



FIDELITY SECURITY LIFE INSURANCE COMPANY

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

POLICY NUMBER: VC-19

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

POLICY 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 in the following pages, subject to and in accordance with the terms and conditions of the Policy.

The Policy may be amended, changed, cancelled or discontinued without the consent of any Insured Person.

The Certificate explains the plan of insurance. An individual identification card will be issued to the Insured containing the group name and Insured's effective date. The Certificate replaces all certificates previously issued to the Insured under the Policy.

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

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

FIDELITY SECURITY LIFE INSURANCE COMPANY


Richard C. Jones
President


Bradford R. Jones
Secretary

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

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DEFINITIONS

Allowance means the benefit amount shown in the Schedule of Benefits that is the maximum amount payable by the Company, subject to the expenses incurred. The Insured Person is responsible for any amounts due above the Allowance. The Allowance cannot be used to satisfy a Copayment.

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

The Benefit Frequency begins on January 1. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency, which is December 31 of the same year.

Copayment or **Copay** means the designated amount, if any, shown in the Schedule of Benefits each Insured Person must pay to a Provider before benefits are payable for a covered Vision Examination or Vision Materials per Benefit Frequency.

Comprehensive Eye Examination means a general evaluation of the complete visual system. The examination includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields, basic sensorimotor examination and Refraction. It always includes initiation of diagnostic and treatment programs. It may include biomicroscopy, examination with cycloplegia or mydriasis and tonometry, as determined by the Provider. These services may be performed at different sessions but comprise only one Comprehensive Eye Examination.

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

Formulary means a list, provided by the Company, of Vision Materials by tier, that are covered under the Policy as shown in the Schedule of Benefits.

Insured means an employee of a K12 school district, educational service district or charter school within Washington, as defined in RCW 41.05.011(6)(b), who meets the eligibility requirements as shown in the Eligibility and Enrollment section, and whose coverage under the Policy is in force and has not ended.

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

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

Medically Necessary Contact Lenses means that adequate functional vision correction cannot be achieved with spectacles but can be achieved with contact lenses. Conditions that qualify for Medically Necessary Contact Lenses are:

1. Anisometropia of 3D in meridian powers;
2. High Ametropia exceeding -12D or +12D in meridian powers;
3. Keratoconus when vision is not correctable to 20/25 in either eye or both eyes using standard spectacle lenses; or
4. vision impairments, other than Keratoconus, when vision can be improved by two lines on the visual acuity chart when compared to best corrected standard spectacle lenses.

Out-of-Network Provider means a Provider, located within the PPO Service Area, but is not an In-Network Provider.

Policy means the Policy issued to the Policyholder providing "vision coverage."

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

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

Preferred Provider Agreement means the agreement between the PPO and a Provider who agrees to become an In-Network Provider. The Preferred Provider Agreement contains the rates and reimbursement methods for services and supplies furnished by an In-Network Provider.

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

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

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

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

Refraction means a test performed by a Provider to determine the glasses or contact lens prescription due to a refractive error (for example, nearsightedness, farsightedness, astigmatism or presbyopia).

SEBB Organization means a K12 school district, educational service district or charter school within Washington.

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

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

ELIGIBILITY AND ENROLLMENT

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

Eligibility

The school employee’s SEBB Organization will inform the school employee whether or not they are eligible for benefits upon employment and whenever their eligibility status changes. The communication will include information about the school employee’s right to appeal eligibility and enrollment decisions. Information about a school employee’s right to an appeal can be found on page 11 of this certificate of coverage. For information on how to enroll see the “Enrollment” section.

To enroll an eligible dependent the subscriber must follow the procedural requirements described in the “Enrollment” section. The SEBB Program or SEBB Organization verifies the eligibility of all dependents and requires the subscriber to provide documents that prove a dependent’s eligibility.

The following are eligible as dependents:

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

Enrollment

A subscriber or subscriber's dependent is eligible to enroll in only one SEBB vision plan even if eligibility criteria is met under two or more subscribers. For example, a dependent child who is eligible for enrollment under two parents working for the same or different SEBB Organizations may be enrolled as a dependent under one parent, but not more than one.

