FIDELITY SECURITY LIFE INSURANCE COMPANY®

2600 Grand Blvd., Suite 900
Kansas City, Missouri 64108-4626
Phone 800-648-8624
A STOCK COMPANY
(Herein Called "the Company")

POLICY NUMBER: VC-146

POLICYHOLDER: State of Tennessee

POLICY EFFECTIVE DATE: January 1, 2023

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

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

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

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

Bryson T. Jones — President

Bradford R. James — Secretary

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.

TABLE OF CONTENTS

DEFINITIONS

Agency Benefits Coordinator (ABC) means a designated and trained employee of the Employer who assists BA to facilitate enrollment, terminations, and guidance to Members related to the vision benefits.

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

Annual Enrollment means a period designated by BA within the current Plan Year during which eligible Employees or Retirees may make coverage elections for the upcoming Plan Year.

Benefits Administration (BA) means a division of the Department of Finance and Administration which performs administrative functions for the State, Local Education, and Local Government Insurance Committees and for the Vision Plan.

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.

Consolidated Omnibus Budget Reconciliation Act (COBRA) means the federal law that allows Employees, Spouses, and Dependents to extend their insurance for a specified length of time after losing coverage if certain conditions are satisfied.

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

Company means Fidelity Security Life Insurance Company.

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

Dependent means an individual who meets the following eligibility criteria based upon an Employee or Retiree's eligibility. An individual cannot enroll as an Employee and as a Dependent under the same group plan (state, local education, or local government.) If both parents of a child qualify as eligible Employees, only one Employee (parent) can enroll Dependent children.

1. A legally married spouse;
2. A child under the age of 26 who meets at least one of the following criteria without consideration of factors such as financial dependency, marital status, enrollment in school, or residency:
   a. Subscriber's natural (biological) child,
   b. Subscriber's adopted child (including a child placed for adoption in anticipation of adoption);
3. A Subscriber's or spouse's stepchild under the age of 26;

4. A person under age 26 who is placed with the Subscriber by a valid order of guardianship, custody, or conservatorship (or legally equivalent order) by a court of competent jurisdiction ("placement order") as provided below:
   a. The Subscriber must provide certification upon enrollment and upon request that: the placement order is in effect and has not expired by subsequent court order or by operation of law, and the Subscriber shall immediately notify Benefits Administration when the placement order terminates or expires.
   b. If a placement order terminates or expires due to the person attaining the legal age of majority, the person may remain an eligible Dependent until age 26 if the Subscriber certifies that the following requirements in (i), (ii) and (iii) are met:
      i. The Subscriber and the person have a relationship as set forth in 26 U.S.C. §152(d)(2), which includes the following relationships:
         (1) The person is a descendant of a son/daughter, stepson/stepdaughter of the Subscriber;
         (2) The person is a brother/sister, half-brother/half-sister, stepbrother/stepsister, son/daughter-in-law, brother/sister-in-law, or niece/nephew of the Subscriber; or
         (3) The person has the same principal place of abode as the Subscriber and is a Member of the Subscriber's household; and
      ii. The Subscriber provides over one-half of the person's financial support for the calendar year in which the Subscriber's taxable year begins; and
      iii. The person is a U.S. citizen, a U.S. national, or a resident of the U.S., Mexico, or Canada; or
   c. Additional documents and certifications may be requested to establish that the person is an eligible Dependent.
5. Dependents over the age of 26 years who meet at least one of the criteria in 2 or 3 in this section and who are incapacitated (mentally or physically incapable of earning a living regardless of age, provided the Dependent is incapable of self-sustaining employment). This provision applies only when the incapacity existed before the Dependent's 26th birthday and the Dependent was enrolled in this vision plan prior to and on their 26th birthday. A request to continue coverage due to incapacity must be provided to Benefits Administration prior to the Dependent's 26th birthday.

Dependents not eligible for coverage include:
   a. Children in the care, custody or guardianship of the Tennessee Department of Children's Services or equivalent placement agency, who are placed with the Subscriber for temporary or long-term foster care, but not including a person who is placed with the Subscriber for the purpose of adoption;
   b. Dependents not listed in the above definitions;
   c. Parents of the Employee/Retiree or spouse;
   d. Ex-spouse; and
   e. Live in companions who are not legally married to the Employee/Retiree.

Employee means a State Employee, Local Education Employee, or Local Government Employee as defined below.

State Employee means:

1. An individual employed by the Employer, who is regularly scheduled to work not less than 30 hours per week;
2. An individual who has received a seasonal appointment and who meets the requirements set forth in TCA 8-27-204(a)(3); or
3. All other individuals required by applicable state or federal law and individuals during periods that they are covered on the state medical benefit plan during a federally mandated stability period.

