



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: Golden Gate University
POLICY EFFECTIVE DATE: January 1, 2020
POLICY ANNIVERSARY DATE: January 1 of the following year and each January 1 thereafter

Fidelity Security Life Insurance Company represents that the Insured Person is insured for the benefits described on the following pages, subject to and in accordance with the terms and conditions of the Policy.

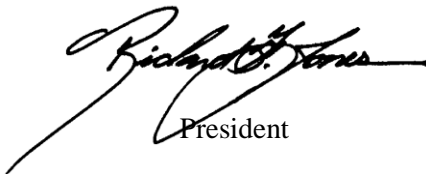
The Policy may be amended, changed, cancelled or discontinued without the consent of any Insured Person.

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

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

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

FIDELITY SECURITY LIFE INSURANCE COMPANY


President


Secretary

This Certificate is not major medical insurance and is not a substitute for major medical insurance. It does not qualify as minimum essential health coverage or essential pediatric vision coverage under the Federal Affordable Care Act.

**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.

THIRTY-DAY RIGHT TO EXAMINE: If an Insured who is age 65 or older is not satisfied for any reason, the Insured may return the Insured's Certificate within 30 days after receipt. The premium will then be refunded. When so returned, the Certificate will be void from the beginning. The Certificate must be returned to the Company at the Company's home office or to the Company's authorized agent.

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SCHEDULE OF BENEFITS Attached (1A)

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

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

Comprehensive Eye Examination means a comprehensive ophthalmological service. Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated by examination, biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

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

1. the Insured's lawful spouse or Domestic Partner;
2. each unmarried child from birth to age 26 who is primarily dependent upon the Insured or the Insured's spouse for support and maintenance;
3. each unmarried child at least 26 years of age to 27 years of age who is primarily dependent upon the Insured or the Insured's spouse for support and maintenance and who is a full-time student; or
4. each unmarried child at least 26 years of age: who is primarily dependent upon the Insured or the Insured's spouse for support and maintenance because the child is incapable of self-sustaining employment by reason of mental incapacity or physical handicap.

Child includes stepchild, foster child, legally adopted child, child legally placed in the Insured's home for adoption and child under the Insured's legal guardianship. A full-time student is one who is enrolled at least the minimum number of hours of class a week the school considers as full-time status.

Domestic Partner will have the same meaning as used in Section 297 of the Family Code. However, for individuals not meeting the definition of Domestic Partner as used in Section 297 of the Family Code, Domestic Partner means an adult who is in a committed relationship with the Insured, and the Insured and the Domestic Partner are mutually responsible for one another financially and otherwise.

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

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

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

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

Medically Necessary Contact Lenses means:

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

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

Policy means the Policy issued to the Policyholder.

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

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

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

Preferred Provider Organization (“PPO”) means a network of Providers and retail chain stores within the PPO Service Area that has signed a Preferred Provider Agreement. A Preferred Provider directory is provided to the Policyholder and may be reviewed during normal business hours.

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.

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 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 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
9. lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

TERMINATION OF INSURANCE

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

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

1. the date the Policy ends;
2. the end of the last period for which any required premium contribution agreed to in writing has been made;
3. the date the Insured is no longer eligible for insurance; or
4. the date the Insured's employment with the Policyholder ends. The Policyholder may, at the Policyholder's option, continue insurance for individuals whose employment has ended, if the Policyholder:
 - a. does so without individual selection between Insureds; and
 - b. continues to pay any premium contribution for those individuals.

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

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

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

1. not capable of self-sustaining employment due to a physically or mentally disabling injury, illness or condition that began before the age limit was reached; and
2. mainly dependent on the Insured for support.

The Company will notify the Insured that the Dependent child's coverage will terminate upon attainment of the limiting age at least 90 days prior to the termination. 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 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 must be given to the Company so that the premium can be determined.

