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: The School Board of Miami-Dade County, Florida
DBA Miami-Dade County Public Schools

POLICY EFFECTIVE DATE: January 1, 2020

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

If you have a question or complaint about this insurance, please write to us at the following address or call us Toll free: 3130 Broadway, Kansas City, Missouri 64111-2406, (800) 648-8624.

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

Benefit Frequency means the period of time in which a benefit is payable as shown in the Schedule of Benefits.

The Benefit Frequency begins on the later of the Insured Person's effective date or last date services were provided to the Insured Person. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

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 means any of the following persons whose coverage under the Policy is in force and has not ended:

1. the Insured's lawful spouse or Domestic Partner;
2. each child from birth to age 25* who is living with the Insured and is primarily dependent upon the Insured or the Insured's spouse for support and maintenance;
3. each unmarried child to age 30* who does not have a dependent of his or her own and is a resident of Florida or a part-time or full-time student; or
4. each unmarried child: who is primarily dependent upon the Insured or the Insured's spouse 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 25th* birthday; and who has been continuously so incapacitated since his or her 25th* birthday.

Child includes stepchild, foster child, legally adopted child, child legally placed in the Insured's home for adoption and child under the Insured's legal guardianship. A student is one who is enrolled for credit in the case of an accredited junior college, college or university; or a trade school.

**(Until the end of the calendar year in which the child reaches the limiting age.)*

Domestic Partner means an adult who is in a committed relationship with the Insured, and the Insured and the Domestic Partner are mutually responsible for one another financially and otherwise. To qualify as a Domestic Partner or Dependent under the Policy, all of the following conditions must be met:

1. the Domestic Partner and the Insured are over the age of 18 and are mentally competent to enter into contracts;
2. the Domestic Partner and the Insured reside in the same household;
3. the Domestic Partner and the Insured have a committed relationship with each other for no less than six months; intend to continue the relationship indefinitely and have no such relationship with any other person;
4. the Domestic Partner and the Insured are not related by blood;
5. the Domestic Partner and the Insured are not married to any third party;
6. the Domestic Partner and the Insured are of the same sex or opposite sex; and
7. the Domestic Partner and the Insured are not claiming Dependent status for the primary purpose of gaining insurance coverage under the Policy.

The term "spouse", wherever used, will include a Domestic Partner.

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

Insured means an employee of the Policyholder who meets the eligibility requirements as shown in the Policyholder's application, and whose coverage under the Policy is in force and has not ended.

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

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

Medically Necessary Contact Lenses means:

1. Keratoconus where the Insured Person is not correctable to 20/30 in either or both eyes using standard spectacle lenses, or the Provider attests to the specified level of visual improvement;
2. High Ametropia exceeding -10D or +10D in spherical equivalent in either eye;
3. Anisometropia of 3D in spherical equivalent or more; or
4. vision for an Insured Person can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle.

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.

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 as follows:

1. if the Policyholder does not require the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured became eligible;
2. if the Policyholder requires the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured became eligible provided, the Insured has agreed to pay the required premium contributions; and
3. if the Insured fails to meet the requirements of 2 within 30 days after becoming eligible, the Insured's coverage will not become effective until the Company has verified that the Insured has met these requirements. The Insured will then be advised of the Insured's effective date.

Effective Date of Dependents' Insurance. Coverage for Dependents becomes effective on the later of:

1. the date Dependent coverage is first included in the Insured's coverage; or
2. the premium due date on or after the date the person first qualifies as the Insured's Dependent. The Insured must agree to pay any premium contribution that may be required prior to coverage becoming effective.

If the Insured and the Insured's spouse are both Insureds, one Insured may request to be a Dependent spouse of the other. A Dependent child may not be covered by more than one Insured.