Local Education Employee means an Employee of participating agency who is:

1. A teacher as defined in TCA 8-34-101-(49);
2. An interim teacher whose salary is based on the local school system's schedule;
3. An Employee not defined in 1 or 2 in this section who is regularly scheduled to work at least 30 hours per week in a non-seasonal, non-temporary position;

4. A non-certified Employee who has completed 12 months of employment with a local education agency that participates in the local education insurance plan and works a minimum of 25 hours per week [a resolution passed by the school system's governing body authorizing the expanded 25-hour rule for the local education agency must be sent to the Policyholder - Benefits Administration before enrollment]; or
5. All other individuals required by applicable state or federal law and individuals during periods that they are covered on the state medical benefit plan during a federally mandated stability period.

Local Government Employee means an individual who is:

1. Scheduled to work at least 30 hours per week in a non-seasonal, non-temporary position;
2. A Member of the chief legislative body of the county or municipal government (defined as only those elected officials who have the authority to pass local legislation); or
3. A utility district commissioner appointed or elected pursuant to TCA 7-82-307, but only during their term of service.
4. A county official, as defined in TCA 8-34-101(9)(A) and (B), regardless of whether the county participates in the local government plan, pursuant to TCA 8-27-704(a); or
5. All other individuals required by applicable state or federal law and individuals during periods that they are covered on the state medical benefit plan during a federally mandated stability period.

Employer means the Policyholder and all affiliated employers, including central state government, state higher education, local government agencies and local education agencies that offer this State of Tennessee Group Vision Insurance Program.

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

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

Low Vision means a severe visual loss that is not correctable with standard lenses and:

1. when the best-corrected acuity is 20/200 or less in the better eye with best conventional spectacle or contact lenses prescription; or
2. when there can be a demonstrated constriction of the peripheral fields in the better eye to 10 degrees or less from the fixation point or the widest diameter subtends an angle less than 20 degrees in the better eye.

Low Vision Aids are classified as follows:

1. *Spectacle-mounted magnifiers* - A magnifying lens is mounted in spectacles (this type of system is called a microscope) or on a special headband. This allows use of both hands to complete the close-up task, such as reading;
2. *Handheld or spectacle-mounted telescopes* - These miniature telescopes are useful for seeing longer distances, such as across the room to watch television, and can also be modified for near (reading) tasks;
3. *Handheld and stand magnifiers* - These magnifiers can serve as supplements to other specialized systems and are convenient for short-term reading of such things as price tags, labels and instrument dials. Both types of magnifiers can be equipped with lights; or
4. *Video magnification* - Table-top (closed-circuit television) or head-mounted systems enlarge reading material on a video display. Some systems can be used for distance viewing tasks. These are portable systems and can be used with a computer or Computer Display. Image brightness, image size, contrast, foreground/background color and illumination can be customized.

Low Vision Supplemental Examination means diagnostic evaluation beyond the Comprehensive Eye Examination and includes a history of functional difficulties that involves such things as reading, activities in the kitchen, glare problems, mobility, the workplace, television viewing, school requirements, hobbies and interests. Preliminary tests may include assessment of ocular functions such as color vision and contrast sensitivity. Measurements will be taken for visual acuity using special low vision test charts, which include a larger range of letters or numbers to more accurately determine a starting point for assessing the level of impairment. Visual fields may also be evaluated. A specialized Refraction must be performed with each eye thoroughly examined. The Provider may prescribe various treatment options, including Low Vision Aids, as well as assist with identifying other resources for vision and lifestyle rehabilitation.

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

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

Member means an Employee, Retiree, COBRA participant or Dependent who meets the eligibility requirements as shown in this Certificate and whose coverage under the Policy is in force and has not ended.

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

Plan Year means the 12-month period beginning January 1 and ending December 31.

Policy means the Vision Insurance Policy issued to the Policyholder.

Policyholder means the State of Tennessee.

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

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

Preferred Provider Organization ("PPO") means a network of Providers within the PPO Service Area that have signed a Preferred Provider Agreement.

Provider means a licensed physician or optometrist who is operating within the scope of his or her license. Provider also includes a dispensing optician.

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

Retiree, with eligibility for the State of Tennessee Group Vision Insurance Program, means a State Retiree, Local Education Retiree, or Local Government Retiree as shown below:

State Retiree means an individual who:

1. was hired before July 1, 2015, has left active employment as a State Employee, and is drawing retirement benefits through TCRS based on their own service, or is a participant in a Higher Education Optional Retirement Plan (ORP), as permitted by TCA 8-27-205. Employees whose employment with the State commenced on or after July 1, 2015, are not eligible for coverage as a Retiree unless they were employed by the State or a participating local education agency, as defined in TCA § 8-27-301, before July 1, 2015, and did not accept a lump sum payment from the TCRS before July 1, 2015; or
2. is enrolled in the state's vision insurance program for active Employees and is a former governor or retired state of Tennessee senator or representative first elected to office prior to July 1, 2015, and meets the requirements set forth in TCA 8-27-208.

