Employee Section

Underwriter Documents

avēsis

Holland Enterprises LLC
50790-264
050130CYL6

☐ I am Waiving Vision Insurance

AVĒSIS ADVANTAGE VISION CARE EMPLOYEE ENROLLMENT FORM

PLEASE PRINT LEGIBLY

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

Policy No. VC-16

TO BE COMPLETED BY THE EMPLOYEE

Employee Last Name	*Employee First Name*	*MI*

Date of Birth / /	*Social Security Number* - -	*Sex* ☐ Male ☐ Female

Street Address	*Apartment No.*

City	*State*	*Zip Code* -

Do you wish to cover your eligible dependents? ☐ Yes ☐ No

If yes, complete the following:

	Dependent Name	*Date of Birth*
Spouse/Domestic Partner		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /

☐ ***I would like to cover additional eligible dependents*** (PLEASE LIST ON A SECOND ENROLLMENT FORM)

By signing below, I agree to receive all documents and correspondence electronically and that I can access the internet or the email address provided. I understand that I may revoke this authorization or request specific paper documents without revoking this authorization by contacting the Company {or Administrator} by mail, email, or telephone.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 and subjects such person to criminal and civil penalties.

I authorize deductions from my earnings at the required contributions towards the cost of the coverage.

Signature	*Date* / /

TO BE COMPLETED BY THE EMPLOYER

☐ **New Enrollment**	☐ **Add** ☐ Dependents	☐ **Change** ☐ Address ☐ Name ☐ Phone ☐ COBRA	☐ **Cancel Coverage** ☐ Policy Holder ☐ Dependent(s)
Reason for Change	☐ Employment Status ☐ Qualifying Event: (PLEASE STATE) _____		
Requested Effective Date / /		*Date of Employment* / /	

A-00713
M-9059/M-9069/M-9086

REV 6/22

FIDELITY SECURITY LIFE INSURANCE COMPANY
3130 Broadway • Kansas City, Missouri 64111-2406 • (800) 648-8624

Group Insurance Certificate Providing Limited Benefits for Vision Care Non-Participating

This Certificate will take the place of any and all Certificates and Riders which may have been issued to You at a prior time under the Policy.

GENERAL INFORMATION

About Your Insurance - This Certificate explains the plan of insurance which is underwritten by Fidelity Security Life Insurance Company. Read it closely to become familiar with Your plan. An individual identification card will be issued to You containing Your Group Number and Your Effective Date.

Important Notice - Benefits are payable only for expenses incurred while this insurance is in force. No agent has the right to change the Policy or to waive any part of it. The Policy under which this Certificate is issued may at any time be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice to any person who claims rights or benefits under the Policy. The insurance under the Policy does not take the place of nor does it affect any requirements for coverage by Workers' Compensation or a similar type of insurance. The benefits for Dependents which are described in this Certificate will be applicable to Your Dependents only if You make application to have Your Dependents insured.

DEFINITIONS

The following terms have specific meaning as used in the Policy.

Covered Person means an employee meeting the eligibility requirements of the Policy who is covered for benefits. Covered Person will also include Your Dependents, if enrolled.

Dependent means any of the following persons: 1) Your lawful spouse includes Your Domestic Partner, as defined; 2) Each unmarried child from birth to age 22 who is primarily dependent upon You for support and maintenance; 3) Each unmarried child at least 22 years of age to age 26 who is primarily dependent upon You for support and maintenance and who is a full-time student; or 4) Each unmarried child at least 22 years of age: who is primarily dependent upon You for support and maintenance because the child is incapable of self-sustaining employment by reason of mental incapacity or physical handicap; who was so incapacitated and is a Covered Person under this Policy on his or her 22nd birthday; and who has been continuously so incapacitated since his or her 22nd birthday.

