation is suspended or terminated, HCA will notify the school employee immediately (by mail at the last address of record) that the school employee may pay premiums as they become due.

If coverage is no longer available to the school employee under this certificate of coverage, then the employee may be eligible to purchase an individual vision plan from this plan consistent with premium rates filed with the Washington State Office of the Insurance Commissioner.

Appeal Rights. Any current or former employee of a SEBB Organization or their dependent may appeal a decision made by the SEBB Organization regarding SEBB eligibility, enrollment, or Premium Surcharges to the SEBB Organization.

Any current or former school employee of an Employer Group that contracts with HCA for SEBB benefits, or their dependent may appeal a decision made by an Employer Group regarding SEBB eligibility, enrollment, or Premium Surcharges to the Employer Group.

Any enrollee may appeal a decision made by the SEBB Program regarding SEBB eligibility, enrollment, premium payments, or Premium Surcharges to the SEBB Appeals Unit.

Any enrollee may appeal a decision regarding the administration of a SEBB vision plan by following the appeal provisions of the plan, except when regarding eligibility, enrollment, and premium payment decisions.

Learn more at www.hca.wa.gov/sebb-appeals.

Relationship to Law and Regulations. Any provision of this certificate of coverage that is in conflict with any governing law or regulation of Washington is hereby amended to comply with the minimum requirements of such law or regulation.

BENEFITS

Benefits are payable for each Insured Person as shown in the Schedule of Benefits for expenses incurred while this insurance is in force. The Insured Person is free to contract at any time to receive treatment or services outside of or not covered by the Policy on any terms or conditions acceptable to the Provider and the Insured Person.

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. 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;
3. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
4. any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment;
5. safety eyewear;
6. non-prescription sunglasses;
7. plano (non-prescription) lenses ;
8. plano (non-prescription) contact lenses;
9. two pair of glasses in lieu of bifocals;
10. 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
11. lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.

TERMINATION OF INSURANCE

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

For All Insureds. Subject to any continuation provision, 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;
3. the date the Insured is no longer eligible for insurance in accordance with the Eligibility and Enrollment section provided by the Policyholder;
4. the date the Insured has a change in employment to a public school that does not offer this vision coverage; or
5. the date the Insured's employment with the Policyholder ends.

For Dependents. Subject to any continuation provision, 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 Eligibility and Enrollment section; or
3. the end of the last period for which any required premium contribution has been made.

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 60-day grace period for the payment of each premium due after the first premium. Coverage will terminate at the end of the period for which premiums were paid. The Company will require payment of all premiums for the period this coverage continues in force. The grace period will not apply if the Company receives written notice of the Policyholder's or the Insured's intent to terminate coverage.

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

CLAIMS

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

Claim Forms. The Company will furnish claim forms to the Insured Person within 15 days after notice of claim is received. If the Company does not provide the forms within that time, the Insured Person may send written proof of the occurrence, character and extent of loss for which the claim is made within the time stated in the Policy for filing proof of loss. Claim forms may be accessed at www.eyemed.com or at https://member.eyemedvisioncare.com/hcasebb/en.

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 upon receipt of due written proof of loss.

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

Assignment. Benefits under the Policy may be assigned.

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

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

GENERAL PROVISIONS

Certificate. The Company will furnish the Certificate to the Policyholder for the Insured which will set forth the essential features of the insurance coverage. Any conflict between the terms of the Certificate and the Policy will be decided in favor of the Certificate.

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

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

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

Insurance Data. The Policyholder must give the Company the names and ages of all individuals initially insured. The names of persons who later become eligible (whether or not the person becomes insured), and the names of those who cease to be eligible must also be given. The eligibility dates and any other necessary data must be given to the Company so that the premium can be determined. The Company has the right to audit the Policyholder's books and records as the books and records relate to this insurance. The Company may authorize someone else to perform this audit. Any such inspection may be done at any reasonable time.

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

SCHEDULE OF BENEFITS

Network: EyeMed – Access.
To access a list of Providers in your area, go to www.eyemed.com. To request a paper copy of the Provider Directory, call Member/Patient Services at (866) 800-5457.