Newborn Children. A Dependent child born while the Insured's coverage is in force will be covered from the moment of birth for 31 days or greater, if elected by the Policyholder. However, coverage for a newborn child(ren) of a Dependent child will continue for 18 months after birth. 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 adopted or is placed with the Insured for adoption while the Insured's coverage is in force, this child will be covered from the date of adoption or placement for 31 days or greater, if elected by the Policyholder. In case of a newborn child, coverage begins at the moment of birth if a written agreement to adopt such child has been entered into by the Insured prior to the child's birth unless the child is not ultimately placed in the Insured's residence. In order to continue coverage beyond this period, the Insured must provide notice to the Company. If proper notice has been given, coverage will continue without additional premium during the 31-day period unless the placement is disrupted prior to legal adoption and the child is removed from placement. If the Insured does not give the Company written notice within 31 days of the birth or placement, the Company will charge the applicable premium for coverage of such child during this 31-day period. If notice is given within 60 days of the adoption, birth or placement of the child, the Company will not deny coverage for the child due to the Insured's failure to timely notify the Company of the adoption, birth or placement of the child. Coverage will end if 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. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
2. medical and/or surgical treatment of the eye, eyes or supporting structures;
3. any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear;
4. services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
5. plano (non-prescription) lenses;
6. non-prescription sunglasses;
7. two pair of glasses in lieu of bifocals;
8. services or materials provided by any other group benefit plan providing vision care;
9. 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
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 date the Insured is no longer eligible for insurance; or
4. the date the Insured's employment with the Policyholder ends. The Policyholder may, at the Policyholder's option, continue insurance for individuals whose employment has ended, if the Policyholder:
   a. does so without individual selection between Insureds; and
   b. continues to pay any premium contribution for those individuals.

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

1. the date the Insured's coverage ends;
2. the date in which the Dependent ceases to be an eligible Dependent as defined in the Policyholder's application; or
3. the end of the last period for which any required premium contribution has been made.

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.

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

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

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

CLAIMS

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

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

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

Time Payment of Claims. Any benefit payable under the Policy will be paid immediately, but not more than 30 days, upon receipt of due written proof of loss.

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

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 the applicable statute of limitations 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 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

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

Benefit	In-Network Cost	Out-of-Network Reimbursement	Benefit Frequency
VISION EXAMINATION			
Comprehensive Eye Examination	$10 Co-payment	up to $40	12 months
VISION MATERIALS			
Standard Plastic Lenses			12 months
Single Vision	$10 Co-payment	up to $40	
Bifocal	$10 Co-payment	up to $60	
Trifocal	$10 Co-payment	up to $80	
Lenticular	$10 Co-payment	up to $80	
Frames	$0 Co-payment, up to $180 retail allowance	up to $45	12 months
Contact Lenses ***(only one option available per Benefit Frequency)***			12 months
Conventional	$0 Co-payment, up to $150 allowance	up to $105	
Disposable	$0 Co-payment, up to $150 allowance	up to $105	
Medically Necessary	Paid in full	up to $210	
Lens Options			12 months
Standard Progressive Lenses	$75 Co-payment	up to $55	
Premium Progressive Lenses	Tier 1 - $105 Co-payment Tier 2 - $115 Co-payment Tier 3 - $130 Co-payment Tier 4 - $200 Co-payment	up to $55	
Standard Polycarbonate - Adults	$30 Co-payment	up to $5	
Standard Polycarbonate – Kida Under 19	$0 Co-payment	up to $20	
Standard Plastic Scratch Coating	$0 Co-payment	up to $8	
UV Treatment	$12 Co-payment	up to $5	
Tint (Solid and Gradient)	$12 Co-payment	up to $5	
Standard Anti-Reflective	$45 Co-payment	up to $5	
Premium Anti-Reflective	Tier 1 - $57 Co-payment Tier 2 – $68 Co-payment Tier 3 - $85 Co-payment	up to $5	

Application for Vision Care Benefits

Underwritten by Fidelity Security Life Insurance Company
Kansas City, Missouri

I. GROUP INFORMATION

Group Name: The School Board of Miami-Dade County, Florida Tax ID#: 59-6000572

DBA Name (If other than above): Miami-Dade County Public Schools

Business Address: 1501 NE 2nd Avenue, Suite 335 City: Miami State: FL ZIP: 33132

Mailing Address: _____ City: _____ State: ____ ZIP: _____

Primary Contact: Rosa Novo Title: Administrative Benefits Director

Phone Number: (305) 995-7141 Fax Number: (305) 995-7190

E-mail Address: rnovo@dadeschools.net

Type of Business: ☐ Proprietorship ☐ Corporation ■ Other (Specify): Government

PLEASE NOTE THE FOLLOWING TYPE BUSINESSES REQUIRE PRIOR CARRIER APPROVAL:

☐ MEWA ☐ PEO ☐ Trust ☐ Union

Service Area: ☐ National (U.S.– does not include Puerto Rico) ■ State Specific (List) Primarily FL

If any subsidiary or affiliated companies are to be insured or any Employees/Members are working at a location other than the business address above, please explain and list states. Employees/members employed within Miami area. Any member may access service in any State.