Local Education Retiree means:

1. an individual who was hired before July 1, 2015, has left active employment as a Local Education Employee and:
   a. if vested in TCRS is drawing retirement benefits through TCRS based on their own service, as permitted by TCA 8-27-305; or
   b. if not vested in TCRS is at least age 55 at the time of termination with 10 or more years of service with a participating local education agency or 10 or more years of combined service with a participating local education agency and the State;
2. Employees whose first employment with a participating local education agency commenced on or hired after July 1, 2015, are not eligible for coverage as a retiree unless they were employed by the State or a participating local education agency, as defined in TCA 8-27-301, before July 1, 2015, and did not accept a lump sum payment from the TCRS before July 1, 2015, and meets the requirements set forth in TCA 8-27-305; or
3. Effective January 1, 2026, and thereafter, eligibility to participate in the state retiree vision plan is only open to Retirees of an LEA that is participating in the state vision plan at the time of retirement. If the LEA subsequently terminates participation in the state vision plan, its retirees are no longer eligible to continue retiree vision coverage.

Local Government Retiree means an individual who:

1. Has retired from the participating Employer and:
   a. if vested in TCRS, receives a monthly benefit through TCRS based on their own services, as permitted by TCA 8-27-705; or
   b. if not vested in TCRS, is at least age 55 at the time of termination with 10 or more years of employment with the participating local government agency from which they retired;
2. Has retired as a utility district commissioner with 20 years of service with the same utility district and is at least age 55 at the time of termination;
3. Has retired as a Member of the chief legislative body of the county or municipal government (defined as only those elected officials who have the authority to pass local legislation) and is at least age 55 at the time of termination with 10 or more years of service with the participating local government agency from which they retired; or
4. Has retired as a county official as defined in 8-34-101(9)(A) and (B) and is at least age 55 at the time of termination with 10 or more years of service with the local government agency from which they retired.
5. Effective January 1, 2026, and thereafter, eligibility to participate in the state retiree vision plan is only open to Retirees of an LGA that is participating in the state vision plan at the time of retirement. If the LGA subsequently terminates participation in the state vision plan, its retirees are no longer eligible to continue retiree vision coverage. This restriction does not apply to county officials as defined in TCA 8-34-101(9)(A) and (B).

Subscriber means an Employee or Retiree who meets the eligibility requirements as shown in this Certificate, makes the enrollment elections, and whose vision coverage under the Policy is in force and has not ended.

Tennessee Code Annotated (TCA) means the laws passed by the Tennessee General Assembly.

Tennessee Consolidated Retirement System (TCRS) means the defined benefit plan component of the State of Tennessee's retirement program that provides retirement, survivor and/or disability benefits to eligible Retirees and their eligible Dependents.

Vision Examination means any eye or visual examination covered under the Policy and shown in the Schedule of Benefits.

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

PARTICIPATION REQUIREMENTS

An agency must be participating in the State of Tennessee Sponsored Group Health Program in order to qualify for participation in the State of Tennessee Group Vision Insurance Program. Employees and Dependents of Employees ARE NOT required to participate in a state-sponsored group basic health plan as a condition of participating in the State Group Vision Insurance Program. Retirees and Dependents of Retirees ARE NOT required to participate in a state-sponsored group basic health plan as a condition of participating in the State Group Vision Insurance Program. An Employee or Retiree's participation in the State Group Vision Insurance Program is required for participation of eligible Dependents, EXCEPT when Dependents are allowed to remain enrolled in the State Group Vision Insurance Program due to the Retiree's death or applicable COBRA regulations. Participation by those enrolled in the State Group Vision Insurance Program is on a calendar year basis, and enrollment may only be changed or cancelled by the Subscriber during the Annual Enrollment Period for the beginning of the next calendar year or if they experience an event permitting Mid-Year Enrollment or Mid-Year Cancellation of Coverage as provided in this Certificate.

ENROLLMENT DEADLINES AND EFFECTIVE DATES OF COVERAGE

The following Enrollment Deadlines and Effective Dates of Coverage are provided by the State of Tennessee.

Annual Enrollment Elections.

(A) The Vision Plan's designated annual enrollment period will be announced in an annual enrollment newsletter and will be published on the State's Partners for Health website. All timely submitted annual enrollment elections and revisions will become effective on January 1 of the upcoming Plan Year and remain in effect through December 31 of the upcoming Plan Year unless a mid- year enrollment change is permitted by this COC.

(B) Employees may make coverage elections during annual enrollment, may choose between any vision option for which the Employee is eligible, and may add or drop eligible Dependents. If no new elections are received by BA during annual enrollment, the coverage in effect immediately prior to annual enrollment is deemed to be elected for the upcoming Plan Year.

(C) When adding new Dependents during annual enrollment, eligibility documentation must be submitted prior to December 1 of the current Plan Year or as otherwise directed by BA. In no event will annual enrollment documentation be accepted after December 31 of the current Plan Year.

(D) During annual enrollment a Retiree may enroll in new coverage, add or drop an eligible Dependent and make changes to existing coverage.

(E) During annual enrollment a surviving Dependent may make changes to existing coverage (switch vision plans) but is not eligible to newly enroll in vision coverage or add new Dependents to existing coverage.

(F) Employees who are eligible for coverage under this Vision Plan and another state-sponsored vision insurance option may switch their coverage (and coverage for their Dependents) to or from the other option during the applicable designated annual enrollment period.