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

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

SCHEDULE OF BENEFITS

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

<u>Benefit</u>	<u>In-Network</u>	<u>Out-of-Network</u>	<u>Benefit Frequency</u>
VISION EXAMINATION			
Comprehensive Eye Examination	\$0 Co-payment	up to \$40	12 months
VISION MATERIALS			
Standard Plastic Lenses			12 months
Single Vision	\$15 Co-payment	up to \$30	
Bifocal	\$15 Co-payment	up to \$50	
Trifocal	\$15 Co-payment	up to \$70	
Lenticular	\$15 Co-payment	up to \$70	
Frames	\$0 Co-payment, up to \$130 retail allowance	up to \$91	24 months
Contact Lenses (only one option available per Benefit Frequency)			12 months
Conventional	\$0 Co-payment, up to \$120 allowance	up to \$84	
Disposable	\$0 Co-payment, up to \$120 allowance	up to \$84	
Medically Necessary	Paid in full	up to \$210	
Lens Options			12 months
Standard Progressive Lenses	\$80 Co-payment	up to \$50	
Premium Progressive Lenses	\$80 Co-payment, up to \$120 allowance	up to \$50	



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AMENDATORY RIDER REGARDING REPLACEMENT COVERAGE

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

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

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

Each such person will be insured under the Policy if:

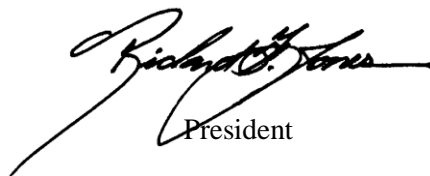
1. the person was insured under the prior plan, including coverage under the prior plan's extension of benefits provision, on the date the Policyholder's coverage with the prior plan ended;
2. the prior plan covered more than 15 people; and
3. the person is in a class of persons eligible for coverage under the Policy.

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

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

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

FIDELITY SECURITY LIFE INSURANCE COMPANY


Richard D. Jones
President


Bradford R. Jones
Secretary



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AMENDMENT RIDER For California Residents Only

By attachment of this Rider, any provision of the Policy/Certificate that provides coverage for a Dependent child up to a certain age is hereby amended as follows:

Coverage for a Dependent child will continue to age 26. Eligibility will not be affected by any factor other than the relationship between the Dependent child and the Insured, including, but not limited to financial dependency, residency, student status, or marital status.

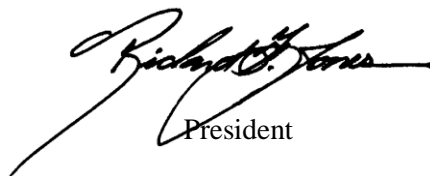
Coverage for a handicapped Dependent child will continue regardless of marital status or whether the Dependent was insured prior to attaining the limiting age. Proof of incapacity must be furnished to the Company at least 60 days after receiving such notification from the Company, but not more than once in any 12-month period after the initial two-year period following such child's attainment of age 26.

Coverage for a Dependent child who is age 26 or older and a full-time student will continue for such Dependent child's medically necessary leave of absence from school. Any breaks in the school semester will not disqualify the Dependent child from coverage. The Company may require written documentation or certification of the medical necessity of a leave of absence be submitted from the student's attending Physician. This continued coverage will terminate on the earlier of: 1) a period not to exceed 12 months; or 2) the limiting age for Dependent children who are full-time students, as shown in the Policy/Certificate.

The Company will notify the Insured 90 days prior to the termination of a child reaching the limiting age.

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.

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CONTINUATION OF COVERAGE (Cal-COBRA) AMENDMENT RIDER Employers with 20 or more Full-time Employees Only For California Residents Only

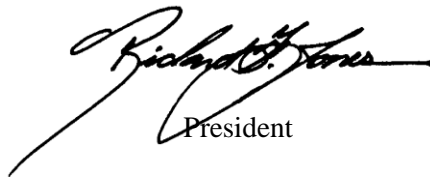
By attachment of this Rider, the Policy/Certificate is amended by the following:

If an Insured Person has exhausted the Insured Person's continuation under the Consolidated Omnibus Budget Reconciliation Act (COBRA) and such continuation for which the Insured Person was eligible was less the 36 months, the Insured Person is eligible to continue coverage under the Policy until the earlier of the following:

1. 36 months from the date the Insured Person's continuation coverage began under COBRA;
2. the end of the period for which the required premium has not been made;
3. the date the Insured Person is entitled to or becomes entitled to Medicare benefits;
4. the date the Insured Person is covered or becomes covered under another health insurance policy, other than a group conversion policy; or
5. the date the Policy is terminated.

