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: Guest Services, Inc.

POLICY EFFECTIVE DATE: January 1, 2022

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

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

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

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

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

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

FIDELITY SECURITY LIFE INSURANCE COMPANY

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.

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DEFINITIONS

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

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

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

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

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

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

1. the Insured's lawful spouse or Domestic Partner;
2. each child of the Insured or the Insured's spouse or Domestic Partner who is under 26 years of age;
3. each child at least 26 years of age who is primarily dependent upon the Insured or the Insured's spouse or Domestic Partner for support and maintenance because the child is incapable of self-sustaining employment by reason of intellectual disability or physical handicap.

Dependent includes a step-child, foster child, legally adopted child, child for whom the Insured is a party to a suit for adoption, child who has been placed in the Insured's home for adoption and child under the Insured's legal guardianship, if such child depends primarily on the Insured for support. Dependent will also include a child for whom the Insured is legally required to support due to court order or divorce decree.

Domestic Partner means a same-sex or an opposite-sex adult who is in a committed relationship with the Insured and the Insured and the Domestic Partner are mutually responsible for one another financially and otherwise.

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

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

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

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

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

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

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

Policy means the Vision Insurance Policy issued to the Policyholder.

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

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

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

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

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).

Retinal Imaging Examination means photographing portion(s) of or the complete retina surface and structures.

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.

EFFECTIVE DATES

Effective Date of Insured's Insurance. The Insured's insurance will be effective as follows:

1. if the Policyholder does not require the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured becomes eligible;
2. if the Policyholder requires the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured becomes eligible, provided;
    a. the Insured has given the Company the Insured's enrollment form (if required) on, prior to, or within 30 days of the date the Insured becomes eligible; and
    b. the Insured has agreed to pay the required premium contributions; and
3. if the Insured fails to meet the requirements of 2 a) and 2 b) within 30 days after becoming eligible, the Insured's coverage will not become effective until the Company has verified that the Insured has met these requirements. The Insured will then be advised of the Insured's effective date.

Effective Date of Dependents' Insurance. Coverage for Dependents becomes effective on the later of:

1. the date Dependent coverage is first included in the Insured's coverage; or
2. the premium due date on or after the date the person first qualifies as the Insured's Dependent. If an enrollment form is required, the Insured must provide such form and agree to pay any premium contribution that may be required prior to coverage becoming effective.

If the Insured and the Insured's spouse or Domestic Partner are both Insureds, one Insured may request to be a Dependent spouse or Domestic Partner of the other. A Dependent child may not be covered by more than one Insured.

Newborn Children. A Dependent child born while the Insured's coverage is in force will be covered from the moment of birth for 31 days or a greater number of days, if elected by the Policyholder. To continue coverage beyond this period, the

Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period.

Adopted Children. If a Dependent child is placed with the Insured for adoption while the Insured's coverage is in force, this child will be covered from the date of placement for 31 days or a greater number of days, if elected by the Policyholder. To continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period. If proper notice has been given, coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement.

BENEFITS

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

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

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

LIMITATIONS

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

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

EXCLUSIONS

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

1. medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures;
2. 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 a Policyholder 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;
13. services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or
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 as shown in the Policy.

In the event coverage is terminated due to nonpayment of premium by the Policyholder, the coverage will not be terminated by the Company with respect to Insured Persons, until the Policyholder has been provided written notice of termination, including a specific date, not less than 15 days from the date of such notice, by which coverage will terminate if overdue premium is not paid. Coverage will not terminate for at least 15 days after such notice has been mailed.

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

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

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

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

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

1. not capable of self-sustaining employment due to an intellectual disability or physical handicap that began before the age limit was reached; and
2. mainly dependent on the Insured for support.

The Company may ask for proof of the eligible Dependent child's incapacity and dependency two months prior to the date the Dependent child would otherwise cease to be covered.

The Company may require the same proof again, but will not 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.

PREMIUMS

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

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

Grace Period. The Policy has a 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 Insured's intent to terminate coverage. The Company will mail a notice of termination due to nonpayment of the premium to the Policyholder not less than 15 days prior to the end of the grace period. The Policyholder will be liable to the Company for the pro rata premium for the time the Policy was in force during the grace period.