A school employee is required to enroll in a vision plan under their SEBB Organization. A school employee must submit a *School Employee Enrollment/Change* form to their SEBB Organization when they become newly eligible for SEBB benefits. The form must be received no later than 31 days after the date the school employee becomes eligible. If the school employee does not return the School Employee Enrollment/Change form by the deadline, the school employee will be enrolled in Metropolitan Life Vision Plan and any eligible dependents cannot be enrolled until the SEBB Program's next annual open enrollment or when an event occurs that creates a special open enrollment.

How to enroll

A school employee must submit a *School Employee Enrollment/Change* form to their SEBB Organization when they become newly eligible for SEBB benefits.

To enroll an eligible dependent, the school employee must include the dependent's information on the form and provide the required document(s) as proof of the dependent's eligibility. A dependent must be enrolled in the same health plan coverage as the subscriber. The dependent will not be enrolled if their eligibility is not verified.

A subscriber or their dependents may also enroll during the SEBB Program's annual open enrollment (see "Annual open enrollment" on page 6) or during a special open enrollment (see "Special open enrollment" beginning on page 7). The subscriber must provide proof of the event that created the special open enrollment.

A school employee must notify their SEBB Organization to remove dependents within 60 days from the last day of the month when the dependent no longer meets the eligibility criteria described under "Eligible Dependents" on page 4. All other subscribers must notify the SEBB Program to remove a dependent within 60 days from the last day of the month when the dependent no longer meets the eligibility criteria described under "Eligible dependents" on page 4. Consequences for not submitting notice within 60 days may include, but are not limited to:

- The dependent losing eligibility to continue vision plan coverage under one of the continuation coverage options described on page 9 of this certificate of coverage;
- The subscriber being billed for claims paid by the vision plan that were received after the dependent lost eligibility;
- The subscriber being unable to recover subscriber-paid insurance premiums for a dependent that lost their eligibility; and
- The subscriber being responsible for premiums paid by the state for the dependent's vision plan coverage after the dependent lost eligibility.

When vision coverage begins

For a school employee and their eligible dependents enrolling during the first annual open enrollment, vision coverage begins on January 1, 2020.

For a school employee and their eligible dependents enrolling when the school employee is newly eligible, vision coverage begins the first day of the month following the date the school employee becomes eligible. The school employee's benefits will begin on the first day of work when their first day of work is on or after September 1, but not later than the first day of school for the current school year as established by the SEBB Organization.

Exception: For a subscriber or their eligible dependents enrolling during a special open enrollment, vision coverage begins the first day of the month following the later of the event date or the date the online enrollment or required form is received.

Exceptions:

1. If the special enrollment is due to birth or adoption of a child, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, vision coverage begins as follows:
 - For an employee, vision coverage will begin the first day of the month in which the event occurs;
 - For the newly born child, vision coverage begins the date of birth;
 - For a newly adopted child, vision coverage begins on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier; or
 - For a spouse or state-registered domestic partner of a subscriber, vision coverage will begin the first day of the month in which the event occurs.
2. For a spouse or state-registered domestic partner of a subscriber, vision coverage begins the first day of the month in which the event occurs.
3. Enrollment of an extended dependent or a dependent with a disability will be the first day of the month following the later of the event date or eligibility certification.

Annual Open Enrollment

School employees may make the following changes to their enrollment during the SEBB Program's annual open enrollment:

- Enroll or remove eligible dependents; or
- Change their vision plan.

Other Subscribers may make the following changes to their enrollment during the SEBB Program's annual open enrollment:

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

The school employee must submit the change online or return the required enrollment/change form to their SEBB Organization. All other subscribers must submit the form to the SEBB Program. The form must be received no later than the last day of the annual open enrollment. The enrollment change will become effective January 1st of the following year.