BENEFIT FREQUENCY		
Vision Examinations	once every calendar year	Insured Persons
Vision Materials		
Frame	once every other calendar year	Insured Persons 19 years of age and older
Frame	once every calendar year	Insured Persons under 19 years of age
Lenses and Lens Options	once every other calendar year	Insured Persons 19 years of age and older
Lenses and Lens Options	once every calendar year	Insured Persons under 19 years of age
Contact Lenses	once every other calendar year	Insured Persons 19 years of age and older
Contact Lenses	once every calendar year	Insured Persons under 19 years of age

BENEFIT	***In-Network Provider***	***Out-of-Network Provider*** *(Reimbursement up to)*
Vision Examinations		
Comprehensive Eye Examination Insured Persons 19 years of age and older	$0 Copayment	$84
Comprehensive Eye Examination Insured Persons under 19 years of age	$0 Copayment	$90
Contact Lenses Fit and Follow-Up (One Fit and two Follow-Up visits) Available once a Comprehensive Eye Examination has been completed. Insured Persons under 19 years of age		
Standard Contacts	$0 Copayment	$65
Premium Contacts	$0 Copayment, up to $65 Allowance	$65
Vision Materials		
Frame	$0 Copayment, up to $200 Allowance	$100
Contact Lenses Only one of the following Contact Lenses benefits may be used for the Contact Lenses benefit. Insured Persons 19 years of age and older		
Conventional Contacts	$0 Copayment, up to $200 Allowance	$200
Disposable Contacts	$0 Copayment, up to $200 Allowance	$200
Medically Necessary Contacts	Paid in Full	$300

BENEFIT	***In-Network Provider***	***Out-of-Network Provider*** *(Reimbursement up to)*
Contact Lenses Only one of the following Contact Lenses benefits may be used for the Contact Lenses benefit. Insured Persons under 19 years of age		
Conventional Contacts	up to $300 Allowance	50% of charge up to $300
Disposable Extended Wear Contacts	up to $300 Allowance	50% of charge up to $300
Disposable Daily Wear Contacts	up to $300 Allowance	50% of charge up to $300
Medically Necessary Contacts	up to $300 Allowance	50% of charge up to $300
Standard Plastic Lenses Insured Persons 19 years of age and older		
Single Vision	$0 Copayment	$25
Bifocal	$0 Copayment	$40
Trifocal	$0 Copayment	$55
Lenticular	$0 Copayment	$55
Progressive – Standard	$55 Copayment	$55
Progressive – Premium		
Tier 1	$85 Copayment	$55
Tier 2	$95 Copayment	$55
Tier 3	$110 Copayment	$55
Tier 4	$175 Copayment	$55
Standard Plastic Lenses Insured Persons under 19 years of age		
Single Vision	$0 Copayment	$25
Bifocal	$0 Copayment	$35
Trifocal	$0 Copayment	$53
Lenticular	$0 Copayment	$53
Progressive – Standard	$0 Copayment	$40
Progressive – Premium		
Tier 1	$85 Copayment	$40
Tier 2	$95 Copayment	$40
Tier 3	$110 Copayment	$40
Tier 4	$175 Copayment	$40
Lens Options		
Anti-Reflective Coating – Standard Insured Persons	$45 Copayment	$5
Anti-Reflective Coating – Premium Insured Persons		
Tier 1	$57 Copayment	$5
Tier 2	$68 Copayment	$5
Tier 3	$85 Copayment	$5
High-Index Lenses Insured Persons under 19 years of age	$0 Copayment	$60
Polycarbonate Lenses – Standard Insured Persons under 19 years of age	$0 Copayment	$20
Scratch Coating – Standard Plastic Insured Persons 19 years of age and older	$0 Copayment	$5
Scratch Coating – Standard Plastic Insured Persons under 19 years of age	$0 Copayment	$8

ADDITIONAL DISCOUNTS

Discounts are not insured benefits.
Only available from In-Network Providers.