CLAIMS

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

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

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

Time Payment of Claims. Any benefit payable under the Policy will be paid immediately, but not more than 30 days, upon receipt of due written proof of loss.

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

Assignment. Benefits under the Policy may be assigned.

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

Physical Examination and Autopsy. The Company, at the Company's expense, will have the right and opportunity to examine any Insured Person for whom a claim is pending when and as often as it may reasonably be required during the pendency of a claim. The Company, at the Company's expense, will have the right to make an autopsy in case of death, unless it is forbidden by law.

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

Claims Experience; Disclosure. The Company, upon request, will provide the Policyholder with a complete record of the Policyholder's claims experience incurred under the Policy. This record will include all claims incurred for the lesser of: 1) the period of time since the Policy was issued or issued for delivery; or 2) the period of time since the Policy was last renewed, reissued or extended, if already issued. This record will be made available promptly to the Policyholder upon request made but not less than 30 days prior to the date upon which the premiums or contractual terms of the Policy may be amended. Nothing in this provision shall require the disclosure of personal or privileged information about an individual that is protected from disclosure under any applicable federal or state law or regulation.

GENERAL PROVISIONS

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

Conformity to Law. Any provision of the Policy that is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

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

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

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

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

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

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

SCHEDULE OF BENEFITS

Guest Services, Inc.

BENEFIT FREQUENCY		
Vision Examination		
Comprehensive Eye Examination	once every calendar year	Insured Person
Retinal Imaging Examination	once every calendar year	Insured Person
Vision Materials		
Frame	once every calendar year	Insured Person
Lenses and Lens Options	once every calendar year	Insured Person
Contact Lenses	once every calendar year	Insured Person
Vision Materials Benefit Allowance	once every calendar year	Insured Person

BENEFIT	*In-Network*		*Out-of-Network Provider (Reimbursement up to)*
	Plus In-Network Provider	*In-Network Provider*	
Vision Examination			
Comprehensive Eye Examination	$0 Copayment	$0 Copayment	$50
Retinal Imaging	$0 Copayment	$0 Copayment	$28
Vision Materials			
Frame	$0 Copayment up to $200 Allowance	$0 Copayment up to $150 Allowance	$75
Contact Lenses Only one of the following Contact Lenses benefits may be used for the Contact Lenses benefit. Contact Lenses are in lieu of Frame, Lenses and Lens Options.			
Conventional	$0 Copayment up to $200 Allowance	$0 Copayment up to $150 Allowance	$105
Disposable	$0 Copayment up to $200 Allowance	$0 Copayment up to $150 Allowance	$105
Medically Necessary	Paid in Full	Paid in Full	$300
Standard Plastic Lenses			
Single Vision	$20 Copayment	$20 Copayment	$50
Bifocal	$20 Copayment	$20 Copayment	$75
Trifocal	$20 Copayment	$20 Copayment	$125
Lenticular	$20 Copayment	$20 Copayment	$125
Progressive – Standard	$70 Copayment	$70 Copayment	$75
Progressive – Premium Tier 1	$90 Copayment	$90 Copayment	$75
Progressive – Premium Tier 2	$100 Copayment	$100 Copayment	$75
Progressive – Premium Tier 3	$115 Copayment	$115 Copayment	$75
Progressive – Premium Tier 4	$70 Copayment up to $120 Allowance	$70 Copayment up to $120 Allowance	$75

BENEFIT	***In-Network***		***Out-of-Network Provider*** *(Reimbursement up to)*
	Plus In-Network Provider	***In-Network Provider***	
Lens Options			
Polycarbonate Lenses – Standard Dependent Children under 19 years of age	$0 Copayment	$0 Copayment	$5

Second Pair of Glasses

VISION MATERIALS BENEFIT ALLOWANCE Vision Materials Benefit Allowances are in addition to Frame, Lenses, Contact Lenses, and Lens Options. Only one Vision Materials Benefit Allowance is available per Benefit Frequency			
BENEFIT	***In-Network***		***Out-of-Network Provider*** *(Reimbursement up to)*
	Plus In-Network Provider	***In-Network Provider***	
Glasses Allowance***	up to $100 Allowance	up to $50 Allowance	$40