(G) Once the Plan's designated annual enrollment period has closed, active Employees and eligible Retirees have one opportunity to revise annual enrollment elections provided that requests are submitted to BA no later than 4:30 CT on December 1 of the current Plan Year. Timely submitted revisions will become effective on January 1 of the upcoming Plan Year.

Enrollment Deadlines and Effective Date of Subscriber's Insurance.

Initial Enrollment and Insurance Elections
You must enroll and make insurance elections for yourself and your eligible Dependents by completing electronic enrollment or by signing an approved payroll deduction or enrollment form, as applicable, within thirty (30) calendar days of becoming eligible (hire date for new hires), but no earlier than the date you become eligible to request coverage. The 30 days includes the date you first become eligible.

Participation in this Vision Plan is on a calendar year basis. Changes to coverage or termination of coverage is not available until the Annual Enrollment Period for the beginning of the next calendar year or by experiencing a mid-year enrollment or mid-year termination event as provided in this certificate.

Enrollment Provisions when Employee and Spouse are Both Employed by the Same Employer. A newly hired Employee can enroll an Employee spouse who originally declined coverage as an Employee. An Employee spouse who is added as a Dependent pursuant to this section is not required to meet the provisions of the Mid-Year Enrollment Section. An Employee may not be enrolled as both Subscriber and Dependent within the same group program (state, local education or local government). If both parents of a child qualify as eligible Employees, only one Employee (parent) can enroll Dependent children.

Effective Date of Employee/Retiree Insurance.

State

(1) Newly Hired Employee: Enrollment must be completed and submitted to ABC/BA within 30 calendar days of Employee's hire date which is their eligibility date. Coverage will begin the first day of the month after the Employee becomes eligible for coverage, the completed enrollment form and documentation is received by ABC/BA, and the Employee has completed one full calendar month of employment with the Employer.
(2) Seasonal Employee Hired Prior to July 1, 2015: Enrollment must be completed and submitted to ABC/BA within 30 calendar days of Employee's date of becoming eligible for coverage as provided in TCA § 8-27-204(a)(3). Coverage will begin the first day of the month after the Employer certifies that the Employee has met the requirements of TCA 8-27-204(a)(3) and ABC/BA receives a completed enrollment form and documentation.
(3) Existing Employee with at Least One Calendar Month of Employment Followed by gaining eligibility for coverage (including part-time to full-time employment and emergency appointment to permanent appointment): Enrollment must be completed and submitted to ABCBA within 30 calendar days of Employee's date of becoming eligible for coverage. Coverage will begin the first day of the month after the Employee becomes eligible for coverage and a completed enrollment form and documentation is received by ABC/BA.

Local Education
Newly Hired Employee (including Employees moving between LEAs, or coming from LGAs, the State Plans, or Higher Education Institutions): Enrollment must be completed and submitted to ABC/BA within 30 calendar days of Employee's hire date which is their eligibility date. Coverage will begin the first day of the month after the Employee becomes eligible for coverage, the Employee satisfies any mandatory waiting period, and the ABC/BA timely receives a completed enrollment form and documentation.

Existing Employee gaining eligibility for coverage (including part-time to full-time employment: Enrollment must be completed and submitted to ABC/BA within 30 calendar days of Employee's date of becoming eligible for coverage. Coverage will begin the first day of the month after gaining eligibility for coverage and ABC/BA's timely receipt of a completed enrollment form.

Local Government
Newly Hired Employee (including Employees moving between LGAs, or coming from LEAs, the State, or Higher Education Institutions): Enrollment must be completed and submitted to ABC/BA within 30 calendar days of Employee's hire date which is their eligibility date. Coverage will begin the first day of the month after the Employee is eligible for coverage, the Employee satisfies any mandatory waiting period, and the ABC/BA receives a timely completed enrollment form and documentation.

Existing Employee gaining eligibility for coverage (including part-time to full-time employment); Enrollment must be completed and submitted to ABC/BA within 30 calendar days of Employee's date of becoming eligible for coverage. Coverage will begin the first day of the month after the Employee becomes eligible for coverage and the ABC/BA receives a timely completed enrollment form.

Effective Date of Dependents' Insurance. The effective date of coverage for any eligible Dependent shall be the later of the effective of your coverage as a Subscriber or the first day of the month after the Dependent becomes an eligible Dependent and ABC/BA is in receipt of a timely completed enrollment election form and documentation as otherwise stated in this certificate.

Transfer from Prior Contract means that individuals enrolled under the prior vision insurance contract with the State immediately prior to the effective date of this vision plan will be automatically enrolled under the new vision insurance contract for this Plan with the State with no break in coverage if premium payments were current and the Subscriber did not make a change during the State's Annual Enrollment. Benefit frequencies and other limitations under this vision insurance contract will not incorporate Subscriber's experience under the prior vision insurance contract.