Vision Care Services	In-Network Provider
Retinal Imaging Examination:	Up to $39
Contact Lenses Fit and Follow-Up (19 years of age and older): (One Fit and two Follow-Up visits) Available once a Comprehensive Eye Examination has been completed.	
Standard Contact Lens Fit & Follow-up	Up to $55
Premium Contact Lens Fit & Follow-up	10% off retail price
Lens Options:	
Photochromic – Non-Glass (19 years of age and older)	20% off retail price
Photochromic – Non-Glass (under 19 years of age)	$75 off retail price
Standard Polycarbonate	$40 off retail price
Tint (Solid and Gradient)	$15 off retail price
UV Coating	$15 off retail price
Other Add-On and Services and Materials:	20% off retail price
Refractive Surgery (Lasik or PRK):	15% off retail price or 5% off promotional price
Additional Pair of Glasses/Lenses:	40% off retail price and a 15% discount on conventional lenses, once the insured benefit is used
Hearing Care:	Up to 66% off hearing aids, an extended warranty and free batteries

The Member will receive a 20% discount on items not covered by the insurance plan at EyeMed In-Network Provider locations. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states, members may be required to pay the full retail rate and not the negotiated discount rate with certain In-Network Providers. Please see EyeMed's on-line In-Network Provider location to determine which In-Network Providers have agreed to the discounted rate. Discounts on Vision Materials may not be applicable to certain manufacturers' products.

F I D E L I T Y S E C U R I T Y L I F E I N S U R A N C E C O M P A N Y®
3130 Broadway • Kansas City, Missouri 64111-2406
Phone: (800) 648-8624
A STOCK COMPANY (herein Called "the Company")

OUTLINE OF COVERAGE
GROUP VISION PLAN
THIS IS A LIMITED BENEFIT PLAN
Policy Form M-9193WA

Read Your Certificate Carefully—This Outline of Coverage provides a very brief description of the important features of your coverage. This is not the insurance Policy and only the actual Policy provisions will control. The Policy itself sets forth in detail, the rights and obligations of both you and the Company. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY!

BENEFITS

Benefits are payable for each Insured Person as shown in the Schedule of Benefits for expenses incurred while this insurance is in force. The Insured Person is free to contract at any time to receive treatment or services outside of or not covered by the Policy on any terms or conditions acceptable to the Provider and the Insured Person.

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. 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;
3. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
4. any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment;
5. safety eyewear;
6. non-prescription sunglasses;

7. plano (non-prescription) lenses ;
8. plano (non-prescription) contact lenses;
9. two pair of glasses in lieu of bifocals;
10. 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
11. lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.

TERMINATION OF INSURANCE

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

For All Insureds. Subject to any continuation provision, 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;
3. the date the Insured is no longer eligible for insurance in accordance with the Eligibility and Enrollment section provided by the Policyholder;
4. the date the Insured has a change in employment to a public school that does not offer this vision coverage; or
5. the date the Insured's employment with the Policyholder ends.

For Dependents. Subject to any continuation provision, 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 Eligibility and Enrollment section; or
3. the end of the last period for which any required premium contribution has been made.

PREMIUM RATE CHANGE

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.

FIDELITY SECURITY LIFE INSURANCE COMPANY®

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

PROTECTION FOR YOU AND YOUR INSURANCE POLICY
THE WASHINGTON LIFE AND DISABILITY INSURANCE GUARANTY ASSOCIATION

PREFACE

This brochure briefly describes the coverage provided through the Washington Life & Disability Insurance Guaranty Association ("Association").

The Association is a non-profit unincorporated legal entity created by the Washington Life and Disability Insurance Guaranty Association Act, Chapter 48.32A RCW ("Act"). Every life and disability insurance company authorized to do business in Washington is a member of the Association. A Board of Directors ("Board"), composed of representatives from member insurers, and the Insurance Commissioner, ex-officio, oversee the operation of the Association.

The expenses of the Association are paid by assessments made against each member insurer. Persons covered by the Act are not charged for the expenses of the Association or the protection provided under the Act.

