



# 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:** Town of Wayland

**STATE OF ISSUE:** Massachusetts

**POLICY EFFECTIVE DATE:** July 1, 2020

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

Fidelity Security Life Insurance Company agrees to pay the benefits provided by the Policy in accordance with its terms and conditions.

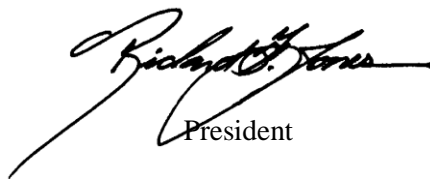
The Policy is issued in consideration of the Policyholder's application (a copy of which is attached) and receipt by the Company of the premiums.

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

The Policy may be modified by mutual agreement between the Policyholder and the Company.

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



\*This plan is not intended to provide comprehensive health coverage. This health plan, alone, **does not meet Minimum Creditable Coverage standards** and **will not satisfy** the individual mandate that you have health insurance. Please see page 2 for additional information.

**GROUP VISION INSURANCE POLICY**  
**THIS IS A LIMITED BENEFIT POLICY**  
*Please read the Policy carefully.*

## PREMIUMS

Premiums are payable in advance by the Policyholder. The first premium is due on the effective date of the Policy. Subsequent premiums are due on the first day of each calendar month thereafter.

The required premium due on each premium due date is the sum of the premiums for all Insureds and their Dependents covered under the Policy. The premiums due will be determined by applying the premium rates then in effect for each plan provided by the Policy to the number of Insured Persons. All premiums are payable to the Company at the Company's home office or to any of the Company's authorized agents.

The premium due may be adjusted due to a change in insurance as requested by the Policyholder or as required by the Company as follows:

1. if an amount of insurance is added or increased during a calendar month, premiums will be increased as of the date the change becomes effective, unless otherwise mutually agreed;
2. if an amount of insurance is deleted or decreased during a calendar month, premium will cease or be decreased at the end of the calendar month in which the deletion or decrease occurred, unless otherwise mutually agreed;
3. if the Policyholder's contribution percentage is changed, premium will be adjusted at the end of the calendar month in which the change occurred, unless otherwise mutually agreed; or
4. if the number of eligible employees increases or decreases by more than 10% premium will be adjusted at the end of the calendar month in which the increase or decrease occurred, unless otherwise mutually agreed.

If premiums are due the Company, or premium refunds are due the Policyholder as a result of clerical error or delay in the reporting of dates and/or data to the Company, all premiums or refunds will be calculated at the current rate of premium payment and are limited to a maximum period of three months.

**Premium Rate Change.** The Company has the right to change the premium rate on any premium due date on or after the fourth Policy Anniversary Date. The Company will provide written notice at least 31 days before the date of change.

**Grace Period.** A grace period of 31 days will be allowed to the Policyholder for the payment of each premium due after the first premium. The Policy will remain in force during the grace period. If the required premium is not paid by the end of the 31-day period, the Policy will terminate. The Policyholder will be required to pay premium for the grace period.

**Return of Premium.** The Company reserves the right to rescind the coverage for one or all Insureds due to misrepresentation or fraud on the Policyholder's application or an Insured's enrollment form, if such misrepresentation materially affected the acceptance of the risk.

If, on the date coverage is rescinded, no claims have been paid under the Policy, the Company will return all premiums paid for such coverage to the Policyholder.

If, on the date coverage is rescinded, claims have been paid under the Policy, the Company reserves the right to deduct an amount equal to the amount of such claims paid from the premiums to be returned to the Policyholder.

**Massachusetts Health Care Reform Law.** As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website ([www.mahealthconnector.org](http://www.mahealthconnector.org)).

This plan is not intended to provide comprehensive health care coverage and **does not meet Minimum Creditable Coverage standards**, even if it does include services that are not available in the Insured's other health plans.