Dependent also means: 1) Your Dependents' unmarried children from birth to age 22 who are primarily dependent upon You for support and maintenance; 2) Your Dependents' unmarried children at least 22 years of age to age 26 who are primarily dependent on You for support and maintenance and who are full-time students; 3) Your Dependents' unmarried children at least 22 years of age who are primarily dependent on you for support and maintenance because they are incapable of self-sustaining employment by reason of mental incapacity or physical handicap, who are so incapacitated and are Covered Persons under this Policy on their 22nd birthday, and who have been continuously so incapacitated since their 22nd birthday. Child includes stepchild, foster child, legally adopted child, child legally placed in your home for adoption, and child under your legal guardianship. A full-time student is one who is enrolled at least 12 semester hours for credit in the case of an accredited junior college, college or university; and, in the case of a trade school, is enrolled in a course requiring attendance of 15 or more hours weekly for six or more months.

Domestic Partner means two same-sex adults who are in a committed relationship and mutually responsible for one another financially and otherwise. To qualify as a Domestic Partner, or Dependent under the Policy, the following conditions must all be met: 1) the Domestic Partner and employee are over the age of 18 and mentally competent to enter into contracts; 2) the Domestic Partner and employee reside in the same household together; 3) the Domestic Partner and employee have a committed relationship with each other for no less than six months; intend to continue the relationship indefinitely and have no such relationship with any other person; 4) the Domestic Partner and employee are not related by blood; 5) the Domestic Partner and employee are not married to any third party; 6) the Domestic Partner and employee are of the same sex; 7) the Domestic Partner and employee are not claiming Dependent status for the primary reason of gaining insurance coverage under the Policy.

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.

TEN-DAY RIGHT TO EXAMINE

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's Certificate within 10 days after receipt. The premium will then be refunded. When 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.

Policy means the Policy issued to the Policyholder.

Policyholder means the Employer named as the Policyholder on the face of the Policy.

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 a comprehensive ophthalmological service as defined in the Current Procedural Technology (CPT) and the Documentation Guidelines listed under "Eyes-examination items". Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated by examination: biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

Vision Materials means corrective lenses and/or frames or contact lenses.

We, Our, Us means Fidelity Security Life Insurance Company.

You, Your, Yours means the employee covered under the Policy.

DEFINITIONS
(PPO and Non-PPO)

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

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

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

Preferred Provider Organization ("PPO") means a network of Providers and retail chain stores within the PPO Service Area who have signed Preferred Agreements with the Company.

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

EFFECTIVE DATES

Effective Date of Employee's Insurance - Your insurance will be effective as follows: 1) If the Policyholder does not require You to contribute towards the premium for this coverage, Your insurance will be effective on the date You became eligible; 2) If the Policyholder requires You to contribute towards the premium for this coverage, Your insurance will be effective on the date You became eligible, provided; a) You have given Us Your enrollment form (if required) on, prior to, or within 30 days of the date You became eligible; and b) You have agreed, in writing, to pay the required contributions; 3) If You fail to meet the requirements (a) and (b) within 30 days after becoming eligible, Your coverage will not become effective until We have verified that You have met these requirements. You will then be advised of Your effective date.

Effective Date of Dependent's Insurance - Coverage for Dependents becomes effective on the later of: 1) the date Dependent Coverage is first included in Your coverage; or 2) the premium due date on or after the date the person first qualifies as Your Dependent. If an enrollment form is required, You must provide such form and agree to pay any premium contribution that may be required prior to coverage becoming effective.

Newborn Children - If a Dependent is covered under Your Certificate, a Dependent child born while this Certificate is in force shall be covered from the moment of birth for 31 days. In order to continue coverage beyond this 31-day period, You must send Us notice and agree to pay any premium contributions that may be required by the Policyholder within this 31-day period.

Adopted Children - If a Dependent child is placed with You for adoption while the Certificate is in force, such child will be covered from the date of placement for 31 days. In order to continue coverage beyond this 31-day period, You must send in notice and agree to pay any premium contributions that may be required by the Policyholder within this 31-day 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.