Coverage is provided for certain life and disability insurance. However, the Association does not cover all such insurance. Coverage that is provided is subject to the limitations and exclusions provided by the Act.

The purpose of this brochure is to help you understand the general nature and the conditions of the protection provided under the Act. It is only a summary, however, and if you have specific questions that are not discussed here you may contact either the Association or the Office of the Insurance Commissioner.

Washington Life and Disability Insurance Guaranty Association
P.O. Box 2292
Shelton, WA 98584
360-426-6744

Company Supervision Division
Office of the Insurance Commissioner
P.O. Box 40259
Olympia, WA 98504-0259
360-725-7214

QUESTIONS AND ANSWERS

1. WHAT INSURANCE POLICIES ARE COVERED UNDER THE ACT?

   The Act applies to life insurance policies, disability insurance policies, and annuity contracts issued by an insurance company authorized to do business in Washington. The term "disability insurance", as used in the Act, includes not only disability income insurance, but also policies commonly referred to as "health insurance" (which includes long term care policies). Together, all of these policies and contracts are sometimes referred to as "covered policies", a term used in this brochure.

2. ARE THERE POLICIES OR INSURERS NOT COVERED BY THE ACT?

   The Act specifically excludes certain types of policies or portions of policies, including, but not limited to: The portion of a policy not guaranteed by the insurer; the portion of a policy to the extent the interest rate or crediting rate exceeds the limits in the Act; policies of reinsurance, unless assumption certificates have been issued; policies issued in Washington by an insurer at a time when the insurer was not licensed or did not have a certificate of authority; policies issued to a self-insured plan or program; certain unallocated employee benefit plan annuities protected by federal law; and unallocated annuity contracts not issued to or in connection with a benefit plan or a government lottery.

The Act also does not apply to policies or contracts issued by health care service contractors, health maintenance organizations, fraternal benefit societies, self-funded multiple employer welfare arrangements, mandatory state pooling plans, mutual assessment companies, insurance exchanges, or an organization that has a certificate or license limited to issuance of certain charitable gift annuities.

3. WHO IS PROTECTED UNDER THE ACT?

You are covered by the Act if you are an owner of or certificate holder under a policy or contract (other than an unallocated annuity contract or structured settlement annuity), and:

- You are a Washington resident; or
- You are not a Washington resident, but only if the insurer is domiciled in Washington; there is an association similar to the Washington Association in your state of residency; and you are not covered in your state of residency, because the insurer was not licensed in that state; or
- You are a beneficiary, assignee, or payee of one of the above, regardless of where you reside (except for non-resident certificate holders under group policies).

Owners of unallocated annuity contracts are covered if the contract was issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in Washington, or the contract was issued to or in connection with a government lottery and the owner is a Washington resident.

A payee under a structured settlement annuity (or beneficiary of a deceased payee) is also covered, if the payee is a Washington resident, or the payee is not a Washington resident, but the contract owner is a resident; or the insurer that issued the annuity is domiciled in Washington and coverage is not available in the state in which the payee resides.

Residency is generally determined at the time of entry of an order of liquidation against the insurer. If you move to another state and reside there when such an order is entered, you may still have protection under the law of that state. You should contact the insurance department in your new state of residence to find out about guaranty act protection there.

4. HOW DOES THE ASSOCIATION PROTECT COVERED PERSONS AGAINST LOSS?

After an order of liquidation is entered against a company, the Association begins its work of carrying out the purpose of the Act, which is to assure the performance of insurance obligations of that company. The Association is authorized to carry out its duties by working with insurance companies in good standing to assume or take over the covered policies. The association may also directly provide benefits and coverage as authorized by the Act. The Association has the authority to collect the funds necessary to provide protection to covered persons against losses on their covered policies.

5. WHERE DOES THE ASSOCIATION GET THE MONEY TO PROVIDE THIS PROTECTION?

The Association is authorized to collect money from all life and disability insurance companies doing business in Washington. The funds collected from an assessment are used to pay claims to covered persons and/or to fund the assumption of covered policies by another insurer.