**If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at [www.mass.gov/doi](http://www.mass.gov/doi).**

## **TERMINATION OF POLICY**

The Policyholder or the Company may terminate or cancel the Policy on the earliest of the following:

1. on any date on or after the fourth Policy Anniversary Date. Written notice must be provided to the other party at least 31 days prior to termination;
2. the date the number or percentage of persons covered under the Policy does not meet the minimum participation requirements of 10;
3. the date the required premium has not been paid, except as provided in the Grace Period provision. The Company will provide written notification of the termination to the Insured; or
4. the date 100% of the eligible employees are not covered when a contribution is not required by the employee.

The Policyholder is responsible for notifying the Insured of the termination of the Policy.

## **CERTIFICATES**

The Company will furnish a Certificate to the Policyholder which will set forth the essential features of the insurance coverage.

## **ADDITIONAL INSUREDS**

Insured Persons may be added at any time if they meet the eligibility requirements stated in the Policyholder's application, complete an enrollment form, if required, and pay any required premium.

## **INCORPORATION PROVISION**

The provisions of the attached Certificate and all Rider(s) issued to amend the Policy after the Policy Effective Date are made a part of the Policy.



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**POLICYHOLDER:** Town of Wayland

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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, the Insured's effective date, the name of the Network and toll-free customer service number. 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



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**There are no pre-existing condition limitations or exclusions under this plan.**

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

**THIS PLAN IS NOT MEDICARE SUPPLEMENT. If you are eligible for Medicare, please review "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare," available from the Company.**

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

1. the Insured's lawful spouse;
2. each child from birth to age 26 or for two years after the end of the calendar year in which such persons last qualified as a Dependent, whichever occurs first; or
3. each child who is mentally or physically incapable of earning his or her own living, if due proof of the incapacity is received by the Company within 31 days of the date upon which the coverage would otherwise be terminated.

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.

**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. The Insight Network is available in all counties in Massachusetts except Nantucket.

**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:
  - a. the Insured has given the Company the Insured’s enrollment form (if required) on, prior to, or within 30 days of the date the Insured became eligible; and
  - b. the Insured has agreed to pay the required premium contributions; and
3. if the Insured fails to meet the requirements of 2 a) and 2 b) 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. If an enrollment form is required, the Insured must provide such form and 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. 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.

## CHOICE OF PROVIDERS

Insured Persons may receive vision care services and Vision Materials from an In-Network Provider or an Out-of-Network Provider. Out-of-Network Provider services and Vision Materials may be secured from an optometrist, ophthalmologist and/or dispensing optician. The Company will reimburse the Insured as shown in the Schedule of Benefits.

If the Insured hasn't requested one sooner, the Insured will be given a PPO Directory when enrolled. The Insured may request a PPO Directory at any time or to locate an In-Network Provider in the Insured's area, the Insured may call the PPO toll-free automated voice response system number located on the back of the Insured's identification card. This service is available 24 hours per day, 7 days per week. The Insured may call and enter the Insured's zip code. The computer will give the Insured a list of the 10 closest In-Network Providers to that zip code including the In-Network Provider's name, telephone number, and the services available at each location.

The Insured may also obtain a PPO Directory via the PPO's website at: [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com). The procedures are the same as the automated voice response system.

In addition, the PPO has service staff available, Monday through Saturday from 8:00 a.m. – 11:00 p.m. and Sunday 11:00 a.m. – 8:00 p.m. EST to assist callers with their selection of In-Network Providers. The toll-free number is 1-877-226-1115.

A physician profile may be available from the Board of Registration in Medicine for Providers licensed to practice in Massachusetts.



## **PROCEDURES FOR USING IN-NETWORK PROVIDER BENEFITS**

The Insured should have the Insured's identification card available when scheduling an appointment and visiting an In-Network Provider. For information on In-Network Providers in the Insured's area, call the PPO's toll-free number listed in the Insured's identification card.

The Insured presents the Insured's identification card at the time the Insured receives services from an In-Network Provider, pays the Co-payment, if any, and any other charges not covered at the time of the service. No paperwork is required.

