Lexington Fayette Urban County Gov't

R-567-2019
Contract #214-2019

Proposed Benefits

EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company

Option Base

Exam & Materials

Select Network

Fully Insured

Employee Paid

Funded Benefits

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	$5 copay	Up to $27
Fit and Follow-up - Standard	$0 copay; contact lens fit and two follow-up visits	Up to $40
Fit and Follow-up - Premium	$0 copay; 10% off retail price, then apply $40 allowance	Up to $40
FRAME		
Frame	$0 copay; 20% off balance over $110 allowance	Up to $55
CONTACT LENSES		
(Contact Lens allowance includes materials only)		
Contacts - Conventional	$0 copay; 15% off balance over $110 allowance	Up to $88
Contacts - Disposable	$0 copay; 100% of balance over $110 allowance	Up to $88
Contacts - Medically Necessary	$0 copay; paid-in-full	Up to $210
STANDARD PLASTIC LENSES		
Single Vision	$5 copay	Up to $30
Bifocal	$5 copay	Up to $40
Trifocal	$5 copay	Up to $60
Lenticular	$5 copay	Up to $60
Progressive - Standard	$70 copay	Up to $40
Progressive - Premium	$70 copay, 20% off retail price less $120 allowance	Up to $40

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

Terms

Contract Term
24 months

Rate Guarantee
24 months

MONTHLY RATES

Subscriber	**$6.27**
Subscriber + Spouse	**$11.81**
Subscriber + Child(ren)	**$12.44**
Subscriber + Family	**$18.19**

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. The Plan reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866-939-3633.

PLAN DETAILS

Quote for group situsedin the State of KY and will be valid until the 01/01/2022 implementation date. Date Quoted 12/23/2021. 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-146, form number M-9184.

PLAN EXCLUSIONS/LIMITATIONS

No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; 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; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; 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 lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. 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. Some provisions, benefits, exclusions or limitations listed herein may vary by state.

By signing below, the Group agrees to receive all documents and correspondence electronically and that the Group can access the internet or the email address provided. The Group understands that the Group may revoke this authorization or request specific paper documents without revoking this authorization by contacting EyeMed by mail, email, or telephone. If Lexington Fayette Urban County Gov't has chosen this benefit design, attach this document to the group application and sign here

Linda Gorton

Signature

Date 1/28/2022

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Q-00035607 – QL-0000059981

Lexington Fayette Urban County Gov't

Saving our members some extra green

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

$avings for Members

40% off

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

20% off

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

Lasik

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

Hearing Care

Through Amplifon Hearing Health Care Network, members receive up to 64% off hearing aids, an extended warranty, and free batteries

ADDITIONAL DISCOUNTS

VISION CARE SERVICES	IN-NETWORK MEMBER COST
DISCOUNTED EXAM SERVICES	
Retinal Imaging	Up to $39
DISCOUNTED LENS OPTIONS	
Anti Reflective Coating - Standard	$45
Photochromic - Non-Glass	20% off retail price
Polycarbonate - Standard	$40
Scratch Coating - Standard Plastic	$15
Tint - Solid or Gradient	$15
UV Treatment	$15
OTHER ADD-ON SERVICES AND MATERIALS	20% off retail price

DISCOUNT DETAILS

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

Application for Vision Care Benefits

Underwritten by Fidelity Security Life Insurance Company
Kansas City, Missouri 64111

I. GROUP INFORMATION

Group Name: Lexington-Fayette Urban County Government Tax ID#: 61-0858140

DBA Name (If other than above): _____

Business Physical Address: 200 E Main St. (Street Address) Lexington (City) KY (State) 40511 (Zip)

Mailing Address: 200 Main St. (Street Address) Lexington (City) KY (State) 40511 (Zip)

Day-to-Day Contact Name: John Maxwell Title: HR Director

Phone Number: (859) 258-3033 E-Mail Address: jmaxwell2@lexingtonky.gov

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

PLEASE NOTE THE FOLLOWING TYPE BUSINESSES REQUIRE PRIOR CARRIER APPROVAL:

☐ MEWA ☐ PEO ☐ Trust ☐ Union ☐ VEBA ☐ Casino/Indian Tribe

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

If any subsidiary or affiliated companies are to be insured or any Employees/Members are working or residing in a state other than the business address above,* ***please list those states:* _____

GROUP DISPLAY NAME ***(Your Group Name as it should appear to your Employees/Members)***

Company Name: LFUCG
(Maximum of 40 characters, including capitalization, punctuation and spacing.)