Events Permitting Mid-Year Enrollment. Without regard to the dates or circumstances on which an individual would otherwise be able to enroll in this vision plan current Employees/Retirees and Dependents as defined in this certificate are permitted to enroll in coverage under this vision plan if the Employee/Retiree or Dependent meets the following conditions, as stated in "Loss of Eligibility for Other Coverage" or "Acquisition of New Dependents" below.

- **Loss of Eligibility for Other Coverage.**
  An Employee/Retiree or Dependent, otherwise eligible to enroll in a vision benefit plan, may be enrolled through this Mid-Year Enrollment provision, provided that they:

  1. Declined coverage in a state-sponsored vision insurance plan when it was previously offered during their initial eligibility period or during a subsequent Annual Enrollment Period;
  2. Had coverage under any group vision insurance plan at the time this coverage was previously offered; and
  3. Experience a loss of eligibility for other vision insurance coverage for reasons including the following (but not for a failure to pay premiums or termination for cause):
     a. Death;
     b. Divorce;
     c. Legal separation;
     d. Cessation of Dependent status;
     e. Termination of employment (voluntary and non-voluntary);
     f. Employer's discontinuation of contribution to insurance coverage (total contribution, not partial);
     g. Reduction in number of work hours of employment;
     h. Spouse maintaining coverage that has reached their lifetime maximum (if legally permitted);
     i. The loss of eligibility due to an HMOs failure to provide benefits in the area where the individual lives, works, or resides; or
     j. Loss of vision benefits through TennCare or Children's Health Insurance Program (CHIP) coverage other than non-payment of premium, or expiration of COBRA coverage.

  If an Employee/Retiree satisfies all three requirements above, the Employee/Retiree and all Dependents of the Employee/Retiree are eligible for Mid-Year Enrollment to this vision plan.

  If a Dependent satisfies all three requirements above, only that Dependent, the Employee/Retiree, and other Dependents satisfying the requirements above are eligible for Mid-Year Enrollment to this vision plan.

  All Mid-Year Enrollment requests due to Loss of Eligibility for Other Coverage and required documentation must be submitted to and received by the ABC/BA within 60 calendar days of the loss of eligibility for other coverage.

  The effective date of coverage due to Loss of Eligibility for Other Coverage shall be the first day of the first calendar month after both the loss of eligibility and the date the ABC/BA receives the request for Mid-Year Enrollment.

Substantiation of Loss of Coverage. If requesting Mid-Year Enrollment based on loss of eligibility for other coverage, the Employee/Retiree must submit appropriate documentation to substantiate all of the following:

1. That the Employee/Retiree or Dependent was covered by another group vision insurance plan at the time they declined the offer of this coverage; and
2. That the Employee/Retiree experienced an event resulting in the Employee/Retiree or Dependent's loss of eligibility for coverage under the other group vision insurance plan, and the date of the Employee/Retiree or Dependent's loss of eligibility.

- **Acquisition of New Dependents**

When an Employee/Retiree acquires a new Dependent by marriage, birth, adoption, or placement for adoption, the Employee/Retiree, Spouse, and any Dependent may be enrolled by Mid-Year Enrollment. When an Employee/Retiree acquires a new Dependent by a legal guardianship order placing child in the custody of the Employee/Retiree and requiring Employee/Retiree to provide insurance coverage for the new Dependent, only the Employee/Retiree and new Dependent may be enrolled by Mid-Year Enrollment.

Any coverage changes made as a result of a Mid-Year Enrollment shall be on account of and correspond with the change in status that affected eligibility for coverage under this vision plan.

All enrollment applications based upon the acquisition of a new Dependent and required supporting documentation must be submitted to and received by the ABC/BA within sixty (60) calendar days of the acquisition date.

The effective date of coverage for a Mid-Year Enrollment for acquiring a new Dependent shall be prospective only from the first day of the first calendar month after both the acquisition of the new Dependent and the date the ABC/BA receives the request for Mid-Year Enrollment.

Substantiation of Acquiring a New Dependent. If requesting enrollment based on acquiring a new Dependent, the Employee/Retiree must submit appropriate documentation as listed on the enrollment application to substantiate the following:

1. The date of birth of a child;
2. The date of the order of adoption or of the order placing the child in custody for adoption;
3. The date of guardianship specified by the order granting guardianship of the person and requiring financial support and insurance coverage; or
4. The date of marriage.

Plan Cancellation and Termination Provisions

Cancellation Provisions. Subscribers may not terminate vision coverage outside of the Annual Enrollment Period unless they experience one of the reasons listed in "Voluntary Termination of Coverage" or "Involuntary Termination of Coverage" below.