If the Insured selects an Out-of-Network Provider, the Insured does not receive PPO preferred pricing. The Insured will make full payment to the Out-of-Network Provider at the time of service and submit a claim for reimbursement.

If the Insured should need emergency care and cannot reach an In-Network Provider, payment for the care related to the emergency will be made at the In-Network Provider level. The Insured also has the option of calling the local pre-hospital emergency medical service system whenever confronted with an emergency care for a vision condition which in the judgment of a prudent layperson would require pre-hospital emergency services. Emergency care benefits are limited to the specific vision care services outlined in the Schedule of Benefits.

## **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 Insured's 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. The Company will provide written notification of the termination to the Insured, by mail, to the last known home address, a letter that includes the following information: a) the date the Policy was terminated; b) that the termination was for nonpayment of premiums; and c) that the termination of the insurance of any Insured Person will be without prejudice to any covered service incurred before the date of termination. The Company will honor claims, to the extent covered under the Policy, for any benefit received by the Insured or the Insured's Dependent prior to the notification date;
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. The Company will provide written notification of the termination to the Insured, by mail, to the last known home address, a letter that includes the following information: a) the date the Policy was terminated; b) that the termination was for nonpayment of premiums; and c) that the termination of the insurance of any Insured Person will be without prejudice to any covered service incurred before the date of termination.

**Extension of Benefits.** If the Insured terminates employment with the Policyholder, coverage under the Policy will continue for 31 days from the date the Insured terminated employment. If the Insured's coverage terminates due to a plant closing or partial closing, coverage under the Policy will be continued for 90 days after the date of the plant closing or partial closing. This Extension of Benefits provision will not apply if the Insured is eligible for similar benefits under another policy.

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 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, 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 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.

**Massachusetts Health Care Reform Law.** As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website ([www.mahealthconnector.org](http://www.mahealthconnector.org)).

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## **GRIEVANCE PROCEDURE**

**Note: References to Insured Person includes the Insured Person's authorized representative.**

**Form and Manner of Request.** Grievances may be made by telephone, in person, by mail, or by electronic means. Oral grievances made by the Insured Person will be reduced to writing by PPO. A copy will be sent to the Insured Person within 48 hours of receipt, except where this time limit is waived or extended by mutual written agreement of the Insured Person and PPO.

Any grievance that required the review of medical records will include the signature of the Insured Person on a form provided promptly by PPO. This will authorize the release of medical and treatment information relevant to the grievance to PPO when necessary, in a manner consistent with state and federal law. The Insured Person will have access to any medical information and records relevant to the grievance relating to the Insured Person which is in PPO's possession and under its control. PPO will request the authorization from the Insured Person when necessary for requests reduced to writing by PPO and for any written requests lacking the authorization.

**Acknowledgment of Grievances.** A written acknowledgment of the receipt of a grievance will be sent to the Insured Person within 15 business days of receipt except where an oral grievance has been reduced to writing by PPO pursuant to the above section, or this time period is waived or extended by mutual written agreement of the Insured Person and PPO.

**Time Requirements for Resolution of Grievances.** PPO will provide the Insured Person with a written resolution of a grievance within 30 business days of receipt of the oral or written grievance.

When a grievance requires the review of medical records, the 30 business day period will not begin to run until the Insured Person submits a signed authorization for release of medical records and treatment information. In the event that the signed authorization is not provided within 30 business days of the receipt of the grievance, PPO may, in its discretion, issue a resolution of the grievance without review of some or all of the medical records.

The time limits may be waived or extended by mutual written agreement of the Insured Person and PPO.

**Review of Grievances.** Grievances will be reviewed by an individual or individuals who are knowledgeable about the matters at issue in the grievance.

Grievances of adverse determinations are reviewed with the participation of an individual or individuals who did not participate in any of PPO's prior decisions on the grievance. In at least one level of review of grievances of adverse determinations, these individuals will be actively practicing health care professionals in the same or similar specialty who typically correct the vision problem, perform the exam or provide the materials that is the subject of the grievance.