II. GROUP BILLING

Billing Physical Address: 200 East Main Street (Street Address) Lexington (City) KY (State) 40511 (Zip)

Primary Contact Name: Kashene Wayne Title: HR Manager

Phone Number: (859) 258-3066 E-Mail Address: kwayne@lexingtonky.gov

Do you have any additional subsidiaries, affiliated companies, or divisions that use another name and will be covered by this plan AND require separate billing invoices? ☐ *Yes* ■ *No If Yes, please attach and send a separate page signed by you with the following information: Name, Address, Billing Contact Name and Phone Number*

III. PREMIUMS*

Please indicate the percentage of premium contributed by the Group and the Employee/Member for both the Employee/Member and Dependents; the total for each row must equal 100%.

	Group Contribution	Employee/Member Contribution
Employee/Members:	0 %	100 %
Dependents:	0 %	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 Eligible Employees/Members: 3000

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

If "Yes," name of existing insurer: _____

Eligible Class(es) of Employees/Members (please check all that apply):

☐ Active employees ■ Retiree / Leave of Absence

■ COBRA–eligible employees ☐ Other: _____

Are the following covered under the plan:

Domestic Partners:* ■ Yes ☐ No **If Yes**, Same Sex:* ■ Yes ☐ No Opposite Sex:* ■ Yes ☐ No

Dependent Children Covered to Age*: ☐ 19 ☐ 23 ■ 26** ☐ Other _____

Dependent Children who are full-time students covered to age*: ☐ 23 ☐ 25 ■ 26 ☐ 27 ☐ Other _____

Dependent Child Age Termination based on:

☐ Day Age is attained ■ End of Month Age is attained ☐ End of Year Age is attained

**Unless state law has different requirements.*

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

MEMBERSHIP INFORMATION

Who will send enrollment for Active Employees/Members? ■ Group ☐ Group's TPA

If TPA, TPA Name: _____

Group/TPA Contact Name: _____

Phone Number: ( ) _____ E-Mail Address: _____

Membership will be an electronic membership file? ■ Yes ☐ No

Who will send enrollment for COBRA Employees/Members? ☐ Group ■ Group's TPA

If TPA, TPA Name: Health Equity

Group/TPA Contact Name: Keith Heier

Phone Number: (214) 596-2144 E-Mail Address: kheier@healthequity.com

Membership will be an electronic membership file? ■ Yes ☐ No

PROBATIONARY PERIOD

For New Employees/Members: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days ■ Other 1st of month

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

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

V. PLAN SELECTION

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

VI. EFFECTIVE DATE

This Policy will become effective at 12:01 a.m. Local Time at the Group's address herein, on

01/01/2022 , provided all the following has been completed prior to this effective date:
MM/DD/YYYY

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, in an agreed upon format. 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 pay premiums monthly.

By signing below, the Group agrees to receive all documents and correspondence electronically and that the Group can access the internet or the email address provided. The Group understands that the Group may revoke this authorization or request specific paper documents without revoking this authorization by contacting the Company or EyeMed by mail, email, or telephone.

All information shown on this application and any attachments is correct and complete as of the date this application is signed. All statements by the Group will be deemed to be representations and not warranties. The Group understands that the Company intends to rely on this information in determining if 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.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Dated at: Lexington (City) KY (State) this 28 (Day) day of January (Month), 2022 (Year)

Signed for the Group: ▶ Linda Gorton Title: Mayor

Printed Name: Linda Gorton

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): Benefit Insurance Marketing Tax ID No.: 61-0966902

Mailing Address: 1151 Red Mile Rd (Street Address) Lexington (City) KY (State) 40504 (Zip)

Day-to-Day Contact Name: Tracy Whipple Title: Account Executive

Day-to-Day Contact Phone Number: (859) 255.9455 Day-to-Day Contact E-Mail Address: tracy@bimgroup.us

Commission checks payable to: ☐ Firm ☐ Broker

Broker Name (print): Benji Marrs SS#:

Broker Phone Number: (859) 255.9455 Broker E-mail Address: benji@bimgroup.us

Broker Signature: ▶ Benji Marrs

WRITING GENERAL AGENT'S CERTIFYING STATEMENT

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

Firm Name (print): Tax ID No.:

Mailing Address: (Street Address) (City) (State) (Zip)

Day-to-Day Contact Name: Title:

Day-to-Day Contact Phone Number: ( ) Day-to-Day Contact E-Mail Address:

Commission checks payable to: ☐ Firm ☐ General Agent

General Agent Name (print): SS#:

General Agent Phone Number: ( ) General Agent E-mail Address:

General Agent Signature: ▶