Special open enrollment

A subscriber may change their enrollment outside of the annual open enrollment if a special open enrollment event occurs. However, the change in enrollment must be allowable under Internal Revenue Code (IRC) and Treasury Regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, the subscriber's dependent, or both. The special open enrollment may allow a subscriber to:

- Change their vision plan; or
- Enroll or remove eligible dependents.

To make an enrollment change, the school employee must make the change online in SEBB My Account or submit the required form(s) to their SEBB Organization. All other subscribers must submit the form(s) to the SEBB Program. Subscribers self-paying for continuation coverage must submit their form(s) to the SEBB Program. The form(s) must be received no later than 60 days after the event that created the special open enrollment. In addition to the required forms, the SEBB Program or SEBB Organization will require the subscriber to provide proof of the dependent's eligibility, proof of the event that created the special open enrollment, or both.

Exception: If a school employee wants to enroll a newborn or child whom the school employee has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the school employee should notify their SEBB organization by submitting an enrollment form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required enrollment/change form must be received no later than sixty days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption. School employees should contact their personnel, payroll, or benefits office for the required forms.

See "Adding a New Dependent to Your Coverage" on page 5.

When can a subscriber change their health plan?

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

1. Subscriber gains a new dependent due to:
 - a. Marriage or registering a state-domestic partnership;
 - b. Birth, adoption or when the subscriber assumes a legal obligation for total or partial support in anticipation of adoption; or
 - c. A child becomes eligible as an extended dependent through legal custody or legal guardianship.
2. Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan;

4. Subscriber has a change in employment from a SEBB organization to a public school that straddles county lines or is in a county that borders Idaho or Oregon, which results in the subscriber having different medical plans available. The subscriber may change their election if the change in employment causes:
 - a. The subscriber's current medical plan to no longer be available, in this case the subscriber may select from any available medical plan; or
 - b. The subscriber has one or more new medical plans available, in this case the subscriber may select to enroll in a newly available plan.
 - c. As used in this subsection the term "public school" shall be interpreted to not include charter schools and educational service districts.
5. Subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;
6. Subscriber or their dependent has a change in residence that affects health plan availability. If the subscriber moves and their current health plan is not available in the new location, the subscriber must select a new health plan otherwise there will be limited network providers and covered services;
7. A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent);
8. Subscriber or their dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the subscriber or the subscriber's dependent loses eligibility for coverage under Medicaid or CHIP;
9. Subscriber or their dependent becomes eligible for state premium assistance subsidy for SEBB health plan coverage from Medicaid or a state CHIP;
10. Subscriber or their dependent becomes entitled to coverage under Medicare, or the subscriber or a subscriber's dependent loses eligibility for coverage under Medicare. If the subscriber's current health plan becomes unavailable due to the subscriber's or a subscriber's dependent's entitlement to Medicare, the subscriber must select a new health plan as described in WAC 182-30-085(1);
11. Subscriber or their dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA); or
12. Subscriber or their dependent experiences a disruption of care that could function as a reduction in benefits for the subscriber or their dependent for a specific condition or ongoing course of treatment. The subscriber may not change their health plan election if the subscriber or a subscriber's dependent physician stops participation with the subscriber's health plan unless the SEBB Program determines that a continuity of care issue exists. The SEBB Program will consider but is not limited to considering the following:
 - a. Active cancer treatment such as chemotherapy or radiation therapy;
 - b. Treatment following a recent organ transplant;
 - c. A scheduled surgery;
 - d. Recent major surgery still within the postoperative period; or
 - e. Treatment of a high-risk pregnancy.

NOTE: If an enrollee's provider or vision care facility discontinues participation with the vision plan, the enrollee may not change vision plans until the SEBB Program's next annual open enrollment or when another qualifying event occurs that creates a special open enrollment, unless the SEBB Program determines that a continuity of care issue exists. This plan cannot guarantee that any one provider, facility, or other provider will be available or remain under contract with us.

When may a subscriber enroll or remove eligible dependents?