Voluntary Termination of Coverage. Voluntary termination of Subscriber or Dependent coverage outside of the Annual Enrollment Period is prohibited unless the Subscriber or Dependent experiences one of the events listed below. For all events the Section 125 consistency rule must be met. For Active Subscribers, the Cancel Request Application Form and required documentation must be received by the ABC/BA within 60 days from the date of the event. For Active Subscribers, if the status change event is new entitlement to Medicare or Medicaid, the Insurance Cancel Request Application Form must be received by BA within 60 days from the date of the Subscriber/Dependent's receipt of notice of the new entitlement Retiree Subscribers do not have a deadline for submission of the Cancel Request Application form. The effective date of voluntary coverage termination is the first day of the calendar month following ABC/BA's receipt of the Insurance Cancel Request Application Form and required documentation. Permissible voluntary coverage termination events are as follows:

1. New eligibility for group vision insurance/benefits through spouse or Dependent's employer;
2. Annual enrollment into a spouse, former spouse, or Dependent's employer's group vision insurance plan;
3. New entitlement to Medicare or Medicaid;
4. Termination of child support order of Dependent child provided by National Medical Support Notice; or
5. Change of residence out of the national service area.

Involuntary Termination of Coverage. Coverage terminates involuntarily when a Member ceases to satisfy coverage eligibility requirements of this vision plan or fails to make premium payments in the manner required by BA. Unless otherwise expressly provided in this vision plan, involuntary termination is effective as follows:

1. Coverage of the Subscriber shall terminate upon the earliest to occur of the following:
   a. The last day of the month in which the Employee separates employment with the Employer and does not enroll in the vision insurance program as a Retiree or otherwise loses eligibility for coverage (this only applies to central state government Employees);
   b. The last day of the month following the month in which the Employee separates employment with the Employer and does not enroll in the vision insurance program as a Retiree or otherwise loses eligibility for coverage (state higher education, local education and local government);
   c. The last day of the month in which the agency participates in this Vision Plan (local education and local government agencies only):
   d. The last day of the month for which the Employee's last contribution was applied;
   e. The date of the Subscriber's enrollment in the State of Tennessee's Sponsored Group Basic Health Insurance Program for Retirees terminates;
   f. The date this vision plan is amended to terminate the coverage of a class of Employees of which the Subscriber is a member;
   g. the date the Subscriber is no longer eligible for insurance; or
   h. The date this vision plan is terminated.

2. An enrolled Dependent's insurance will cease on the earlier of:
   a. the date the Subscriber's coverage ends unless the Dependent is eligible for continued coverage as a Dependent of a Retiree and is enrolled in one of the state sponsored group basic health insurance plans;
   b. the end of the month in which the enrolled Dependent ceases to be an eligible Dependent as defined in this Certificate;
   c. the date the enrolled Dependent's enrollment in the State of Tennessee's Sponsored Group Basic Health Insurance Plan for Retirees and Dependents terminates; or
   d. the end of the last period for which any required premium contribution has been made.

It is the responsibility of the Subscriber to immediately notify the Employer (if the Subscriber is an Employee) or BA (if the Subscriber is a Retiree) of a status change event causing a Dependent to become ineligible for coverage. When failure to notify the Employer or BA results in claims paid for ineligible Dependents, all claim amounts will be recovered from the Subscriber.

Pending Divorce Actions. If a Subscriber submits a timely request to terminate coverage of a Dependent for any of the above listed Mid-Year change events or drops coverage of a Dependent during annual enrollment while a divorce case is pending, the termination will be processed and final. Court orders in matters to which the State is not a party have no application to the vision plan offered by the State and do not entitle the Subscriber to rescind a termination request or to permit re-enrollment of a Dependent.

It is the responsibility of the Subscriber to comply with all applicable law regarding termination of vision insurance while a divorce action is pending. Neither the State, BA, nor the vision plan is responsible for said compliance or the Subscriber's failure to comply.

BA may rely upon the direction, information, or election of a Subscriber to remove a Dependent while a divorce action is pending as being proper and in compliance with all legal requirements and the State shall not be responsible for removal of a Dependent if it is determined that the Subscriber's request was in violation of court orders or applicable law, or if proper notice was not provided by the Subscriber to the Dependent.

A former or ex-spouse is not eligible for coverage on the vision plan even if a court order requires the Subscriber to provide vision insurance coverage to a former/ex-spouse. If a spouse ceases to be eligible due to divorce from a Subscriber, that spouse shall be eligible to continue Coverage through COBRA.

BENEFITS

Benefits are payable for each Member as shown in the Schedule of Benefits for expenses incurred while this insurance is in force.

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

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

LIMITATIONS

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

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

EXCLUSIONS

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

1. medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures;
2. Refraction, when not provided as part of a Comprehensive Eye Examination;
3. 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;
4. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
5. any Vision Examination or any corrective Vision Materials required by the Employer as a condition of employment;
6. safety eyewear;
7. solutions, cleaning products or frame cases;

8. non-prescription sunglasses;
9. plano (non-prescription) lenses;
10. plano (non-prescription) contact lenses;
11. two pair of glasses in lieu of bifocals;
12. electronic vision devices, except as provided in the Low Vision Aids benefit;
13. services rendered after the date a Member ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Member are within 31 days from the date of such order; or
14. lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.

TERMINATION OF INSURANCE

The Policyholder or the Company may terminate or cancel the Policy pursuant to the terms of the contract between the State of Tennessee and the Company (contract no. 73804).