*** *Glasses Allowance* includes Frame, Lenses and Lens Options.

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AMENDATORY RIDER REGARDING REPLACEMENT COVERAGE

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

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

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

Each such person will be insured under the Policy if:

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

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

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

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

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Bryson Z. Jones — President

Bradford R. James — Secretary

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COMMONWEALTH OF VIRGINIA

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number:

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

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Commonwealth of Virginia
Bureau of Insurance
1300 East Main Street
P.O. Box 1157
Richmond, Virginia 23218
(804) 371-9691 (Local)
(800) 552-7945 (In-state)
(877) 310-6560 (National Toll-free)

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company, or the Bureau of Insurance, have your policy number available.

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NOTICE OF ADMINISTRATOR'S CAPACITY

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

1. Fidelity Security Life Insurance Company (FSL) has, by agreement, arranged for First American Administrators, Inc. to provide administrative services for your insurance plan. As administrator, First American Administrators, Inc., is authorized to process claim payments, and perform other services, according to the terms of its agreement with the insurance company. First American Administrators, Inc. is not the insurance company or the policyholder.

2. The policyholder is the entity to whom the insurance policy has been issued. The policyholder is identified on either the face page or schedule page of the policy or certificate.

3. Fidelity Security Life Insurance Company is liable for the funds to pay your insurance claims.

As First American Administrators, Inc. is authorized to process claims for the insurance company, they will do so promptly. In the event there are delays in claims processing, you will have no greater rights to interest or other remedies against First American Administrators, Inc. than would otherwise be afforded to you by law.

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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 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

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")

CONSUMER NOTICE

Consumer Complaint

If you have a complaint related to quality of care, choice and accessibility of providers, or network adequacy, you may contact:

EyeMed Vision Care, LLC
Attn: Quality Assurance Department
4000 Luxottica Place
Mason, Ohio 45040
or you may call the toll free number at:
1-877-226-1115

If you feel that your complaint has not been satisfactorily resolved, you may also contact:

Office of Licensure and Certification (OLC)
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233
Phone Number: 1-804-367-2104 (Ask for MCHIP)
Fax Number: 1-804-527-4503
E-mail: mchip@vdh.virginia.gov

or

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Or you may call: 1-877-310-6560
In the Richmond metropolitan area, call: 804-371-9032
Fax Number: 804-371-9944
E-mail: ombudsman@scc.virginia.gov

Referral and Authorization Requirements

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, if applicable. To obtain authorization please contact EyeMed at:

EyeMed Vision Care, LLC
Attn: Quality Assurance Department
4000 Luxottica Place
Mason, Ohio 45040
or you may call the toll free number at:
1-877-226-1115

Questions

If you have any questions regarding a complaint concerning the services that you have been provided which have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance at:

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
or you may call: 1-877-310-6560
In the Richmond Metropolitan Area call: 804-371-9032
Fax Number: 804-371-9944

E-mail: ombudsman@scc.virginia.gov

Provider Directories

You may review an up to date provider list at any time by city, county, state or a certain mile radius from your location (distance at your choice) by visiting the EyeMed website at www.discovereyemed.com or by contacting the EyeMed customer care center at (866) 939-3633. You may also request a hard copy of the provider directory through the contacts provided above.

Provider Compensation

If you have questions regarding how your eye care provider is compensated, please contact the Claims Administrator, EyeMed, at:

First American Administrators, Inc.
Attn: Provider Relations
4000 Luxottica Place
Mason, Ohio 45040
or you may call the toll free number at:
1-877-226-1115

This plan is subject to regulation by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

Emergency Services

Your plan covers Vision Examinations and/or Vision Materials. If you have an after-hours emergency for a Covered Benefit, please contact your EyeMed eye care provider the next day. If you have an eye-related emergency, please contact your medical care provider or go to the nearest medical facility.