SCHEDULE OF BENEFITS

Covered Persons have the right to obtain vision care from the Provider of their choice. However, payment of the Benefit varies depending on the type of Provider chosen. Benefits are payable as shown in the following Schedule:

Benefit	Preferred Provider	Non-Preferred Provider (Up to a Maximum Dollar Amount of):	Benefit Period
Vision Examination:	$10.00 copayment	$35.00	12 Months
Vision Materials:	$10.00 copayment	N/A	
Standard Lenses			12 Months
Single	Paid in full after copayment	$25.00	
Bifocal	Paid in full after copayment	$40.00	
Trifocal	Paid in full after copayment	$50.00	
Lenticular	Paid in full after copayment	$80.00	
Standard Progressives	$120.00	$40.00	
Frames	$50.00	$45.00	12 Months
*Contact Lenses**			12 Months
Elective	$130.00	$110.00	
Medically Necessary	Paid in full	$250.00	

**Contact Lenses* includes fit, follow-up and Materials.

Any services which cannot be obtained by a Preferred Provider within the PPO Service Area because: 1) due to their specialized nature, there is no Preferred Provider located within the PPO Service Area; 2) are provided by a Provider not in the PPO Service Area; and 3) are specifically authorized in advance by the Covered Person's Provider and approved by the Company, shall be paid in accordance with the Schedule of Benefits, without further deductions, subject to all Policy maximums, limitations, conditions and exclusions.

Benefit Period for Vision Examination is shown in the Schedule of Benefits and begins on the Policy Effective Date.

Benefit Period for Vision Materials is shown in the Schedule of Benefits and begins on the Policy Effective Date.

Vision Examination Benefit - A Covered Person is eligible for one Vision Examination in each successive Benefit Period.

Vision Materials Benefit - If a Vision Examination results in a Covered Person needing corrective Vision Materials for their visual health and welfare, those Vision Materials prescribed by Providers will be supplied, subject to certain limitations and exclusions of the Policy, as follows:

- Lenses - Up to two lenses provided one time in each successive Benefit Period.
- Frame - One frame provided one time in each successive Benefit Period.
- Contact Lenses - Contact lenses benefit provided in lieu of lenses and/or frame.

LIMITATION

Vision Examination and Vision Materials - Fees charged by a Provider for services other than Vision Examination or covered Vision Materials must be paid in full by the Covered Person to the Provider. Such fees or materials are not covered under this Policy.

Benefit allowances provide no remaining balance for future use within the same Benefit Period, except for Contact Lenses benefit.

EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from: 1) Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes, or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear, required by an Employer as a condition of employment and safety eyewear, unless specifically covered under the Policy; 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; or 8) Services or materials provided by any other group benefit plan providing vision care.

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

TERMINATION OF INSURANCE

For all Covered Persons - All Covered Persons' insurance will end automatically on the earliest of the following dates: a) The date the Policy ends; b) The end of the last period for which any required contribution agreed to in writing has been made; c) The date You are no longer eligible for insurance; d) The date Your employment with the Employer ends. Your coverage will end on the last day of the month in which employment ends. The Employer may, at its option, continue insurance for individuals whose employment has ended, if it: (i) does so without individual selection between employees; and (ii) if it continues making premium payments for those individuals.

For Dependents - A Dependent's insurance will automatically stop on the earlier of: a) the date Your coverage ends; b) the end of the month in which the Dependent ceases to be Your Dependent; c) the end of the last period for which any required contribution has been made.

A Dependent Child will not cease to be a Dependent solely because of age if the child is: a) not capable of self-sustaining employment due to mental incapacity or physical handicap that began before the age limit was reached; and b) mainly dependent on You for support.

You must provide proof of the eligible child's incapacity and dependency within thirty-one days of the child's attainment of the limiting age at which the Dependent would otherwise cease to be covered.