**Form of Written Resolution.** A written resolution will include identification of the specific information considered and an explanation of the basis for the decision.

In the case of a grievance that involves an adverse determination the written resolution will include a substantive clinical justification therefor that is consistent with generally accepted principles of professional medical practice, and will at a minimum:

1. identify the specific information upon which the adverse determination was based;
2. discuss the Insured Person's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;
3. specify alternative treatment options covered by the Company, if any; and
4. reference and include applicable clinical practice guidelines and review criteria.

**Opportunity for Reconsideration.** PPO may offer to the Insured Person, the opportunity for reconsideration of PPO's final adverse determination where relevant medical information:

1. was received too late to review within the 30 business day time limit; or
2. was not received but is expected to become available within a reasonable time period following the written resolution.

When an Insured Person chooses to request reconsideration, PPO must agree in writing to a new time period for review, but in no event greater than 30 business days from the agreement to reconsider the grievance. The time period for requesting external review will begin to run on the date of the resolution of the reconsidered grievance.

**Expedited Review of Grievances.** PPO will provide for an expedited resolution concerning coverage or provision or immediate and urgently needed services, which will include, but not be limited to provisions for the automatic reversal of decisions denying coverage for services pending the outcome of the internal grievance process, within 48 hours of receipt of certification by the physician that, in his or her opinion:

1. the service at issue in a grievance is medically necessary;
2. a denial of coverage for such services would create a substantial risk of serious harm to the patient; and
3. such risk of serious harm is so immediate that the provision of such services should not await the outcome of the normal grievance process.

**Failure of PPO to Meet Time Limits.** A grievance not properly acted on by PPO within the time limits required by Massachusetts' laws and regulations will be deemed resolved in favor of the Insured Person.

Time limits include any extensions made by mutual written agreement of the Insured Person and PPO.

## QUALITY ASSURANCE

The delivery of quality vision care is of prime concern to PPO and to the Policyholders and the Insured Persons which the PPO serves. It is PPO's credo that Insured Persons receive high quality vision care services, spectacles and contact lenses, where these products are available through their respective plans. Ultimately, it is the perceived value and expectations of each of the PPO's Insured Persons or patients that will decide the quality of care delivered. Quality care assures Insured Person satisfaction.

The PPO Quality Assurance Program includes:

- Patient surveys with patient input on vision care services provided.
- Patient grievance procedures with formal and timely grievance management.
- Provider profiling programs to review, evaluate, and identify Provider achievements or deficiencies and to initiate appropriate remediation.
- Oversight Committees consisting of Grievance, Peer Review and Quality Assurance Committees whose functions are to review and make recommendations for remediation or termination of a Provider.
- Product quality assurance standards to insure the delivery of quality ophthalmic products.

Please call 1-877-226-1115 to determine the status or outcome of a utilization review.

## 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:

<b><u>Benefit</u></b>	<b><u>In-Network</u></b>	<b><u>Out-of-Network</u></b>	<b><u>Benefit Frequency</u></b>
<b>VISION EXAMINATION</b>			
<b>Comprehensive Eye Examination</b>	\$10 Co-payment	up to \$50	12 months
<b>VISION MATERIALS</b>			
<b>Standard Plastic Lenses</b>			12 months
Single Vision	\$25 Co-payment	up to \$42	
Bifocal	\$25 Co-payment	up to \$78	
Trifocal	\$25 Co-payment	up to \$130	
Lenticular	\$25 Co-payment	up to \$130	
<b>Frames</b>	\$0 Co-payment, up to \$130 retail allowance	up to \$104	12 months
<b>Contact Lenses (<i>only one option available per Benefit Frequency</i>)</b>			12 months
Conventional	\$0 Co-payment, up to \$130 allowance	up to \$104	
Disposable	\$0 Co-payment, up to \$130 allowance	up to \$104	
Medically Necessary	Paid in full	up to \$210	
<b>Lens Options</b>			12 months
Standard Polycarbonate (For covered Dependent children under 26* years of age.)	\$0 Co-payment	up to \$32	
Standard Progressive Lenses	\$25 Co-payment	up to \$140	
Premium Progressive Lenses			
Tier I	\$55 Co-payment	up to \$196	
Tier II	\$65 Co-payment	up to \$196	
Tier III	\$80 Co-payment	up to \$196	
Tier IV	\$200 Co-payment	up to \$196	
Standard Anti-Reflective Coating	\$45 Co-payment	up to \$36	
Premium Anti-Reflective Coating			
Tier I	\$57 Co-payment	up to \$52	
Tier II	\$68 Co-payment	up to \$52	
Tier III	\$85 Co-payment	up to \$52	