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

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

When vision coverage ends

Vision coverage ends on the following dates:

1. The SEBB Organization terminates the employment relationship. In this case, eligibility for the employer contribution ends the last day of the month in which the employer-initiated termination notice is effective;
2. The school employee terminates the employment relationship. In this case, eligibility for the employer contribution ends the last day of the month in which the school employee's resignation is effective; or
3. The school employee's work pattern is revised such that the school employee is no longer anticipated to work six hundred thirty (630) hours during the school year. In this case, eligibility for the employer contribution ends as of the last day of the month in which the change is effective.

Premium payments and applicable premium surcharges become due the first of the month in which vision coverage is effective. Premium payments and applicable premium surcharges are not prorated during any month, even if an enrollee dies or asks to terminate their vision before the end of the month.

When vision plan enrollment ends, the enrollee may be eligible for continuation coverage under the Policy if they apply within the timelines explained in the "Options for continuation of SEBB vision coverage" on page 9.

If a subscriber enrolls in continuation coverage, the subscriber is responsible for timely payment of premiums and applicable premium surcharges. If the monthly premium or applicable premium surcharge remains unpaid for 30 days, it will be considered delinquent. A subscriber is allowed a grace period of 30 days from the date the monthly premium or applicable premium surcharge becomes delinquent to pay the unpaid premium balance or surcharge. If the subscriber's premium balance or applicable premium surcharge remains unpaid for 60 days from the original due date, the subscriber's vision coverage (including enrolled dependents) will be terminated retroactive to the last day of the month for which the monthly premium and any applicable premium surcharge was paid.

A school employee who needs the required forms for an enrollment or benefit change may contact their SEBB Organization. All other subscribers may contact the SEBB Program at the 1-800-200-1004.

Medicare entitlement

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

Options for continuation of SEBB vision coverage

A school employee and their dependent covered by this vision plan has options for continuing insurance coverage during temporary or permanent loss of eligibility. There are two continuation coverage options for SEBB vision plan enrollees:

1. SEBB Continuation Coverage (COBRA)
2. SEBB Continuation Coverage (Unpaid Leave)

These two options temporarily extend group insurance coverage when the enrollee's SEBB vision plan coverage ends due to a qualifying event. SEBB Continuation Coverage (COBRA) includes eligibility and administrative requirements under federal law and regulation and also includes coverage for some enrollees who are not qualified beneficiaries under federal COBRA continuation coverage. SEBB Continuation Coverage (Unpaid Leave) is an alternative created by the SEBB Program with wider eligibility criteria and qualifying event types. Enrollees who qualify for both types of SEBB Continuation Coverage (COBRA and Unpaid Leave) may choose to enroll in only one of the options.

“The enrollee's election must be received by the SEBB Program no later than sixty days from the date the enrollee's SEBB health plan coverage ended or from the postmark date on the election notice sent by the SEBB Program, whichever is later. The enrollee's first premium payment and applicable premium surcharges are due no later than forty-five days after the election period ends as described in the prior sentence. Payment of premium and applicable premium surcharges associated with continuing SEBB health plan coverage must be made to the HCA.”

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

The SEBB Program administers both continuation coverage options. Refer to the *SEBB Continuation Coverage Election Notice* booklet for details.

Option for Coverage under Public Employees Benefits Board (PEBB) Retiree Insurance

A retiring employee is eligible to continue enrollment or defer enrollment in public employees benefits board (PEBB) insurance coverage as a retiree if they meet procedural and substantive eligibility requirements. See the *PEBB Retiree Enrollment Guide* for details.