We may require the same proof again, but We will not ask for it more than once a year after this coverage has been continued for two (2) years. This continued coverage will end: a) on the date the Policy ends; b) the date the incapacity or dependency ends; c) the last day of the month for which required premium for the child is paid; or d) 60 days after the date We request proof which is not given to Us.

CLAIMS

Notice Of Claim. Written notice of claim must be given: (a) within 30 days after a covered loss begins; or (b) as soon as reasonably possible after that. This notice may be given to Us at Our Home Office or to Our Administrator. Notice should include the Covered Person's name and the Policy and Certificate numbers.

Claim Forms. When We receive notice of claim, We will send the claimant forms for filing proof of loss within 15 days. If claim forms are not supplied within this 15-day period, a claimant may submit proof in writing, setting forth the nature and extent of the loss.

Proof Of Loss. Proof of loss must be furnished to Us within 90 days after the date of loss. We will not deny or reduce a claim if it was not reasonably possible to give Us proof within the time allowed. In any event, the Covered Person must give Us proof within one (1) year after it is due unless he is legally incapacitated.

Time Of Payment Of Claims. Immediately after receiving written proof of loss, We will pay all benefits then due a Covered Person.

Payment Of Claims. All claims will be paid to You, unless We have the obligation to pay the facility or Provider directly. However, in the event a benefit becomes payable to Your estate, We may pay such benefit, up to an amount equal to $1,000, to any relative by blood or connection by marriage whom We deem to be equitably entitled thereto. Payment made in good faith fully discharges Us to the extent of any payments made.

Legal Actions. No legal actions may be brought to recover under the Policy: (1) within 60 days after written proof of loss has been furnished as required; or (2) after three years (five years in Kansas and six years in South Carolina) from when written proof of loss is required.

Claim Appeal Procedure. If We partially or fully deny a claim for benefits submitted by a Covered Person and he or she disagrees or does not understand the reasons for this denial, the Covered Person may appeal this decision, and they have the right to: 1) Request a review of the denial; 2) Review pertinent plan documents; and 3) Submit in writing, any data, documents or comments which are relevant to Our review of this denial.

The Covered Person's appeal must be submitted in writing within 180 days of receiving written notice of denial. We will review all information and send written notification within 60 days of the Covered Person's request.

GENERAL PROVISIONS

Entire Contract. The Policy is a legal contract. It is between the Policyholder and Us. The entire contract consists of: (1) the Policy, the Certificate, endorsements and attachments, if any; (2) the Policyholder's Application; and (3) the employees' enrollment forms, if any. Any statement made by the Policyholder or by a Covered Person in an application will, in the absence of fraud, be deemed a representation and not a warranty. No such statement will void the coverage or reduce the benefits or be used in defense to a claim unless it is in writing and a copy of the application is furnished to the Covered Person.

Modification Of Policy. The Policy may be modified at any time by agreement between the Policyholder and Us without consent of any employee. No modification will be valid unless approved by one of Our officers: (1) the President; (2) a Vice President; or (3) the Secretary. The approval must be endorsed on or attached to the Policy. No agent has authority to modify the Policy or waive any of the Policy's provisions to extend the time for premium payment by making any promise or representation.

Incontestability. The validity of the Policy shall not be contested except for non-payment of premiums, fraudulent misstatements or material misrepresentations after it has been in force for two (2) years. Coverage under this Certificate shall not be contested except for non-payment of premiums or material misrepresentation after it has been in force for two (2) years. No statement, except fraudulent misstatements, made by You relating to: 1) Your insurability; or 2) The insurability of Your Dependents; shall be used in contesting the validity of the coverage of the person about whom the statement was made after coverage has been in force for a period of two (2) years. Any such statement must be contained in a written instrument signed by You, a copy of which has been furnished to You.