\*Or for two years after the end of the calendar year in which such persons last qualified as a Dependent, whichever occurs first.



# FIDELITY SECURITY LIFE INSURANCE COMPANY

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

## AMENDMENT RIDER For Massachusetts Residents Only

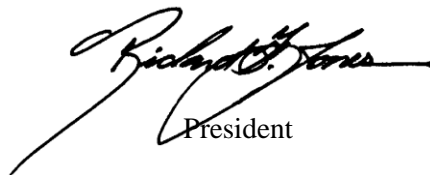
By attachment of this Rider, the Policy/Certificate is amended by the following:

**Voluntary and Involuntary Disenrollment.** Under Massachusetts law, the Company is required to report the voluntary and involuntary disenrollment rate amount among the Company's Insureds. The rates are:

Voluntary disenrollment rate: 5% of Insureds  
Involuntary disenrollment rate: 0% of Insureds

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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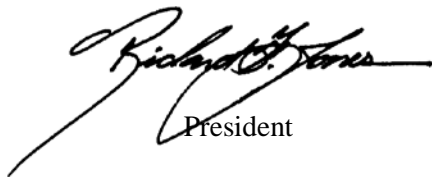
## AMENDMENT RIDER

By attachment of this Rider, the third paragraph of the **PREMIUMS** section in the Policy is amended to add the following:

5. if a government action, including fees, taxes and assessments, or change in law or regulation materially affects the Company's risk, premium may be adjusted and will be effective upon written notification from the Company at least 31 days before the date of change.

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

FIDELITY SECURITY LIFE INSURANCE COMPANY

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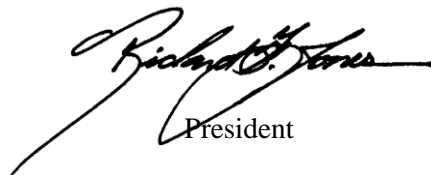
By attachment of this Rider, the Policy/Certificate is amended by the following:

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.

Dependent will include a dependent child of a Dependent child.

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

# FACTS

## WHAT DOES Fidelity Security Life Insurance Company, Fidelity Security Life Insurance Company of New York (NY Only) and Affiliates DO WITH YOUR PERSONAL INFORMATION?

### Why?

Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.

### What?

The types of personal information we collect and share depend on the product or service you have with us. This information can include:

- Social Security number and transaction history
- medical information and insurance claim information
- assets and checking account information

When you are no longer our customer, we continue to share your information as described in this notice.

