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: State of Tennessee

POLICY EFFECTIVE DATE: January 1, 2013

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 on 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 number, and the Insured's effective date. The Certificate replaces all certificates previously issued to the Insured under the Policy.

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

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

FIDELITY SECURITY LIFE INSURANCE COMPANY

President Secretary

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

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DEFINITIONS

Benefit Frequency means the period of time in which a benefit is payable.

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

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

Dependent, with eligibility for State of Tennessee Sponsored Group Vision Insurance Program, means any of the following persons whose coverage under the Policy is in force and has not ended. The Insured's:

1. legally married spouse;
2. child from birth to the last day of the month in which such child turns age 26; or
3. child at least 26 years of age: who is primarily dependent upon the Insured for support and maintenance because the child is incapable of self-sustaining employment by reason of mental incapacity or physical handicap; who was so incapacitated and is an Insured Person under the Policy on his or her 26th birthday; and who has been continuously so incapacitated since his or her 26th birthday;.

Child includes natural child, stepchild, legally adopted child, child legally placed in the Insured's home for adoption and child under the Insured's legal guardianship. If both mother and father are covered under the Vision Insurance Program, their children will be covered as dependents of the mother or father, but not both.

A Dependent cannot enroll as an Employee or Retiree and as a Dependent under the same group plan (State, Local Education, or Local Government).

Employee, with eligibility for State of Tennessee Sponsored Group Vision Insurance Program, means a State Employee, Local Education Employee, or Local Government Employee.

State Employee means an individual who is:

1. regularly scheduled to work not less than thirty (30) hours per week;
2. hired prior to July 1, 2015 who has received a seasonal appointment and who meets the requirements set forth in TCA 8/27/204(a)(3); or
3. deemed eligible by applicable federal law, state law, or action of the State Insurance Committee.

Local Education Employee means an individual of a Local Education Agency participating in the State of Tennessee's Sponsored Group Health Insurance Plan who is:

1. a teacher as defined by Tennessee Code Annotated (TCA), § 8-34-101 (46);
2. an interim teacher whose salary is based on the local school system's schedule;
3. an employee not defined above who is regularly scheduled to work at least 30 hours per week in a non-seasonal, non-temporary position;

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

Local Government Employee means an individual of a Local Government Agency participating in the State of Tennessee's Sponsored Group Health Insurance Plan who is:

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

Formulary means a list, provided by the Company, of Vision Materials covered under the Policy.

Enrollment Period means the participation period for an Insured shall be on a calendar year basis and enrollment may only be canceled by an Insured during the State of Tennessee's Annual Enrollment Period for the beginning of the next calendar year or due to a special qualifying event.

Insured means an Employee or Retiree of the Policyholder and his/her dependent who meets the eligibility requirements as shown in the Policyholder's application, who participates in the State of Tennessee Sponsored Group Vision Insurance Plan and whose coverage under the Policy is in force and has not ended.

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

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

Medically Necessary Contact Lenses means:

1. multiple rigid contact lenses for the treatment of Keratoconus; or
2. contact lenses provided following cataract surgery.

Out-of-Network Provider means a Provider, located within the PPO Service Area, who has not signed a Preferred Provider Agreement with the PPO.

Policy means the Policy issued to the Policyholder.

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

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

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

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

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

Retiree with eligibility for State of Tennessee Sponsored Group Vision Insurance Program means a State Retiree, Local Education Retiree, or Local Government Retiree.

State Retiree means an individual who:

1. has left active employment as a State Employee;
2. receives a benefit from the Tennessee Consolidated Retirement System (TCRS) or is a member of one of the Higher Education Optional Retirement plans (ORP); and
3. is enrolled in the State of Tennessee's Sponsored Group Health Insurance Plan.

Local Education Retiree means an individual who:

1. has retired from the employer;
2. receives a benefit from the Tennessee Consolidated Retirement System (TCRS); and
3. is enrolled in the State of Tennessee's Sponsored Group Health Insurance Plan.

Local Government Retiree means an individual who:

1. has retired from the employer;
2. receives a benefit from the Tennessee Consolidated Retirement System (TCRS); and
3. is enrolled in the State of Tennessee's Sponsored Group Health Insurance Plan.

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

Vision Materials means those materials shown in the Schedule of Benefits.

EFFECTIVE DATES

Effective Date of Insured's Insurance. The Insured's insurance will be effective on the following date, provided the Insured has agreed to pay the required premium contributions:

1. **State** – New hire enrollment coverage shall become effective on the first day of the month following the hire date and completion of one full calendar month of employment. Annual enrollment coverage shall become effective on the following January 1 or on another date specified by the State.
2. **Local Education** – New hire coverage shall become effective on the first day of the month after the Employee's eligibility date. Annual enrollment coverage shall become effective on the following January 1 or on another date specified by the State.
3. **Local Government** – New hire coverage shall become effective on the first day of the month following date of hire or the first day of the month following the end of the Employee's probationary period (if the employing agency applies a probationary period to insurance coverage). Annual enrollment coverage shall become effective on the following January 1 or on another date specified by the State.

Effective Date of Dependent's Insurance. The effective date of coverage for a Dependent becomes effective on:

1. the same date as the Employee's effective date;
2. if the Dependent is enrolled subsequent to the Employee's enrollment, the first of a month determined by the State, except for certain qualifying events for which the coverage will be effective on the event date, such as birth; or
3. the first of the following calendar year (January 1) after the Employee has enrolled the dependent during the Annual Enrollment Period.

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

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

BENEFITS

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

Comprehensive Eye Examination. An Insured Person is eligible for one Comprehensive Eye Examination in each Benefit Frequency.

In-Network Provider Benefits. The Insured Person must pay any Co-payment 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.