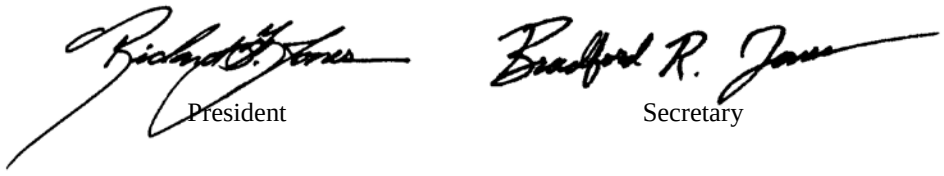
Fraud. If You or the Policyholder commits fraud pertaining to an employee against Us, as determined by a court of competent jurisdiction, Your coverage will end automatically without notice.

Misstatement Of Age. If a Covered Person's age has been misstated, the benefits will be those which the premium paid would have bought for the correct age. If a Covered Person's correct age was over the maximum issue age, coverage will be voided and the premiums paid for such Covered Person will be refunded.

Assignment Of Benefits. You may assign Your benefits. However, an assignment is not binding until We have received and acknowledged in writing the original or copy of the assignment before payment of the benefit. We do not guarantee the legal validity or effect of such assignment.

Grace Period. A grace period of 31 days will be allowed for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. If the premium is not paid within the grace period, coverage will terminate as of the premium due date. The grace period will not apply if the Covered Person gives written notice to Us of his or her intent not to continue this coverage.

FIDELITY SECURITY LIFE INSURANCE COMPANY



President Secretary

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REFRACTIVE SURGERY BENEFIT RIDER

This Rider amends the Policy/Certificate to which it is attached. The following refractive surgical benefits are added:

DEFINITIONS

Injury means a bodily Injury sustained directly and independently of all other causes resulting in a covered loss under this Rider.

LASEK (Laser Assisted Epithelium Keratomileusis) means a slight variation of the traditional LASIK procedure as described below. This surgical procedure utilizes a trephine to create an epithelial flap (as opposed to the deeper stromal flap with LASIK) and an alcohol solution to preserve the epithelial cells. Once the epithelial flap is created and lifted, the treatment proceeds as for traditional PRK, with light smoothing at its conclusion. The epithelial flap is then repositioned with a small spatula.

LASIK (Laser Assisted In-Situ Keratomileusis) means a surgical procedure involving the use of a computer-controlled excimer laser to reshape the cornea (epithelium) without invading the adjacent cell layers. An automated microkeratome is used to shave off a thin, hinged layer of the cornea that is lifted, and the exposed surface is reshaped using the laser. After altering the cornea curvature, the flap is replaced and is adhered without stitches. In **IntraLase Initiated LASIK**, a special laser is used instead of a blade to create the flap. In **Custom Wavefront** or **Wavefront-Guided LASIK** procedures, a 3-dimensional measurement of how the eye processes images is used to guide the laser in re-shaping the front part of the eye (cornea).

PRK (Photorefractive Keratectomy) means a surgical procedure involving removal of the surface layer of the cornea by gentle scraping and use of a computer-controlled excimer laser to reshape the stroma.

Physician means an Ophthalmologist or Optometrist licensed under applicable state law to perform the surgical procedures for which benefits are payable under this Rider, and who is acting within the lawful scope of his or her license to render such service. A Physician cannot be the Covered Person or a member of the Covered Person's Immediate Family. "Immediate Family" means the Covered Person or the Covered Person's spouse, parent, child, grandparent, brother, sister, in-law or any person residing with the Covered Person.

Refractive Surgery means a surgical procedure which permanently alters the focusing power of the eye(s) in order to change refractive errors.

BENEFITS

Refractive Surgery Benefit. We will pay a one-time surgical indemnity benefit of $ 150.00 (per Covered Person) for one of the following refractive surgical procedures to one or both eyes: LASIK (including Custom Wavefront, Wavefront-Guided or IntraLase initiated LASIK), LASEK or PRK, if performed by a Physician on a Covered Person while covered under this Rider, subject to the Exclusions provision.