### How?

All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons Fidelity Security Life Insurance Company and Affiliates choose to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Fidelity Security Life share?	Can you limit this sharing?
<b>For our everyday business purposes –</b> such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
<b>For our marketing purposes –</b> to offer our products and services to you	Yes	No
<b>For joint marketing with other financial companies</b>	Yes	No
<b>For our affiliates' everyday business purposes –</b> information about your transactions and experiences	Yes	No
<b>For our affiliates' everyday business purposes –</b> information about your creditworthiness	No	We don't share
<b>For our affiliates to market to you</b>	No	We don't share
<b>For nonaffiliates to market to you</b>	No	We don't share

### Questions?

Call 800-648-8624 or go to [www.fslins.com](http://www.fslins.com) or [www.ftj.com](http://www.ftj.com)

Who we are	
Who is providing this notice?	Fidelity Security Life Insurance Company and Affiliates including our Administrative, Insurance and Financial Service Providers.
What we do	
How does Fidelity Security Life Insurance Company and Affiliates protect my personal information?	<p>To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings.</p> <p>These physical, electronic and procedural safeguards were created to protect your information. We also limit employee access as appropriate.</p>
How does Fidelity Security Life Insurance Company and Affiliates collect my personal information?	<p>We collect your personal information, for example, when you</p> <ul style="list-style-type: none"> <li>■ apply for insurance or pay insurance premiums</li> <li>■ file an insurance claim or give us your contact information</li> <li>■ show your driver's license</li> </ul> <p>We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.</p>
Why can't I limit all sharing?	<p>Federal law gives you the right to limit only</p> <ul style="list-style-type: none"> <li>■ sharing for affiliates' everyday business purposes – information about your creditworthiness</li> <li>■ affiliates from using your information to market to you</li> <li>■ sharing for nonaffiliates to market to you</li> </ul> <p>State laws and individual companies may give you additional rights to limit sharing.</p>
Definitions	
Affiliates	<p>Companies related by common ownership or control. They can be financial and nonfinancial companies.</p> <ul style="list-style-type: none"> <li>■ <i>Our affiliates include Fidelity Security Life Insurance Company of New York, Forrest T. Jones &amp; Company, Inc., Forrest T. Jones Consulting Company and National Pension &amp; Group Consultants, Inc.</i></li> </ul>
Nonaffiliates	<p>Companies not related by common ownership or control. They can be financial and nonfinancial companies.</p> <ul style="list-style-type: none"> <li>■ <i>Fidelity Security Life Insurance Company does not share with nonaffiliates so they can market to you.</i></li> </ul>
Joint marketing	<p>A formal agreement between nonaffiliated financial companies that together market financial products or services to you.</p> <ul style="list-style-type: none"> <li>■ <i>Our joint marketing partners include insurance agencies, broker dealers and investment advisor firms.</i></li> </ul>
Other important information	

# Application for Vision Care Benefits

Underwritten by Fidelity Security Life Insurance Company  
Kansas City, Missouri



## I. GROUP INFORMATION

Group Name: Town of Wayland Tax ID#: 04-6001341

DBA Name (If other than above): \_\_\_\_\_

Business Address: 41 Cochituate Road

City: Wayland County: \_\_\_\_\_ State: MA ZIP: 01778

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Primary Contact: Donna M. Lemoyne Title: Benefits Manager

Phone Number: (\_\_\_\_\_) 508-358-3612 Fax Number: (\_\_\_\_\_) \_\_\_\_\_

E-mail Address: dlemoyne@wayland.ma.us

Type of Business: ☐ Proprietorship ☐ Corporation ☒ Other (Specify): Municipality

### 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) \_\_\_\_\_

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. \_\_\_\_\_

Locations within the Town

Billing Contact Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

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: \_\_\_\_\_

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

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: 703 Number Applying: \_\_\_\_\_

Number of Dependents: \_\_\_\_\_ Number of Retirees: \_\_\_\_\_

Are Domestic Partners covered under this Plan\*? ☐ Yes ☒ No Same Sex\*? ☐ Yes ☐ No Opposite Sex\*? ☐ Yes ☐ NoDependent Children Covered to Age\*: ☒ 26\*\* ☐ Other \_\_\_\_\_Dependent Children Covered if Full-Time Student\*? ☐ Yes ☒ NoIf "Yes," Dependent Full-Time Students Covered to Age\*: ☐ 27 ☐ Other \_\_\_\_\_*\*Unless state law has different requirements.**\*\*Or for two years after the end of the calendar year in which such person last qualified as a Dependent, whichever occurs first.*

Eligibility Reporting Contact (produces the eligibility file): \_\_\_\_\_

Address (if different from Group): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

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

Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Days/Hours of Availability: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

**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: \_\_\_\_\_

**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 July, 2020, 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, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.**

Dated at: \_\_\_\_\_ this 5th day of February, 2020

Signed for the Group: ➤  Title: Town Administrator

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

Company Name Town of Wayland

(Maximum of 30 characters, including punctuation and spacing.)