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. The Company will reimburse the Insured Person for the Out-of-Network Provider benefits up to the maximum dollar amount shown in the Schedule of Benefits.

Vision Materials. If a Vision Examination results in an Insured Person needing corrective Vision Materials for the Insured Person's visual health and welfare, those Vision Materials prescribed by the Provider will be supplied, subject to certain limitations and exclusions of the Policy, as follows:

- *Lenses* provided one time in each Benefit Frequency.
- *Frames* provided one time in each Benefit Frequency.
- *Contact Lenses* provided one time in each Benefit Frequency in lieu of lenses.

LIMITATIONS

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

Benefit 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. treatment of injury or sickness covered by Workers' Compensation or employer's liability laws;
2. services or supplies received without cost from any federal, state or local agency. This exclusion will not apply if prohibited by law;
3. cosmetic surgery or procedures for purely cosmetic reasons;
4. charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for the treatment in any such facility;

5. services by a Provider beyond the scope of his or her license;
6. vision services for which the Insured Person incurs no charge;
7. vision services where charges for such services exceed the charge that would have been made and actually collected if no coverage existed;
8. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
9. safety eyewear; or
10. lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

TERMINATION OF INSURANCE

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

For All Insureds. The Insureds' insurance will cease on the earliest of the following dates:

1. the date the Policy ends;
2. the end of the last period for which any required premium contribution agreed to in writing has been made;
3. the last day of the month in which the Insured separates from active employment with the Policyholder for Central State Government Employees;
4. the last day of the month following the month of the Insured's separation from active employment with the Policyholder for non-Central State Government Employees (Higher Education, Local Education, and Local Government employees);
5. the date the Insured Retiree's enrollment in the State of Tennessee's Sponsored Group Health Insurance Plan for Retirees terminates; or
6. the date the Insured is no longer eligible for insurance.

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

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

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

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

The Company may ask for proof of the eligible Dependent child's incapacity and dependency within 31 days of the date the Dependent child would otherwise cease to be covered.

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

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

Dependent Continuation Benefit. If the Insured dies, the Dependent spouse who was covered under the Policy at the time of the Insured's death may continue coverage under the Policy. All references to the Insured in the Policy will then apply to the surviving spouse. Coverage will also continue for any insured Dependent children covered at the time of the Insured's death. If there is no surviving spouse covered under the Policy, coverage for insured Dependent children will remain in force, subject to any other termination provisions for Dependent children. Dependents not previously covered under the Policy are not eligible for this continuation.

If the Insured Retiree's coverage terminates due to the Insured Retiree becoming eligible for Medicare due to age, the Dependent spouse who was covered under the Policy on the date the Insured's coverage terminated will continue coverage under the Policy as long as the Dependent spouse remains enrolled in the State of Tennessee's Sponsored Group Health Insurance Plan. All references to the Insured in the Policy will then apply to the Dependent spouse. Coverage will also continue for any Dependent children covered at the time of the Insured's termination. If there is no Dependent spouse covered under the Policy, coverage for insured Dependent children will remain in force, subject to any other termination provisions for Dependent children. Dependents not previously covered under the Policy are not eligible for this continuation.

CLAIMS

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

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

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

Time Payment of Claims. Any benefit payable under the Policy will be paid within 30 days, upon receipt of due written proof of loss.

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

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

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

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

Entire Contract. The Policy, including any endorsements and riders, the Certificate, the Policyholder's application, which is attached to the Policy when issued, 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 shall 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, in the absence of fraud, can be used in a contest after the Insured Person's insurance has been in force for two years. 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, or its authorized representative, EyeMed Vision Care, LLC, the names and ages of all individuals insured. The names of persons who later become insured, and the names of those who cease to be insured must also be given. The Insured Person's effective and termination dates and any other necessary data must be given to the Company so that the premium can be determined and claims can be processed.

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

Policyholder: State of Tennessee

Insured Persons have the right to obtain vision care from the Provider of his or her choice. However, payment of benefits varies depending on whether an In-Network or an Out-of-Network Provider is chosen. Benefits are payable as shown in the following Schedule of Benefits:

Benefit	In-Network	Out-of-Network	Benefit Frequency
VISION EXAMINATION			
Comprehensive Eye Examination	$10 Co-payment	up to $45	Once every Calendar Year
VISION MATERIALS			
Standard Plastic or Glass Lenses			Once every Calendar Year
Single Vision	$15 Co-payment	up to $30	
Bifocal	$15 Co-payment	up to $50	
Trifocal	$15 Co-payment	up to $65	
Lenticular	$15 Co-payment	up to $65	
Frames	$0 Co-payment $115 retail allowance	up to $70	Once every two Calendar Years
Contact Lenses (only one option available per Benefit Frequency)			Once every Calendar Year
Conventional	$0 Co-payment $130 allowance	up to $50	
Disposable	$0 Co-payment $130 allowance	up to $50	
Medically Necessary	$0 Co-payment Paid in full	up to $100	
Lens Options			Once every Calendar Year
Standard Polycarbonate	$30 Co-payment	up to $5	
Standard Polycarbonate (For covered Dependent children under 19 years of age.)	$0 Co-payment	up to $5	
UV Treatment	$10 Co-payment	up to $5	
Photochromic Lenses (Transitions Plastic)	$70 Co-payment	up to $5	
Standard Progressive Lenses (add on to Bifocal)	$55 Co-payment	up to $50	
Premium Progressive Lenses (add on to Bifocal)			
Tier 1	$75 Co-payment	up to $50	
Tier 2	$85 Co-payment	up to $50	
Tier 3	$100 Co-payment	up to $50	
Tier 4	$55 Co-payment, up to $120 allowance	up to $50	