Billing Contact Name: Ms. Oria Lacayo Phone: (305) 995-7006

Billing Address: 1501 NE 2nd Avenue, Suite 335 City: Miami State: FL ZIP: 33132

If you have subsidiaries, affiliated companies, or divisions who use another name and will be covered by this plan, AND require separate billing invoices, please attach the following information on a separate sheet of paper signed by you:

• Name • Address • Billing Contact & Phone Number

Will this plan replace any existing coverage? ■ Yes ☐ No

If "Yes," indicate name of existing insurer: UnitedHealthcare

If "Yes," are any Employees/Members on COBRA continuation? ■ Yes ☐ No How many? 200

Do you intend to offer Employees/Members COBRA continuation? ■ Yes ☐ No

II. PLAN SELECTION

Please refer to the attached proposal page. Services are provided by EyeMed Vision Care.

III. PREMIUMS

Group's Premium Contribution for*: Employees/Members: 0 % Dependents: 0 %

Employee's/Member's Premium Contribution for: Employees/Members: 100 % Dependents: 100 %

Are Employee/Member and Dependent premiums paid through a Section 125 Plan? ■ Yes ☐ No

Are Employee/Member and Dependent premiums collected via payroll deduction? ■ Yes ☐ No

Premiums shall be payable at the rates included on the attached proposal page.

**If the Group's contribution percentage is changed or the number of eligible Employees/Members increases or decreases, premium may be adjusted as allowed under the Policy. The premium may be adjusted at the end of the calendar month in which the change occurred.*

IV. ELIGIBILITY

Number of Employees/Members: 44,000 Number Applying: 22,000

Number of Dependents: 23,000 Number of Retirees: _____

Are Domestic Partners covered under this Plan*? ■ Yes ☐ No Same Sex*? ■ Yes ☐ No Opposite Sex*? ■ Yes ☐ No

Dependent Children Covered to Age*: ☐ 25 ■ 26**

Dependent Part-Time or Full-Time Students are covered to Age 30*.

**Unless state law has different requirements.*

***Dependent Children covered to age 26 regardless of financial dependency, residency, student status or marital status.*

Eligibility Reporting Contact (produces the eligibility file): Silvia Costa

Address (if different from Group): _____

City: _____ State: ____ ZIP: _____

E-mail Address: SilviaCosta@dadeschools.net

Phone: (305) 995-2016 Fax: (305) 995-7190

Eligibility Authorization Contact (Benefits Administrator or Third Party Administrator responsible for verifying vision election for Employees/Members):

Name: Silvia Costa Phone: (305) 995-7190

Days/Hours of Availability: 8:00-4:30 E-mail Address: SilviaCosta@dadeschools.net

PROBATIONARY PERIOD

For New Employees/Members: ☐ 30 days ☐ 60 days ■ 90 days ☐ 180 days ☐ Other _____

Probationary Period is waived for present Employees/Members: ■ Yes ☐ No

Number of Employees/Members who have not yet completed the probationary period: Ongoing Eligibility

V. EFFECTIVE DATE

This plan will become effective at 12:01 a.m. Local Time at the Group's address herein, on the first day of January 1, 20 20, provided all of the following have been completed prior to this effective date:

A. This application has been received and accepted by the Company (must be submitted 30 days in advance of the effective date).

B. EyeMed has been furnished a working file of all eligible Employees/Members, according to the layout guidelines. It is understood and agreed that EyeMed may rely on this information to provide services to individuals designated as eligible.

The Group hereby makes application to Fidelity Security Life Insurance Company for Vision Care Benefits. The Group agrees to maintain and furnish any records necessary to administer this plan and to forward premiums monthly.

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

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Dated at: Miami-Dade County this 16 day of September, 20 20

Signed for the Group: ➤ Rosa Novo Title: Administrative Benefits Director

VI. COMPANY DISPLAY NAME (Your Group name as it should appear to your employees)

Company Name Miami-Dade Cty Public Schools
(Maximum of 30 characters, including punctuation and spacing.)

ATTENTION: THE DEPARTMENT OF INSURANCE REQUIRES THAT ONLY THE AGENT AND/OR GENERAL AGENT WHO SOLD THE PRODUCT AND HOLDS A VALID LIFE AND HEALTH LICENSE MAY COMPLETE THE CERTIFYING STATEMENT

WRITING AGENT'S CERTIFYING STATEMENT

I certify that I have accurately recorded on this application the information supplied by the applicant, if such information has been provided directly to me for recording purposes, and I am properly licensed in the state in which the Group is domiciled.