6. DOES THE ASSOCIATION PAY OUT THE MONEY IT COLLECTS RIGHT AWAY OR DO COVERED PERSONS HAVE TO WAIT?

   The Association generally cannot make an assessment for covered policies issued by a company until after an order of liquidation has been entered against the company, and a reasonable estimate can be made of the amount of money needed. Insurance companies receiving an assessment notice must make their payments within thirty days.
   Because it takes time for an action to be commenced against a financially impaired insurer, for a Court to issue an order, and for funds to be collected to satisfy the obligations of that insurer, some delay, hopefully short, is unavoidable before payments can be made. Although it is impossible to predict how long this process will take in any given case, an average time period of twelve to eighteen months is not unusual.

   When necessary, the Association may borrow money to make payments more promptly, particularly in cases that will take an unusual amount of time to be resolved.

7. WHAT IS THE AMOUNT OF PROTECTION PROVIDED BY THE ACT?

   The Act provides the following maximum amounts of protection:

Life Insurance Death Benefits…….…..	$500,000
Disability Benefits and Health Benefits (including Long Term Care Benefits)…	$500,000
Present Value of Individual Annuities……	$500,000
Unallocated Annuity Contracts, other than certain government retirement plans (limit is per contract owner or plan sponsor)……	$5,000,000
Government Retirement Plans in Unallocated Annuities established under Internal Revenue Code § § 401, 403(b), or 457 (limit is per participant)…..……	$100,000

   This protection becomes effective at the time of entry of a Court order of liquidation against the insurer. Of course, if the amount owed under the contract or policy is less than the maximum benefit under the Act, the covered person will be entitled to protection only up to the actual amount owed.

   Furthermore, the maximum protection available to each covered person remains the same, regardless of the number of contracts through which he or she has a claim.

8. IF A HUSBAND AND WIFE EACH INDIVIDUALLY OWN A COVERED POLICY, IS THE PROTECTION UNDER THE ACT PROVIDED TO EACH OF THEM?

   Yes. As long as the residency requirements are met, both would be entitled to the protection provided by the Act, up to the maximum amount.

9. WHY DOESN'T MY INSURANCE COMPANY ADVERTISE THE FACT THAT ITS POLICIES AND CONTRACTS ARE PROTECTED UNDER THE ACT?

   Under Washington law, insurance companies are prohibited from advertising that their policies or contracts may be covered under the Act.

   You should not rely on coverage under the Act when selecting an insurance company.

10. WHY HASN'T MY AGENT TOLD ME ABOUT THE GUARANTY ACT?

    Your insurance agent is subject to the same prohibitions as your insurance company. As a representative of the company, an agent must exercise great care when soliciting business and consequently, will generally not discuss the subject of a guaranty act with clients.

11. WHO SHOULD I CONTACT IF I BELIEVE THERE HAS BEEN A VIOLATION OF THE ACT?

    You should contact the Association if you believe your rights have been violated under the Act. If you are dissatisfied with the actions of the Association, you may also contact the Office of the Insurance Commissioner.

CONCLUSION

This brochure has been prepared by the Washington Life and Disability Insurance Guaranty Association. Its purpose is to inform the public in a general way of the protections that are available in this state on insurance policies and annuity contracts issued by companies authorized to do business in Washington. The Association does not, by this brochure, endorse any company or its products, but rather seeks to address some of the concerns that you may have regarding the security of insurance policies and annuity contracts.

For more information or answers to specific questions you may contact the Washington Life and Disability Insurance Guaranty Association or the Office of the Insurance Commissioner, whose addresses and telephone numbers are shown in the Preface.

FIDELITY SECURITY LIFE INSURANCE COMPANY®

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

Health Care Insurer Appeals Process Information Packet

Please read this notice carefully. This notice contains important information about how to appeal decisions made by your insurer.

I. Levels of Review

You may ask your insurer to review its decisions involving your requests for service or your request to have your claims paid. In general, the following three levels will be available to you:

Level 1 Expedited Medical Review.
Level 2 Informal Reconsideration.
Level 3 Formal Appeal.

These levels of review are discussed more fully below.