For All Subscribers. The Subscribers' insurance will cease on the earlier of:

1. the date the Policy ends;
2. the end of the last period for which any required premium contribution agreed to in writing has been made;
3. the last day of the month in which the Subscriber separates from active employment with the Policyholder for central state government Employees;
4. the last day of the month following the month of the Subscriber's separation from active employment with the Policyholder for non-central state government Employees (state higher education, local education, and local government Employees);
5. the date of the Subscriber's enrollment in the State of Tennessee's Sponsored Group Health Insurance Plan for Retirees terminates; or
6. the date the Subscriber is no longer eligible for insurance.

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

1. the date the Subscriber's coverage ends;
2. the end of the month in which the enrolled Dependent ceases to be an eligible Dependent as defined in the Policyholder's application;
3. the date the enrolled Dependent's enrollment in the State of Tennessee's Sponsored Group Basic Health Insurance Plan for Retirees and Dependents terminates; or
4. the end of the last period for which any required premium contribution has been made.

For an incapacitated Dependent child, the Company may ask for proof of the eligible Dependent child's incapacity and dependency within 31 days of the date the Dependent child would otherwise cease to be covered.

The Company may require the same proof again but will not request it more than once a year after this coverage has been continued for two years. This continued coverage will end on the earlier of:

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.

Survivor means that for a:

1. *Survivor in Current Plan* – Upon the Subscriber's death, surviving Dependents covered under this vision plan on the date of a Subscriber's death may continue their enrollment in this vision plan with one of the two options listed below.
   a. Deceased Subscriber was eligible for continuation of coverage as a Retiree at time of death - Dependents may elect COBRA or Retiree continuation of vision elections in effect for them on the date of Subscriber's death; or
   b. Deceased Subscriber was not eligible for continuation of coverage as a Retiree at time of death – Dependents may elect COBRA continuation for vision elections in effect for them on the date of Subscriber's death.
2. *Survivor with New Local Government or Local Education Agency Joining Plan* – Upon a new agency joining the State Group Insurance Program (SGIP), surviving Dependents of deceased Employees or Retirees may enroll in this vision plan if the following criteria is satisfied.
   a. The new agency opts to offer the SGIP vision insurance plan to its Employees;
   b. Surviving Dependents were enrolled in COBRA or the new agency's regular vision insurance plan and the agency's medical plan in the month prior to the new agency joining the SGIP; and
   c. Surviving Dependents choose to enroll in the SGIP medical and vision insurance programs.

   For a new local education Agency, Retiree coverage shall not be available to Survivors of a deceased Retiree whose employment with a participating agency commenced on or after July 1, 2015.

PREMIUMS

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

Premium Changes. The Company has the right to change the premium rates according to the terms of the Company's contract with the State of Tennessee (contract no. 73804).

Grace Period. The Policy has a 31-day grace period for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. Coverage will terminate at the end of the grace period if all premiums due are not paid. The Company will require payment of all premiums for the period this coverage continues in force, including the premiums for the grace period. The grace period will not apply if the Company receives written notice of the Policyholder's or the Subscriber's intent to terminate coverage.

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 Member 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 Member will be deemed as notice to the Company.

Claim Forms. The Company will furnish claim forms to the Member within 15 days after notice of claim is received. If the Company does not provide the forms within that time, the Member 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 within 30 days, upon receipt of due written proof of loss.

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

Assignment. Benefits under the Policy may be assigned.

Right of Recovery. If payment for claims exceeds the amount for which the Member 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 Subscriber, within 18 months from the date the claim is paid.

Legal Actions. No Member can bring an action at law or in equity against the Company 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 Member resides, the limit is extended to meet the minimum time allowed by such law. Nothing in this document shall be construed to be a waiver of sovereign immunity by the State of Tennessee.

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 Insurance Obligation. The Policy, including any endorsements and riders, this Certificate, the Policyholder's application, which is attached to the Policy when issued, constitutes the entire agreement between the Company and the Members. A copy of the Policy may be examined at the office of the Policyholder during normal business hours.

Amendments and Changes. No Member 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 Member, 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 agree 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 a Member, in the absence of fraud, can be used in a contest after the Member's insurance has been in force for two years. No statement a Member makes can be used in a contest unless it is in writing and signed by the Member.

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

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

State of Tennessee – Basic Plan

BENEFIT FREQUENCY		
Vision Examinations		
Comprehensive Eye Examination	once every calendar year	Insured Person
Low Vision Supplemental Examination	once every 2 calendar years	Insured Person
Vision Materials		
Frame	once every 2 calendar years	Insured Person
Lenses and Lens Options	once every calendar year	Insured Person
Contact Lenses	once every calendar year	Insured Person
Low Vision Aids	once every 2 calendar years	Insured Person