Firm Name (print): _____ Tax ID No.: _____

Address: 4017 Mourning Dove Dr. City: Matthews State: NC ZIP: 28104

Phone: (704) 847-4084 Fax: ( ) _____

Primary Contact: Dawn Richards Secondary Contact: _____

Title: Account Executive Title: _____

E-mail Address: dawn.richards@eyemed.com E-mail Address: _____

Commission checks payable to: ☐ Firm ☐ Agent

Florida Licensed Agent's Name (print): Dawn Richards

SS#: _____ Florida License I.D. No.: NPR 2484652

Florida Licensed Agent's Signature: ➤ _____

WRITING AGENT'S CERTIFYING STATEMENT

I certify that I have accurately recorded on this application the information supplied by the applicant, if such information has been provided directly to me for recording purposes, and I am properly licensed in the state in which the Group is domiciled.

Firm Name (print): _____ Tax ID No.: _____

Address: _____ City: _____ State: ____ ZIP: _____

Phone: (_____) _____ Fax: (_____) _____

Primary Contact: _____ Secondary Contact: _____

Title: _____ Title: _____

E-mail Address: _____ E-mail Address: _____

Commission checks payable to: ☐ Firm ☐ General Agent

Florida Licensed Agent's Name (print): _____

SS#: _____ Florida License I.D. No.: _____

Florida Licensed Agent's Signature: ➤ _____

The Group hereby makes application to Fidelity Security Life Insurance Company for Vision Care Benefits. The Group agrees to maintain and furnish any records necessary to administer this plan and to forward premiums monthly.

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Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Dated at: Miami-Dade County this 16 day of September, 20 20

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VI. COMPANY DISPLAY NAME (Your Group name as it should appear to your employees)

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Firm Name (print): _____ Tax ID No.: _____

Address: 4017 Mourning Dove Dr City: Matthews State: NC ZIP: 28104

Phone: (704) 847-4084 Fax: ( ) _____

Primary Contact: Dawn Richards Secondary Contact: _____

Title: Account Executive Title: _____

E-mail Address: dawn.richards@eyemed.com E-mail Address: _____

Commission checks payable to: ☐ Firm ☐ Agent N/A

Florida Licensed Agent's Name (print): Dawn Richards

SS#: _____ Florida License I.D. No.: NPR 2484652

Florida Licensed Agent's Signature: ➤ _____

Miami-Dade County Public Schools - FL

Proposed Benefits

EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company

Option 1 BAFO

Exam and Materials

Insight Network

Fully Insured

Employee Paid

Funded Benefits

Frequency

Examination
Once every 12 months

Lenses (in lieu of contact lenses)
Once every 12 months ✓

Contacts (in lieu of lenses)
Once every 12 months ✓

Frame
Once every 12 months ✓

Vision Care Services	Member Cost In-Network	Out of Network Member Reimbursement up to:
Exam *With Dilation as Necessary*	$10 Copay	$40
Frames *Any available frame at provider location*	$0 Copay; $180 allowance, 20% off balance over $180	$45
Contact Lenses *(Contact Lens allowance includes materials only)*		
Conventional	$0 Copay, $150 allowance, 15% off balance over $150	$105
Disposable	$0 Copay, $150 allowance, plus balance over $150	$105
Medically Necessary	$0 Copay, Paid-In-Full	$210
Standard Plastic Lenses		
Single Vision	$10 Copay	$40
Bifocal	$10 Copay	$60
Trifocal	$10 Copay	$80
Lenticular	$10 Copay	$80
Standard Progressive	$75 Copay	$55
Premium Progressive Tier 1	$105 Copay	$55
Premium Progressive Tier 2	$115 Copay	$55
Premium Progressive Tier 3	$130 Copay	$55
Premium Progressive Tier 4	$200 Copay	$55
Covered Lens Options		
Standard Anti-Reflective	$45 Copay	$5
Premium Anti-Reflective Tier 1	$57 Copay	$5
Premium Anti-Reflective Tier 2	$68 Copay	$5
Premium Anti-Reflective Tier 3	$85 Copay	$5
Standard Polycarbonate - under age 19	$0 Copay	$20
Standard Polycarbonate – 19 and over	$30 Copay	$5
Standard Plastic Scratch Coating	$0 Copay	$8
UV Treatment	$12 Copay	$5
Tint (Solid & Gradient)	$12 Copay	$5

Monthly Rate	
Subscriber	$5.60
Subscriber + Family	$13.99

OK BAS/MW 9/26/19

All plans are based on a 60-month contract term and 60-month rate guarantee
Monthly Rate is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies

EyeMed Vision Care reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, visit http://www.discovereyemed.com