Transitional continuation coverage

School employees and their dependents may gain temporary eligibility for School Employees Benefits Board (SEBB) benefits, on a self-pay basis, if they meet the following criteria:

1. A school employee and their dependents who are enrolled in medical, dental, or vision under a group plan offered by a SEBB organization on December 31, 2019, who lose eligibility because the school employee is not eligible for SEBB benefits, may elect to enroll in one or more of the following SEBB benefits: Medical, dental, or vision coverage. These benefits will be provided for a maximum of eighteen months.
2. A dependent of a SEBB eligible school employee who is enrolled in medical, dental, or vision under a school employee's account on December 31, 2019, who loses eligibility because they are not an eligible dependent may enroll in medical, dental, and vision for a maximum of thirty-six months.
3. A dependent of a school employee who is continuing medical, dental, or vision coverage through a SEBB organization on December 31, 2019, may elect to finish out their remaining months, up to the maximum number of months authorized by Consolidated Omnibus Budget Reconciliation Act (COBRA) for a similar event, by enrolling in a medical, dental, or vision plan offered through the SEBB program.

Family and Medical Leave Act of 1993

A school employee on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward SEBB insurance coverage in accordance with the FMLA. The SEBB Organization determines if the school employee is eligible for leave and the duration of the leave under FMLA. The school employee must continue to pay the school employee monthly premium contribution and applicable premium surcharge during this period to maintain eligibility. If the school employee's monthly premium or applicable premium surcharge remains unpaid for 60 days from the original due date, insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharge was paid.

If a school employee exhausts the period of leave approved under FMLA, they may continue insurance coverage by self-paying the monthly premium and applicable premium surcharge set by the Health Care Authority (HCA), with no contribution from the SEBB Organization while on approved leave. For additional information on continuation coverage, see the section titled "Options for continuation of SEBB vision coverage."

Paid Family Medical Leave Act

A school employee on approved leave under the Washington state Paid Family and Medical Leave Program (PFML) may continue to receive the employer contribution toward SEBB insurance coverage in accordance with PFML. The Employment Security Department determines if the school employee is eligible for leave and the duration of the leave under PFML. The school employee must continue to pay the school employee monthly premium contribution and applicable premium surcharge during this period to maintain eligibility. If the school employee's monthly premium or applicable premium surcharge remains unpaid for 60 days from the original due date, insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharge was paid. If a school employee exhausts the period of leave approved under PFML, they may continue insurance coverage by self-paying the monthly premium and applicable premium surcharge set by HCA, with no contribution from the SEBB Organization while on approved leave. For additional information on continuation coverage, see the section titled "Options for continuation of SEBB vision coverage" on page 9.

General provisions

Payment of premium during a labor dispute

Any school employee or dependent whose monthly premiums are paid in full or in part by the SEBB Organization may pay premiums directly to the plan or the Health Care Authority (HCA) if the school employee's compensation is suspended or terminated directly or indirectly as a result of a strike, lockout, or any other labor dispute for a period not to exceed six months.

While the school employee's compensation is suspended or terminated, HCA shall notify the school employee immediately by mail to the last address of record, that the school employee may pay premiums as they become due.

Appeal rights

Any current or former school employee of a SEBB Organization or their dependent may appeal a decision by the SEBB Organization regarding SEBB eligibility, enrollment, or premium surcharges to the SEBB Organization. Any enrollee may appeal a decision made by the SEBB Program regarding SEBB eligibility, enrollment, premium payments, or premium surcharges to the SEBB Appeals Unit. Any enrollee may appeal a decision regarding administration of a health plan by following the appeal provisions of the plan, except when regarding eligibility, enrollment, and premium payment decisions.

Relationship to law and regulations

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

BENEFITS

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

In-Network Provider Benefits. The Insured Person must pay any Copayment or any cost above the Allowance shown in the Schedule of Benefits at the time the covered service is provided. Benefits will be paid to the In-Network Provider who will file a claim with the Company on behalf of the Insured Person.

Out-of-Network Provider Benefits. The Insured Person must pay the Out-of-Network Provider the full cost at the time the covered service is provided and file a claim with the Company, unless the Out-of-Network Provider allows assignment of benefits. The Company will pay the Out-of-Network benefits up to the maximum dollar amount shown in the Schedule of Benefits

LIMITATIONS

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

Allowances provide no remaining balance for future use within the same Benefit Frequency.

EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from:

1. medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures;
2. services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
3. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
4. any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment;
5. safety eyewear;
6. non-prescription sunglasses;
7. plano (non-prescription) lenses ;
8. plano (non-prescription) contact lenses;
9. two pair of glasses in lieu of bifocals;
10. services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or
11. lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.

TERMINATION OF INSURANCE

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

For All Insureds. Subject to any continuation provision, the Insureds' insurance will cease on the earlier of:

1. the date the Policy ends;
2. the end of the last period for which any required premium contribution agreed to in writing has been made;
3. the date the Insured is no longer eligible for insurance in accordance with the Eligibility and Enrollment section provided by the Policyholder;
4. the date the Insured has a change in employment to a public school that does not offer this vision coverage; or
5. the date the Insured's employment with the Policyholder ends.

For Dependents. Subject to any continuation provision, a Dependent's insurance will cease on the earlier of:

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

PREMIUMS

The Company provides insurance coverage in return for premium payment. Premiums are payable to the Company by the Policyholder on behalf of the Insured Person. The Insured Person's first premium is due on the Insured Person's Effective Date. Premiums must be paid to the Company on or before the due date. The initial premium rates are shown in the Policyholder's application.

Premium Changes. The Company has the right to change the premium rates on any premium due date as allowed in the Policy. The Company will provide written notice to the Policyholder at least 31 days before the date of the change. The premium rates also may be changed at any time the terms of the Policy are changed.

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

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

CLAIMS

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

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

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

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

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

Assignment. Benefits under the Policy may be assigned.

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

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

GENERAL PROVISIONS

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

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

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

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

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

Insurance Data. The Policyholder must give the Company the names and ages of all individuals initially insured. The names of persons who later become eligible (whether or not the person becomes insured), and the names of those who cease to be eligible must also be given. The eligibility dates and any other necessary data must be given to the Company so that the premium can be determined.

The Company has the right to audit the Policyholder's books and records as the books and records relate to this insurance. The Company may authorize someone else to perform this audit. Any such inspection may be done at any reasonable time.

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

SCHEDULE OF BENEFITS

Network: EyeMed – Access.

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

<i>BENEFIT FREQUENCY</i>		
<u>Vision Examinations</u>	once every 12 months	Insured Persons
<u>Vision Materials</u>		
Frame	once every 24 months	Insured Persons 19 years of age and older
Frame	once every 12 months	Insured Persons under 19 years of age
Lenses and Lens Options	once every 24 months	Insured Persons 19 years of age and older
Lenses and Lens Options	once every 12 months	Insured Persons under 19 years of age
Contact Lenses	once every 24 months	Insured Persons 19 years of age and older
Contact Lenses	once every 12 months	Insured Persons under 19 years of age

<i>BENEFIT</i>	<i><u>In-Network Provider</u></i>	<i><u>Out-of-Network Provider</u></i> <i>(Reimbursement up to)</i>
<u>Vision Examinations</u>		
Comprehensive Eye Examination Insured Persons 19 years of age and older	\$0 Copayment	\$84
Comprehensive Eye Examination Insured Persons under 19 years of age	\$0 Copayment	\$90
Contact Lenses Fit and Follow-Up (One Fit and two Follow-Up visits) Available once a Comprehensive Eye Examination has been completed Insured Persons under 19 years of age		
Standard Contacts	\$0 Copayment	\$65
Premium Contacts	\$0 Copayment up to \$65 Allowance	\$65
<u>Vision Materials</u>		
Frame Insured Persons	\$0 Copayment up to \$150 Allowance	\$75
Contact Lenses Only one of the following Contact Lenses benefits may be used for the Contact Lenses benefit. Insured Persons 19 years of age and older		
Conventional Contacts	\$0 Copayment up to \$150 Allowance	\$150
Disposable Contacts	\$0 Copayment up to \$150 Allowance	\$150
Medically Necessary Contacts	Paid in Full	\$300