A. Expedited Medical Review (Level 1)

1. Eligibility

a. Claim for a covered service not yet provided:

You may obtain Expedited Medical Review of your denied request for a covered service that has not already been provided if:

* You have coverage with the insurer.
* Your insurer has denied your request for a covered service.
* Your physician or treating provider certifies in writing and provides supporting documentation that the time required to process your request through the Informal Reconsideration process could cause a significant negative change in your medical condition.

b. Claim for a covered service already provided but not paid for:

You may not obtain expedited medical review of your denied request for a covered service that has already been provided. Instead, you may start the review process by seeking Formal Appeal (Level 3).

2. Decision:

After receiving the certification and the supporting documentation, the insurer has 24 hours to make a decision and orally communicate that decision to you or your health care provider. Written notice of the decision will also be mailed to you within one day after the decision has been orally communicated to you and/or your health care provider.

The written notice will include the criteria used, the clinical reasons for that decision and any references to supporting documentation. This notice will also be sent to your physician or treating provider.

a. Denial upheld

If your insurer agrees that the covered services should have been denied, you may ask for further review through the Formal Appeal process (Level 3) discussed below.

b. Denial reversed

If your insurer agrees that the covered service should have been provided, your insurer must authorize the service.

B. Informal Reconsideration (Level 2)

1. Eligibility

a. Claim for a covered service not yet provided:

If your insurer denies your request for a covered service that has not yet already been provided, and you do not qualify for an Expedited Medical Review (Level 1), you may ask for Informal Reconsideration (Level 2) of that denial by calling, writing or faxing your request to:

{Fidelity Security Life Insurance Company}
{Technical Services Department}
{3130 Broadway, Kansas City, MO 64111}
{Phone: 800-648-8624}
{Fax: 816-968-0575}

b. Claim for a covered service already provided, but not paid for:

You may not obtain Informal Reconsideration of your denied request for the payment of a covered service. Instead, you may start the review process by seeking Formal Appeal (Level 3)

2. Deadlines Applicable to the Informal Reconsideration Process:

You have up to two years after your insurer denies your request for a covered service to request an Informal Reconsideration.

Within two business days after receiving your request for Informal Reconsideration, your insurer will send you a notice showing that your request was received. At that time if the insurer does not have sufficient information to complete the Informal Reconsideration process the insurer will advise you that it may not proceed with its review unless additional information is provided. The insurer agrees to assist you in gathering the necessary information. You will also receive another copy of this information packet with that notice.

3. Decision

Unless you or your health care provider agree in writing to an extension of up to 30 business days, your insurer has 30 days to make a decision and orally communicate that decision to you or your health care provider. Written notice of the decision will also be mailed to you within 5 business days after the decision has been orally communicated to you and/or your health care provider. This notice will also be sent to your physician or treating provider.

a. Denial upheld

If your insurer continues to agree that the covered service should have been denied, you will receive a notice of that decision. The notice will include a description of the criteria used, the clinical reasons for that decision and any references to supporting documentation.

You may ask for further review through the Formal Appeal process (Level 3) discussed below.

b. Denial reversed

If your insurer agrees that the covered service should have been provided, your insurer must authorize the service.

C. Formal Appeal (Level 3).

1. Eligibility

a. Claim for a covered service not yet provided:

If your insurer denies your request for a covered service after either the Expedited Medical Review (Level 1) or Informal Reconsideration (Level 2) you may send a written request for Formal Appeal within 60 days of the last denial to:

{Fidelity Security Life Insurance Company}
{Technical Services Department}
{3130 Broadway, Kansas City, MO 64111}
{Phone: 800-648-8624}
{Fax: 816-968-0575}

If you elect this option, you or your physician or treating provider must give the insurer any material justification or documentation to support your request for the service.

b. Claim for a covered service already provided, but not paid for:

If your insurer denies your claim for a covered service that has already been provided, you may send written request for Formal Appeal within two years of the last denial to:

{Fidelity Security Life Insurance Company}
{Technical Services Department}
{3130 Broadway, Kansas City, MO 64111}
{Phone: 800-648-8624}
{Fax: 816-968-0575}

If you elect this option, you or your physician or treating provider must give the insurer any material justification or documentation to support your request for the service.