EXCLUSIONS

Refractive Surgery Vision Benefit Exclusions
Benefits are not payable for any of the following:

1. Routine vision examinations or corrective vision materials, including corrective eyeglasses, fittings, lenses, frames or contact lenses; or
2. Medical or surgical procedures, services or treatments:
   a. not specifically covered under this Rider;
   b. provided free of charge in the absence of insurance;
   c. payable under any Workers' Compensation law, or similar statutory authority;
   d. payable under any governmental plan or program whether Federal, state or subdivisions thereof.

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

FIDELITY SECURITY LIFE INSURANCE COMPANY

President Secretary

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AMENDMENT RIDER

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

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

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

FIDELITY SECURITY LIFE INSURANCE COMPANY

Bryson T. Jones — President

Bradford R. James — Secretary

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NOTICE OF PROTECTION PROVIDED BY THE NORTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the North Dakota Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under North Dakota law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with North Dakota law, with funding from assessments paid by other insurance companies.

The protections provided by the Association are based on contract obligations up to the following amounts:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of type of coverage is $300,000; however, may be up to $500,000 with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. If coverage is available, it will be subject to substantial limitations. There are also various residency requirements and other limitations under North Dakota law. To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ndlifega.org or contact:

North Dakota Life & Health Insurance
Guaranty Association
P.O. Box 2422
Fargo, North Dakota 58108

North Dakota Insurance Department
600 East Boulevard Avenue, Dept. 401
Bismarck, ND 58505

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

A written complaint to allege a violation of any provision of the Life and Health Insurance Guaranty Association Act must be filed with the North Dakota Insurance Department, 600 East Boulevard Avenue, Dept. 401, Bismarck, North Dakota 58505; telephone (701) 328-2440. Financial information for an insurance company, if the information is not proprietary, is available at the same address and telephone number and on the Insurance Department website at www.nd.gov/ndins.

Insurance companies and agents are not allowed by North Dakota law to use the existence of the Association or its coverage to sell, solicit or induce you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and North Dakota law, then North Dakota law will control.

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LENS OPTIONS BENEFIT RIDER

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

BENEFIT

Lens Option. If a Covered Person is prescribed corrective Lenses by a Provider for the Covered Person's visual health and welfare and the Lenses are covered under the Policy, the Lens Options are payable as shown below in the Schedule of Benefits.

For this Rider, "Lens Option" means any of the following: transitions lenses, progressive lenses (premium).

SCHEDULE OF BENEFITS

Benefit	Preferred Provider	Non-Preferred Provider	Benefit Period
Lens Option Allowance	$140.00	$48.00	12 months

LIMITATION

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

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

FIDELITY SECURITY LIFE INSURANCE COMPANY

Bryson T. Jones — Bradford R. James

President — Secretary

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NOTICE OF ADMINISTRATOR'S CAPACITY

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

1. Fidelity Security Life Insurance Company (FSL) has, by agreement, arranged for Avesis Third Party Administrators, LLC. to provide administrative services for your insurance plan. As administrator, Avesis Third Party Administrators, LLC. may be authorized to market, underwrite, bill and collect premiums, process claims payment, and perform other services, according to the terms of its agreement with the insurance company. Avesis Third Party Administrators, LLC. 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.

If Avesis Third Party Administrators, LLC. 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 Avesis Third Party Administrators, LLC. than would otherwise be afforded to you by law.

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes how the Company, (herein referred to as "we", "our" or "us"), protects personal health information we have about you which relates to our medical, dental, vision and prescription drug coverage. Protected Health Information ("PHI") is individually identifiable information about you. All of the following are examples of PHI: demographic information like your name, address and social security number; health information that relates to your past, present or future physical or mental health that is collected, created or received from you, a health care provider, a health plan, employer or a health care clearinghouse; the providing of health care; or the past, present or future payment for providing health care to you.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your PHI. We are required to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect February 1, 2022, or the date coverage became effective for you, whichever is later, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time. The new terms of our notice will be effective for all PHI that we maintain, including PHI we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and send the new notice to you at the time of change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the "Contact Information" provided at the end of this Notice.