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.

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AMENDMENT RIDER For Texas Residents Only

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

Any provision of the Policy/Certificate that terminates coverage before the end of the month is amended as follows:

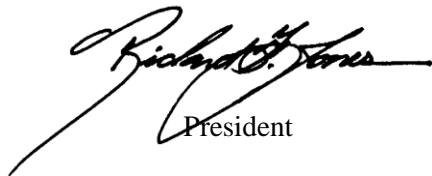
An Insured's coverage will end on the later of:

1. the last day of the month in which the Insured's eligibility ends; or
2. the last day of the month following notification of termination by the Policyholder to the Company.

The Policyholder will be responsible for all premiums due prior to termination. The Policyholder will be deemed to have notified the Company in the month in which the Insured ceases to be part of the group if the Company receives notification within the first three days of the subsequent month, not including Saturdays, Sundays, and legal holidays. If the notification is sent during this additional three-day notification period, the Policyholder must transmit the notification of an Insured's loss of eligibility during the previous month by a method that provides immediate written notification, such as an internet portal, electronic mail, or telefacsimile. Immediate written notification sent via electronic means will be presumed received on the date it is submitted; hand-delivered notification will be presumed received on the date the delivery receipt is signed.

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.

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OUTLINE OF COVERAGE GROUP VISION PLAN THIS IS A LIMITED BENEFIT PLAN Policy Form M-9083CA

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.

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

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

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

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

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

LIMITATIONS

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

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

EXCLUSIONS

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

1. orthoptic or vision training, subnormal vision aids and 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 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
9. lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

TERMINATION OF INSURANCE

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

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

1. the date the Policy ends;
2. the end of the last period for which any required premium contribution agreed to in writing has been made;
3. the date the Insured is no longer eligible for insurance; or
4. the date the Insured's employment with the Policyholder ends. The Policyholder may, at the Policyholder's option, continue insurance for individuals whose employment has ended, if the Policyholder:
 - a. does so without individual selection between Insureds; and
 - b. continues to pay any premium contribution for those individuals.

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

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

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

1. not capable of self-sustaining employment due to a physically or mentally disabling injury, illness or condition that began before the age limit was reached; and
2. mainly dependent on the Insured for support.

The Company will notify the Insured that the Dependent child's coverage will terminate upon attainment of the limiting age at least 90 days prior to the termination. 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.

PREMIUM RATE CHANGE

Premium Rate Change. The Company has the right to change the premium rate on or after the fourth Policy Anniversary Date. The Company will provide written notice at least 60 days before the date of change.



FIDELITY SECURITY LIFE INSURANCE COMPANY

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

NOTICE

THIS NOTICE is to advise you that in the event a complaint should arise about this insurance, please contact our Customer Service Department at:

Fidelity Security Life Insurance Company
3130 Broadway
Kansas City, MO 64111-2406
800-648-8624, Extension 1100

If we at Fidelity Security Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

California Department of Insurance
Consumer Services Division
300 S. Spring Street, 14th Floor
Los Angeles, CA 90013
800-927-4357 (Inside California)
213-897-8921 (Outside California and Area Codes 213, 310, and 818)
TDD: 800-482-4TDD (4833)
<https://www.insurance.ca.gov/01-consumers/>



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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.



FIDELITY SECURITY LIFE INSURANCE COMPANY

Notice of Non-Discrimination and Availability of Disability Accessibility Assistance

Your plan complies with applicable State and Federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

For people with disabilities, we offer free aids and services, such as sign language interpreters, large print, audio and accessible electronic formats. Please contact your administrator at its customer service phone number 1-888-249-5194, or email address www.eyemed.com for assistance.