2. Deadlines Applicable to the Formal Appeal Process:

Within five business days after receiving your request for Formal Appeal, your insurer will send you a notice showing that your request was received. You will also receive another copy of this information packet with that notice.

a. Claim for covered service not yet provided:

Your insurer has 30 days to make a decision and mail a notice of that decision to you, send you the written decision, a description of the criteria used, the clinical reasons for that decision and any references to supporting documentation. Your insurer will also send a copy of this information to your physician or treating provider.

b. Claim for a covered service already provided, but not paid for:

Your insurer has 60 days to make a decision and mail a notice of that decision to you, send you the written decision and a description of the supporting documentation. Your insurer will also send a copy of this information to your physician or treating provider.

3. Decision

a. Denial upheld

If your insurer continues to agree that the covered service or claim for a covered service should have been denied, you will receive a notice of that decision.

b. Denial reversed

If your insurer agrees that the covered service should have been provided, or that your claim should have been paid, your insurer must authorize the service or pay the claim.

II. Obtaining Medical Records

A. Requesting Medical Records

You have the right to ask for a copy of medical records. Your request must be in writing. Your request must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

B. Designated Decision Maker

If you have a designated health care decision maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision maker or a person designated in writing by your health care decision maker unless you limit access to your medical records only to yourself or your health care decision maker.

C. Confidentiality

Medical Records disclosed under any State Regulations remain confidential.

III. Documentation for an Appeal

If you decide to file an appeal, you must give the person who will be responsible for processing the appeal any material justification or documentation for the appeal at the time the appeal is filed. You must also give that person the address and phone number where you can be contacted.

IV. Confidentiality

If you participate in the review process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other person.

V. Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. “Properly addressed” means your last known address.

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")

NOTICE OF HEALTH CARE BENEFIT MANAGER'S CAPACITY

PLEASE READ: This notice advises insured persons of the identity and relationship among the Health Care Benefit Manager ("Administrator"), the policyholder and Fidelity Security Life Insurance Company (FSL) as the insurer:

1. FSL has, by agreement, arranged for First American Administrators, Inc. to provide administrative services for your insurance plan. As Health Care Benefit Manager, First American Administrators, Inc., may be authorized to provide Benefit determinations, Claims processing and repricing for services and procedures, Payment to providers and facilities for services or procedures, Dispute resolution, grievances, or appeals relating to determinations of benefits, Provider credentialing and recredentialing, and/or Provider network management according to the terms of its agreement with FSL. First American Administrators, Inc. is not the insurance company or the policyholder.

   Please visit FSL's website, https://www.fslins.com/, for a listing of all Washington Health Care Benefit Managers and the specific services they perform.

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. FSL is liable for the funds to pay your insurance claims.

If 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")

NOTICE OF HEALTH CARE BENEFIT MANAGER'S CAPACITY

PLEASE READ: This notice advises insured persons of the identity and relationship among the Health Care Benefit Manager ("Administrator"), the policyholder and Fidelity Security Life Insurance Company (FSL) as the insurer:

1. FSL has, by agreement, arranged for EyeMed Vision Care, L.L.C. to provide administrative services for your insurance plan. As Health Care Benefit Manager, EyeMed Vision Care, L.L.C., may be authorized to provide Benefit determinations, Claims processing and repricing for services and procedures, Payment to providers and facilities for services or procedures, Dispute resolution, grievances, or appeals relating to determinations of benefits, Provider credentialing and recredentialing, and/or Provider network management according to the terms of its agreement with FSL. EyeMed Vision Care, L.L.C. is not the insurance company or the policyholder.

   Please visit FSL's website, https://www.fslins.com/, for a listing of all Washington Health Care Benefit Managers and the specific services they perform.

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. FSL is liable for the funds to pay your insurance claims.

If EyeMed Vision Care, L.L.C. 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 EyeMed Vision Care, L.L.C. than would otherwise be afforded to you by law.