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

<i>BENEFIT</i>	<i><u>In-Network Provider</u></i>	<i><u>Out-of-Network Provider</u></i> <i>(Reimbursement up to)</i>
Scratch Coating – Standard Plastic Insured Persons 19 years of age and older	\$0 Copayment	\$5
Scratch Coating – Standard Plastic Insured Persons under 19 years of age	\$0 Copayment	\$8



FIDELITY SECURITY LIFE INSURANCE COMPANY

3130 Broadway Kansas City, Missouri 64111-2406

Phone: (800) 648-8624

A STOCK COMPANY (herein Called “the Company”)

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

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

BENEFITS

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

In-Network Provider Benefits. The Insured Person must pay any Copayment or any cost above the Allowance shown in the Schedule of Benefits at the time the covered service is provided. Benefits will be paid to the In-Network Provider who will file a claim with the Company on behalf of the Insured Person.

Out-of-Network Provider Benefits. The Insured Person must pay the Out-of-Network Provider the full cost at the time the covered service is provided and file a claim with the Company, unless the Out-of-Network Provider allows assignment of benefits. The Company will pay the Out-of-Network benefits up to the maximum dollar amount shown in the Schedule of Benefits

LIMITATIONS

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

Allowances provide no remaining balance for future use within the same Benefit Frequency.

EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from:

1. medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures;
2. services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
3. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
4. any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment;
5. safety eyewear;
6. non-prescription sunglasses;
7. plano (non-prescription) lenses ;

8. plano (non-prescription) contact lenses;
9. two pair of glasses in lieu of bifocals;
10. services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or
11. lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.

TERMINATION OF INSURANCE

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

For All Insureds. Subject to any continuation provision, the Insureds' insurance will cease on the earlier of:

1. the date the Policy ends;
2. the end of the last period for which any required premium contribution agreed to in writing has been made;
3. the date the Insured is no longer eligible for insurance in accordance with the Eligibility and Enrollment section provided by the Policyholder;
4. the date the Insured has a change in employment to a public school that does not offer this vision coverage; or
5. the date the Insured's employment with the Policyholder ends.

For Dependents. Subject to any continuation provision, a Dependent's insurance will cease on the earlier of:

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

PREMIUM RATE CHANGE

The Company has the right to change the premium rates on any premium due date as allowed in the Policy. The Company will provide written notice to the Policyholder at least 31 days before the date of the change. The premium rates also may be changed at any time the terms of the Policy are changed.



FIDELITY SECURITY LIFE INSURANCE COMPANY

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

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

PREFACE

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

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

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

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

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

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

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

QUESTIONS AND ANSWERS

1. WHAT INSURANCE POLICIES ARE COVERED UNDER THE ACT?

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

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

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

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

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

3. WHO IS PROTECTED UNDER THE ACT?

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

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

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

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

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

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

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

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

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

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

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

The Association generally cannot make an assessment for covered policies issued by a company until after an order of liquidation has been entered against the company, and a reasonable estimate can be made of the amount of money needed. Insurance companies receiving an assessment notice must make their payments within thirty days.

Because it takes time for an action to be commenced against a financially impaired insurer, for a Court to issue an order, and for funds to be collected to satisfy the obligations of that insurer, some delay, hopefully short, is unavoidable before payments can be made. Although it is impossible to predict how long this process will take in any given case, an average time period of twelve to eighteen months is not unusual.

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

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

The Act provides the following maximum amounts of protection:

Life Insurance Death Benefits.....	\$500,000
Disability Benefits.....	\$500,000
Present Value of Individual Amounts.....	\$500,000
Unallocated Annuity Contracts, other than certain government retirement plans (limit is per contract owner or plan sponsor).....	\$5,000,000
Government Retirement Plans established under Internal Revenue Code § § 402, 403(b), or 457 (limit is per participant).....	\$100,000

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSION

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

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

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FIDELITY SECURITY LIFE INSURANCE COMPANY

3130 Broadway
Kansas City, Missouri 64111-2406
Phone 800-648-8624
A STOCK COMPANY
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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.