BENEFIT	*In-Network Provider*	*Out-of-Network Provider* *(Reimbursement up to)*
Vision Examination		
Comprehensive Eye Examination	$10 Copayment	$40
Low Vision Supplemental Examination	$0 Copayment, up to $300 Allowance	$300
Contact Lenses Fit and Follow-Up (One fit and two Follow-Up visits) Contact Lenses Fit and Follow-Up is available once a Comprehensive Eye Examination has been completed.		
Standard	$40 Copayment	$5
Premium	$50 Copayment	$5
Vision Materials		
Frame	$0 Copayment, up to $105 Allowance	$55
Contact Lenses Only one of the following Contact Lenses benefits may be used for the Contact Lenses benefit. Contact Lenses are in lieu of Lenses and Lens Options.		
Conventional	$0 Copayment, up to $105 Allowance	$75
Disposable	$0 Copayment, up to $105 Allowance	$75
Medically Necessary	$0 Copayment, up to $155 Allowance	$80
Standard Plastic Lenses		
Single Vision	$20 Copayment	$55
Bifocal	$20 Copayment	$55
Trifocal	$20 Copayment	$55
Lenticular	$20 Copayment	$90
Progressive – Standard	$90 Copayment	$55
Progressive – Premium Tier 1	$110 Copayment	$55
Progressive – Premium Tier 2	$140 Copayment	$55
Progressive – Premium Tier 3	$155 Copayment	$55
Progressive – Premium Tier 4	$225 Copayment	$55
Lens Options		
Polycarbonate Lenses – Standard Dependent Children under 19 years of age	$0 Copayment	$10
Standard Anti-Reflective Coating - Standard	$45 Copayment	$5

BENEFIT	***In-Network Provider***	***Out-of-Network Provider*** ***(Reimbursement up to)***
Premium Anti-Reflective Coating – Premium Tier 1	$57 Copayment	$5
Premium Anti-Reflective Coating – Premium Tier 2	$68 Copayment	$5
Premium Anti-Reflective Coating – Premium Tier 3	$85 Copayment	$5
Polarized	$90 Copayment	$5
Low Vision Aids	$0 Copayment, up to $300 Allowance	$300

FIDELITY SECURITY LIFE INSURANCE COMPANY®

2600 Grand Blvd., Suite 900
Kansas City, Missouri 64108-4626
Phone 800-648-8624
A STOCK COMPANY
(Herein Called "the Company")

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

President Secretary

FIDELITY SECURITY LIFE INSURANCE COMPANY®

2600 Grand Blvd., Suite 900
Kansas City, Missouri 64108-4626
Phone 800-648-8624
A STOCK COMPANY
(Herein Called "the Company")

NOTICE

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

Fidelity Security Life Insurance Company
2600 Grand Blvd., Suite 900
P.O. Box 418131
Kansas City, MO 64141-8131
800-648-8624

FIDELITY SECURITY LIFE INSURANCE COMPANY®
2600 Grand Blvd., Suite 900
Kansas City, Missouri 64108-4626
Phone 800-648-8624
A STOCK COMPANY
(Herein Called "the Company")

NOTICE CONCERNING COVERAGE UNDER THE TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of Tennessee who purchase life insurance, annuities, or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. **This summary does not cover all provisions of the law or describe all of the conditions and limitations relating to coverage. This summary does not in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.**

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, an annuity, or if they are insured under a group insurance contract issued by an insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guaranty Association if:

(1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);

(2) the insurer was not authorized to do business in this state;

(3) their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

(2) any policy of reinsurance (unless an assumption certificate was issued);

(3) interest rate yields that exceed an average rate;

(4) dividends;

(5) credits given in connection with the administration of a policy by a group contractholder;

(6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);

(7) unallocated annuity contracts (which give rights to group contractholders, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For any one insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

- $300,000 for policies and contracts of all types, except as described in the next point
- $500,000 for basic hospital, medical and surgical insurance and major medical insurance issued by companies that become insolvent after January 1, 2010

Within these overall limits, the Guaranty Association cannot guarantee payment of benefits greater than the following:

- life insurance death benefits – $300,000
- life insurance cash surrender value – $100,000
- present value of annuity benefits for companies insolvent before July 1, 2009 – $100,000
- present value of annuity benefits for companies insolvent after June 30, 2009 – $250,000
- health insurance benefits for companies declared insolvent before January 1, 2010 – $100,000
- health insurance benefits for companies declared insolvent on or after January 1, 2010:
    - $100,000 for limited benefits and supplemental health coverages
    - $300,000 for disability
    - $300,000 for long-term care insurance
    - $500,000 for basic hospital, medical and surgical insurance or major medical insurance

****

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

Tennessee Life and Health Guaranty Association
150 3rd Avenue South, Suite 1600
Nashville, TN 37201

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37243

****

FIDELITY SECURITY LIFE INSURANCE COMPANY®

2600 Grand Blvd., Suite 900
Kansas City, Missouri 64108-4626
Phone 800-648-8624
A STOCK COMPANY
(Herein Called "the Company")

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®

2600 Grand Blvd., Suite 900
Kansas City, Missouri 64108-4626
Phone 800-648-8624
A STOCK COMPANY
(Herein Called "the Company")

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 January 1, 2026, 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. *FSL does not currently collect, use or disclose genetic or neurotechnology data.

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: 2600 Grand Blvd., Suite 900, Kansas City, MO 64108-4626