Plan Details
Quote for group situsedin the State of FL and will be valid until the 1/1/2020 implementation date. Date Quoted 4/3/2019. Benefit allowances provide no remaining balance for future use within the same benefit frequency. Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group. Percentage discounts are not part of the insurance benefit. Insured benefits are underwritten by Fidelity Security Life Insurance Company. Policy Number VC-19; Policy Form No. M-9083

Plan Exclusions
No benefits will be paid for services or materials connected with or changes arising from:
-orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
-medical and/or surgical treatment of the eye, eyes or supporting structures;
-any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear;
-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;
-plano (non-prescription) lenses;
-non-prescription sunglasses;
-two pair of glasses in lieu of bifocals;
-services or materials provided by any other group benefit plan providing vision care;
-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 services rendered to the Insured Person are within 31 days from the date of such order; or
-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.

By signing below, the Group agrees to receive all documents and correspondence electronically and that the Group can access the internet or the email address provided. The Group understands that the Group may revoke this authorization or request specific paper documents without revoking this authorization by contacting EyeMed by mail, email, or telephone. If Miami-Dade County Public Schools - FL has chosen this benefit design, attach this document to the group application and sign here:

Miami-Dade County Public Schools - FL
Saving our members some extra green

We're committed to keeping money in our members' pockets.
That's why we offer our members additional discounts above the proposed plan benefits.

$avings for Members

40% off
additional pairs of glasses and a 15% discount on conventional lenses once funded benefit is used – an industry exclusive

20% off
any item not covered by the plan, including non-prescription sunglasses

Lasik
Lasik or PRK from US Laser Network
15% off retail price or 5% off promotional price

Hearing Care
Amplifon Hearing Health Care Network
40% off hearing exams and a low price guarantee on discounted hearing aids

Additional Discounts

Vision Care Services	Member Cost In-Network
Discounted Exam Services	
Retinal Imaging Benefit	Up to $39
Contact Lens Fit and Follow-up	
(Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)	
Standard Contact Lens Fit & Follow-Up:	$40
Premium Contact Lens Fit & Follow-Up:	10% off retail price
Discounted Lens Options	
Photochromic (Plastic)	$75
Other Add-on Services and Materials	20% off Retail Price

9/28/15

Discount Details
Member receives a 20% discount on items not covered by the plan at EyeMed In-Network locations. Discount does not apply to EyeMed Provider's professional services, or contact lenses.
Plan discounts cannot be combined with any other discounts or promotional offers.
In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate.
Discounts on vision materials may not be applicable to certain manufacturers' products
EyeMed Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.
Service and amounts listed above are subject to change at any time

FIDELITY SECURITY LIFE INSURANCE COMPANY

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

AMENDATORY RIDER REGARDING REPLACEMENT COVERAGE

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

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

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

Each such person will be insured under the Policy if:

(a) the person was insured under the prior plan, including coverage under the prior plan's extension of benefits provision, on the date the Policyholder's coverage with the prior plan ended; and
(b) the person is in a class of persons eligible for coverage under the Policy.

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

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

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

FIDELITY SECURITY LIFE INSURANCE COMPANY

Richard B. Jones — President

Bradford R. Jones — Secretary

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AMENDMENT RIDER

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

Any provision of the Policy/Certificate that provides coverage for a Dependent child up to a certain age is amended to cover such child to age 26, regardless of financial dependency, residency, student status, or marital status.

Coverage for an unmarried Dependent child will continue until the end of the calendar year in which the child attains age 30, provided the child:

a. does not have a dependent of his or her own;
b. is a resident of Florida or a full-time or part-time student; and
c. is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

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

FIDELITY SECURITY LIFE INSURANCE COMPANY

President Secretary

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NOTICE OF ADMINISTRATOR'S CAPACITY

PLEASE READ: This notice advises insured persons of the identity and relationship among the administrator, the policyholder and the insurer:

1. Fidelity Security Life Insurance Company (FSL) has, by agreement, arranged for First American Administrators, Inc. to provide administrative services for your insurance plan. As administrator, First American Administrators, Inc., is authorized to process claim payments, and perform other services, according to the terms of its agreement with the insurance company. First American Administrators, Inc. is not the insurance company or the policyholder.

2. The policyholder is the entity to whom the insurance policy has been issued. The policyholder is identified on either the face page or schedule page of the policy or certificate.

3. Fidelity Security Life Insurance Company is liable for the funds to pay your insurance claims.

As First American Administrators, Inc. is authorized to process claims for the insurance company, they will do so promptly. In the event there are delays in claims processing, you will have no greater rights to interest or other remedies against First American Administrators, Inc. than would otherwise be afforded to you by law.