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

#### WRITING BROKER'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): LifePlus Insurance Agency, Inc. Tax ID No.: 201072662

Address: 475 School St, Suite 5 City: Marshfield State: MA ZIP: 02050

Phone: (\_\_\_\_\_) 781-837-9222 Fax: (\_\_\_\_\_) \_\_\_\_\_

Primary Contact: Peter A. Cook, Jr Secondary Contact: \_\_\_\_\_

Title: \_\_\_\_\_ Title: \_\_\_\_\_

E-mail Address: Peter@lpins.com E-mail Address: \_\_\_\_\_

Commission checks payable to: ☒ Firm ☐ Broker

Broker's Name (print): Peter A. Cook, Jr SS#: \_\_\_\_\_

Broker's Signature: ➤  \_\_\_\_\_



## Proposed Benefits

EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company

Option EE Paid

Exam & Materials

Insight Network

Fully Insured

Employee Paid

Funded Benefits

## Frequency

### Examination

Once every plan year

### Lenses (in lieu of contacts)

Once every plan year

### Contacts (in lieu of lenses)

Once every plan year

### Frame

Once every plan year

Vision Care Services	Member Cost In-Network	Out of Network Member Reimbursement
<b>Exam</b> <i>With Dilation as Necessary</i>	\$10 copay	Up to \$50
<b>Frames</b> <i>Any available frame at provider location</i>	\$0 copay; 20% off balance over \$130 allowance	Up to \$104
<b>Contact Lenses</b> <i>(Contact Lens allowance includes materials only)</i>		
Conventional	\$0 copay; 15% off balance over \$130 allowance	Up to \$104
Disposable	\$0 copay; plus balance over \$130 allowance	Up to \$104
Medically Necessary	\$0 copay; Paid-In-Full	Up to \$210
<b>Standard Plastic Lenses</b>		
Single	\$25 copay	Up to \$42
Bifocal	\$25 copay	Up to \$78
Trifocal	\$25 copay	Up to \$130
Lenticular	\$25 copay	Up to \$130
Standard Progressive	\$25 copay	Up to \$140
Premium Progressive Tier 1	\$55 copay	Up to \$196
Premium Progressive Tier 2	\$65 copay	Up to \$196
Premium Progressive Tier 3	\$80 copay	Up to \$196
Premium Progressive Tier 4	\$200 copay	Up to \$196
<b>Covered Lens Options</b>		
Anti Reflective Coating - Standard	\$45 copay	Up to \$36
Anti Reflective Coating - Premium Tier 1	\$57 copay	Up to \$52
Anti Reflective Coating - Premium Tier 2	\$68 copay	Up to \$52
Anti Reflective Coating - Premium Tier 3	\$85 copay	Up to \$52
Polycarbonate - Standard - under 26	\$0 copay	Up to \$32
<b>Monthly Rates</b>		
Subscriber	\$7.34	
Subscriber + Spouse	\$13.96	
Subscriber + Child(ren)	\$14.69	
Subscriber + Family	\$21.60	

All plans are based on a 48-month contract term and 48-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.

### Plan Details

Quote for group situated in the State of MA and will be valid until the 07/01/2020 implementation date. Date Quoted 01/29/2020. 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. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-19, form number 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. 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.

DocuSigned by:  
*Louise Miller*

2/5/2020 | 3:36 PM EST

Signature  
P201603 TC - 10

Date

Q-00012052 – QL-0000020259