Uses and Disclosures of Your PHI

In conducting our business we may create, receive and maintain PHI records regarding you and the insurance services we provide you. The main reasons for which we may use and may disclose your PHI are to evaluate and process any requests for medical coverage and claims for benefits you may make. The following describe these and other uses and disclosures, together with some examples:

For Treatment: We may use or disclose your PHI to facilitate medical treatment by providers. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to treat you. We may request the services of a business associate to assist us in these activities.

For Payment: We may use and disclose your PHI to facilitate payment of benefits under your insurance coverage. For example, we might disclose your PHI to determine your eligibility for benefits, to coordinate benefits with other insurance carriers, to examine medical necessity, to obtain payments including obtaining payment under a contract for re-insurance, and related health care data processing, and to issue explanations of benefits. We also may use your PHI to obtain payment from third parties that may be responsible for your premium payments, such as family members.

For Health Care Operations: We may use and disclose your PHI as necessary, and as permitted by law, for our health care operations. Health care operations include: (i) rating our risk and determining our premiums for your insurance; (ii) conducting quality assessment and improvement activities; (iii) conducting or arranging for medical review, legal services, audit services, fraud and abuse detection and compliance programs; and (iv) business planning and development.

On Your Authorization: You may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. You should understand that we will not be able to take back any disclosures we have already made with authorization. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this notice. We also need to obtain your prior written authorization if your PHI relates to psychotherapy notes or where the PHI is to be used for marketing or sales purposes.

To Your Family and Friends: We may disclose your PHI to a family member, friend, or other person to the extent necessary to help with your health care or for payment of your health care. We may use or disclose your name, location and general condition or death to notify, or assist in the notification, of (including identifying or locating) a person involved in your care.

Before we disclose your PHI to a person involved with your health care or payment for your health care, we will provide you with an opportunity to object to such uses or disclosures. If you are not present, or in the event of your incapacity or an emergency, we will disclose your PHI based on our professional judgment of whether the disclosure would be in your best interest.

To Your Employer or Organization Sponsoring Your Health Plan: We may disclose your PHI and the PHI of others enrolled in your group insurance plan to the employer or other organization that sponsors your group insurance plan to permit the plan administrator to perform plan administration functions. We may also disclose summary information about the enrollees in your group insurance plan to the plan administrator to use to obtain premium bids for the health insurance coverage offered through your group insurance plan or to decide whether to modify, amend or terminate your group insurance plan. The summary information we may disclose may summarize claims history, claims expenses, or types of claims experienced by the enrollees in your group insurance plan. The summary information will be stripped of demographic information about the enrollees in the group insurance plan, but the plan administrator may still be able to identify you or other participants in your group health plan from the summary information. We may also disclose enrollment and disenrollment information to either the plan administrator or plan sponsor of your group insurance plan.

For Underwriting: We may receive your PHI for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. We will not use or further disclose your PHI for any other purpose, except as required by law, unless the contract of health insurance or health benefits is placed with us, or where we disclose such information to MIB, LLC., a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. In those cases, our use and disclosure of your PHI will only be as described in this notice. We are also prohibited from using or disclosing your genetic information for underwriting.

For the Public Benefit: We may use or disclose your PHI without your authorization when required or permitted by law for the following purposes deemed in the public interest or benefit:

- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to organ procurement organizations;
- to avert a serious threat to health and safety;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

To Avert a Serious Threat to Health or Safety: We may disclose PHI to avert a serious threat to someone's health or safety. We may also disclose PHI to federal, state or local agencies engaged in disaster relief, as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.