If you believe that your plan has failed to provide you these services or discriminated against you on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a complaint with the State Department of Health Care Services, Office of Civil Rights at:

P.O. Box 997413, MS 0009
Sacramento, CO 95899-7413
(916) 440-7370
civilrights@dhcs.ca.gov

You are entitled to obtain the administrator representative's name, address, phone and email during your contact to provide the department so the department may contact that person about your complaint.

Notice of Availability of Language Assistance Services

English:

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-888-249-5194. For more help call the CA Dept. of Insurance at 1-800-927-4357.

Spanish:

Servicios de idiomas sin costo. Puede tener acceso a un intérprete para que le lea los documentos en su idioma. También podemos enviarle algunos documentos traducidos. Para obtener ayuda, llámenos al número en su tarjeta de asegurado o al 1-888-249-5194. Si necesita ayuda adicional, comuníquese con el Departamento de Seguros de California al 1-800-927-4357.

Arabic:

الخدمات اللغوية المجانية. يُمكنك الحصول على خدمات أحد المترجمين الفوريين. كما يمكنك الاستعانة بخدمات أحد المتخصصين لقراءة بعض الوثائق وإرسال بعضها إليك بلغتك. وللحصول على المساعدة، اتصل بنا على الأرقام المدرجة على بطاقة الهوية الخاصة بك أو على 1-888-249-5194. وللحصول على مزيد من المساعدة، اتصل بإدارة كاليفورنيا للتأمين الصحي على الرقم 1-800-927-4357.

Armenian

Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են ընթերցել ձեզ համար և ուղարկել դրանք ձեզ ձեր լեզվով: Օգնության համար զանգահարեք ձեր ինքնության (ID) քարտի վրա նշված հեռախոսահամարով կամ 1-888-249-5194 հեռախոսահամարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆոռնիայի Ապահովագրության բաժանմունք՝ 1-800-927-4357 հեռախոսահամարով:

Chinese

免費語言服務。 您可以獲得口譯員的協助。發給您的文件可提供閱讀服務，部分文件可提供您使用的語言版本。如需協助，請撥打 ID 卡上載明的號碼或 1-888-249-5194 與我們連絡。如需其他協助，請撥打 1-800-927-4357 與加州保險局連絡。

Hindi

□बना लागत क□ भाषा सेवाएँ। आप दुभा□षया प्□र□ कर सकते ह□। आप दस्□ताव □ताव □ताव□े पढ़वा सकते ह□ और कुछ दस्□ताव □ताव □ताव□े आपको आपक□ भाषा म□ भेजे जा सकते ह□। मदद के □लए, हम□ अपने ID कार्ड पर सूचीबद्ध नंबर पर या 1-888-249-5194 पर कॉल कर□। अ□धक मदद के □लए 1-800-927-4357 पर CA बीमा □वभाग कोकॉल कर□।

Hmong

Muaj Cov Kev Pab Txhais Lus Pub Dawb. Koj tuaj yeem tau txais ib tus neeg txhais lus. Koj tuaj yeem tau txais kev pab muab cov ntaub ntauv nyeem rau koj mloog thiab muab qee cov xa tuaj rau koj ua koj hom lus. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob saum koj daim npav ID lossis 1-888-249-5194. Yog xav paub ntxiv, hu rau CA Dept. of Insurance ntawm 1-800-927-4357.

Japanese

無料の言語サービス。メンバーは通訳者を通じて連絡を取ることができます。また、お望みの言語で通訳者に文書を読んでもらったり、送付するよう依頼することも可能です。ヘルプについては、IDカードに記載されている番号、または 1-888-249-5194 までお電話ください。詳細については、カリフォルニア保険局 (1-800-927-4357) までお問い合わせください。

Khmer:

សេវាភាសាអង់គ្លេសឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់ម្នាក់។ អ្នកអាចឱ្យគេអានឯកសារនានាឱ្យអ្នកស្តាប់ និងបញ្ជូនឱ្យអ្នកនូវឯកសារមួយចំនួនជាភាសាអង់គ្លេស។ ដើម្បីទទួលបានជំនួយ សូមហៅទូរសព្ទមកយើងខ្ញុំតាមរយៈលេខដែលមានចុះនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក ឬ 1-888-249-5194 ។ ដើម្បីអានឯកសារច្រើនទៀត សូមហៅទូរសព្ទទៅផ្នែក CA នៃក្រុមហ៊ុនធានារ៉ាប់រងតាមរយៈលេខ 1-800-927-4357។

Korean:

무료 통역/번역 서비스 제공 통역 서비스를 이용하실 수 있습니다. 원하는 언어로 문서 내용을 듣고 일부 내용은 문서로 받으실 수도 있습니다. 관련하여 도움이 필요하시면 ID 카드에 안내된 번호 또는 1-888-249-5194 번으로 연락주시기 바랍니다. 더 자세한 안내가 필요하시면 CA Dept. of Insurance (1-800-927-4357) 로 문의해 주세요.

Persian:

خدمات زبانی رایگان می توانید از خدمات یک مترجم لفظی بهره مند شوید. می توانید بخواهید تا مدارک برای شما خوانده شود و بعضی از آنها به زبان تان به شما ارسال شود. برای دریافت کمک، از طریق شماره مندرج در کارت شناسایی تان 1-888-249-5194 یا ما تماس بگیرید. برای دریافت کمک مکمل، با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید.

Punjabi:

ਬਿਨਾਂ ਲਾਗਤ ਦੇ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਹਾਨੂੰ ਇੱਕ ਦੁਆਰੀਆ ਮਿਲ ਸਕਦਾ ਹੈ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ ਅਤੇ ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ID ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਜਾਂ 1-888-249-5194 'ਤੇ ਸਾਨੂੰ ਕਾਲ ਕਰੋ। ਹੋਰ ਮਦਦ ਲਈ, ਕੈਲੀਫੋਰਨੀਆ ਸ਼ੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 'ਤੇ ਕਾਲ ਕਰੋ।

Russian:

Бесплатные услуги перевода. Вам могут предоставить переводчика. Вам могут зачитать документы на вашем родном языке, а также отправить некоторые из них в переводе на нужный вам язык. Чтобы получить помощь, позвоните нам по номеру, указанному на вашей карте участника плана, или по номеру 1-888-249-5194. Кроме того, вы можете обратиться за помощью в Департамент страхования Калифорнии, позвонив по номеру 1-800-927-4357.

Tagalog:

Mga Serbisyo sa Wika na Walang Bayad. Maaari kang makakuha ng interpreter. Maaari mong ipabasa ang mga dokumento sa iyo o ipapadala ang mga ito sa iyo sa iyong wika. Para sa tulong, tumawag sa amin sa numerong nakalista sa iyong ID card o sa 1-888-249-5194. Para sa higit pang tulong, tumawag sa CA Dept. of Insurance sa 1-800-927-4357.

Thai

ไม่มีค่าบริการเกี่ยวกับภาษา ท่านสามารถขอใช้บริการได้ ท่านสามารถขอให้เจ้าหน้าที่อ่านเอกสารได้ท่านฟังและเอกสารบางอย่างจะส่งถึงท่านโดยใช้ภาษาของท่าน หากต้องการความช่วยเหลือ โปรดโทรหาเราตามหมายเลขที่ระบุอยู่บนบัตรประจำตัวของท่านหรือที่หมายเลข 1-888-249-5194 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดต่อตามแผนก CA Dept. of Insurance ที่หมายเลข 1-800-927-4357

Vietnamese:

Các dịch vụ ngôn ngữ miễn phí. Bạn có thể có một phiên dịch viên. Bạn có thể được nghe hoặc nhận tài liệu bằng ngôn ngữ của bạn. Để nhận hỗ trợ, hãy gọi cho chúng tôi qua số điện thoại trên thẻ ID hoặc qua 1-888-249-5194. Để nhận thêm hỗ trợ, hãy gọi tới Cơ quan Bảo hiểm của CA qua số 1-800-927-4357.