To Business Associates: Certain aspects and components of our business are preformed through contracts with outside persons or organizations. Examples of these outside persons and organizations include our duly appointed insurance agents, third party administrators, financial auditors, actuarial and underwriting services, reinsurers, legal services, enrollment and billing services, claim payment and medical management services and collection agencies. At times it may be necessary for us to provide your PHI to one or more of these outside persons or organizations who assist us with our payment or health care operations. In all cases, we disclose only the minimum information necessary for these business associates to perform their responsibilities, and we require them to abide by specific HIPAA rules to appropriately safeguard the privacy of your information.

For Disclosures of PHI Deemed Highly Sensitive or Confidential: For certain kinds of PHI, federal and state law may require enhanced privacy protection. These may include PHI that is (1) About alcohol and drug abuse prevention, treatment and referral; (2) About HIV/AIDS testing, diagnosis or treatment; (3) About genetic testing; or (4) About psychotherapy notes. If the PHI is subject to enhanced protection, we can only disclose it with your prior written authorization unless specifically permitted or required by law.

Your Rights Regarding PHI That We Maintain About You

The following are your various rights as a consumer under HIPAA concerning your PHI. Should you have questions about or wish to exercise a specific right, please contact us in writing using the "Contact Information" provided at the end of this Notice.

Right to Inspect and Copy Your PHI: In most cases, you have the right to inspect and/or obtain an electronic or hard copy of the PHI that we maintain about you. You may also send a written request designating another individual to receive your PHI on your behalf. Written requests must be signed and dated by you or your personal representative using the "Contact Information" provided at the end of this Notice. The request must clearly identify the individual to receive your PHI. We may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. However, certain types of PHI will not be made available for inspection and copying. This includes psychotherapy notes and PHI collected by us in connection with, or in reasonable anticipation of any claim or legal proceeding. In very limited circumstances we may deny your request to inspect and obtain a copy of your PHI. If we do, you may request that the denial be reviewed. The review will be conducted by an individual chosen by us who was not involved in the original decision to deny your request. We will comply with the outcome of that review.

Right to List of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your PHI for purposes other than for treatment, payment, health care operations, purposes of national security, to law enforcement, to corrections personnel, directly to you or as otherwise authorized by you during the six years prior to the date the accounting is requested. For example, we would account for your PHI or demographic information we disclose during an audit by an insurance department or pursuant to a court order. You must make your request in writing using the "Contact Information" provided at the end of this Notice. Your request should indicate in what form you want the list (for example, paper or electronic). If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on PHI we use or disclose about you for treatment, payment or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, we are not required to agree to it. If we do agree to it, we will comply with your request. To request a restriction, you must make your request in writing using the "Contact Information" provided at the end of this Notice. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). We will not agree to restrictions on PHI uses or disclosures that are legally required, or which are necessary to administer our business.

Unauthorized Access: You are entitled to receive notification of unauthorized access to your PHI. We maintain physical, electronic and procedural safeguards that are compliant with applicable federal and state privacy laws. However, if your PHI is ever compromised, we will notify you of the incident.

Right to Request Confidential Communications: You have the right to request that we communicate with you about PHI in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing using the "Contact Information" provided at the end of this Notice and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Amend Your PHI: If you believe that your PHI is incorrect or that an important part of it is missing, you have the right to ask us to amend your PHI while it is kept by or for us. You must provide your request and your reason for the request in writing using the "Contact Information" provided at the end of this Notice. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend PHI that: (i) is accurate and complete; (ii) was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment; (iii) is not part of the PHI kept by or for us; or (iv) is not part of the PHI which you would be permitted to inspect and copy.

Right to Notification Following a Breach of Unsecured Protected Health Information: We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with us using the "Contact Information" provided at the end of this Notice. All complaints must be submitted in writing. You may file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling (877) 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. You will not be retaliated against for filing a complaint.

Contact Information: If you have questions regarding this Notice or need further assistance regarding this Notice, please contact us at:

Contact Office: Fidelity Security Life Insurance Company, HIPAA Customer Service
Telephone: 800-648-8624 Fax: 816-968-0660
Address: 3130 Broadway, Kansas City, MO 64111-2406