



FIDELITY SECURITY LIFE INSURANCE COMPANY

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

POLICY NUMBER: VC-19
POLICYHOLDER: University of Kentucky
STATE OF ISSUE: Kentucky
POLICY EFFECTIVE DATE: July 1, 2011
POLICY ANNIVERSARY DATE: July 1 of the following year and each July 1 thereafter

Fidelity Security Life Insurance Company agrees to pay the benefits provided by the Policy in accordance with its terms and conditions.

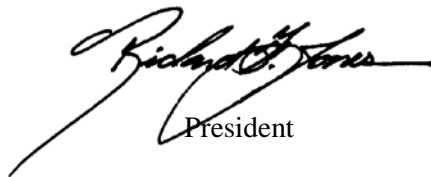
The Policy is issued in consideration of the Policyholder's application (a copy of which is attached) and receipt by the Company of the premiums.

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

The Policy may be modified by mutual agreement between the Policyholder and the Company.

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

FIDELITY SECURITY LIFE INSURANCE COMPANY



President



Secretary

GROUP VISION INSURANCE POLICY
THIS IS A LIMITED BENEFIT POLICY
This Policy is a legal contract between the Policyholder and the Company.

Please read the Policy carefully.

PREMIUMS

Premiums are payable in advance by the Policyholder. The first premium is due on the effective date of the Policy. Subsequent premiums are due on the first day of each calendar month thereafter.

The required premium due on each premium due date is the sum of the premiums for all Insureds and their Dependents covered under the Policy. The premiums due will be determined by applying the premium rates then in effect for each plan provided by the Policy to the number of Insured Persons. All premiums are payable to the Company at the Company's home office or to any of the Company's authorized agents.

The premium due may be adjusted due to a change in insurance as requested by the Policyholder or as required by the Company as follows:

1. if an amount of insurance is added or increased during a calendar month, premiums will be increased as of the date the change becomes effective, unless otherwise mutually agreed;
2. if an amount of insurance is deleted or decreased during a calendar month, premium will cease or be decreased at the end of the calendar month in which the deletion or decrease occurred, unless otherwise mutually agreed;
3. if the Policyholder's contribution percentage is changed, premium will be adjusted at the end of the calendar month in which the change occurred, unless otherwise mutually agreed; or
4. if the number of eligible employees increases or decreases by more than 10% premium will be adjusted at the end of the calendar month in which the increase or decrease occurred, unless otherwise mutually agreed.

If premiums are due the Company, or premium refunds are due the Policyholder as a result of clerical error or delay in the reporting of dates and/or data to the Company, all premiums or refunds will be calculated at the current rate of premium payment and are limited to a maximum period of three months.

Premium Rate Change. The Company has the right to change the premium rate on or after the fourth Policy Anniversary Date. The Company will provide written notice at least 31 days before the date of change.

Grace Period. A grace period of 31 days will be allowed to the Policyholder for the payment of each premium due after the first premium. The Policy will remain in force during the grace period. If the required premium is not paid by the end of the 31-day period, the Policy will terminate. The Policyholder will be required to pay premium for the grace period.

Return of Premium. The Company reserves the right to rescind the coverage for one or all Insureds due to misrepresentation or fraud on the Policyholder's application or an Insured's enrollment form, if such misrepresentation materially affected the acceptance of the risk.

If, on the date coverage is rescinded, no claims have been paid under the Policy, the Company will return all premiums paid for such coverage to the Policyholder.

If, on the date coverage is rescinded, claims have been paid under the Policy, the Company reserves the right to deduct an amount equal to the amount of such claims paid from the premiums to be returned to the Policyholder.

TERMINATION OF POLICY

The Policyholder or the Company may terminate or cancel the Policy on the earliest of the following:

1. on any date on or after the fourth Policy Anniversary Date. Written notice must be provided to the other party at least 31 days prior to termination;
2. the date the number or percentage of persons covered under the Policy does not meet the minimum participation requirements of 10;
3. the date the required premium has not been paid, except as provided in the Grace Period provision; or
4. the date 100% of the eligible employees are not covered when a contribution is not required by the employee.

The Policyholder is responsible for notifying the Insured of the termination of the Policy.

CERTIFICATES

The Company will furnish a Certificate to the Policyholder which will set forth the essential features of the insurance coverage.

ADDITIONAL INSUREDS

Insured Persons may be added at any time if they meet the eligibility requirements stated in the Policyholder's application, complete an enrollment form, if required, and pay any required premium.

INCORPORATION PROVISION

The provisions of the attached Certificate and all Rider(s) issued to amend the Policy after the Policy Effective Date are made a part of the Policy.



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AMENDMENT TO THE APPLICATION FOR VISION CARE BENEFITS

CURRENT GROUP INFORMATION (AS REFLECTED IN THE COMPANY'S RECORDS):

Group Name: University of Kentucky
DBA, if applicable: _____
Policy Number: VC-19 Group Number: 1011431/1011432/1011433/1011434

EFFECTIVE 7-1-17 THE APPLICATION FOR VISION CARE BENEFITS IS AMENDED
AS NOTED BELOW:

☐ **NAME CHANGE (SAME TAX ID #):**

New Group Name: _____
DBA, if applicable: _____

☐ **CHANGE IN PRIMARY BUSINESS ADDRESS (SAME STATE):**

New Street Address: _____
P.O. Box: _____
City: _____ State: _____ Zip Code: _____

☐ **CHANGE TO COVERAGE FOR DOMESTIC PARTNERS*:**

Are Domestic Partners to be covered under this Plan? ☐ Yes ☐ No

Same Sex*? ☐ Yes ☐ No Opposite Sex*? ☐ Yes ☐ No

* Except as required by state law.

☐ **CHANGE TO DEPENDENT AGE COVERAGE**:**

Dependent Children to be covered to Age** ☐ 19 ☐ 21 ☐ 25 ☐ 26*** ☐ Other _____
Dependent Children to be covered if Full-Time Student** ☐ Yes ☐ No
If "Yes", Dependent Full-Time Student Covered to** ☐ 21 ☐ 25 ☐ 27 ☐ Other _____

**Unless state law has different requirements for Dependent Child status.

*** Regardless of financial dependency, residency, student status, or marital status.

☒ **NEW RATES, BENEFITS, NETWORK OR PLANS:**

- ☒ A. New Rates Please refer to the attached proposal page.
- ☒ B. New Benefits Please refer to the attached proposal page.
- ☒ C. New Network Please refer to the attached proposal page.
- ☒ D. New Plan Please refer to the attached proposal page.
-

☐ **CHANGE IN RENEWAL DATE:**

Original Renewal Date: _____

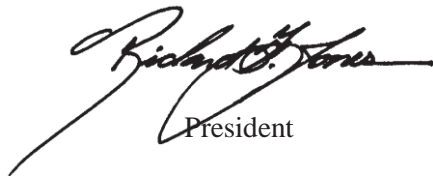
New Renewal Date: _____

☐ **CHANGE IN GROUP SIZE (FLORIDA POLICYHOLDERS ONLY):**

Original Number of Full-time Employees: _____

New Number of Full-time Employees: _____

FIDELITY SECURITY LIFE INSURANCE COMPANY


President


Secretary

EyeMed

VISION CARE®

Application for Vision Care Benefits

Underwritten by Fidelity Security Life Insurance Company
Kansas City, Missouri

I. GROUP INFORMATION

Group Name: University of Kentucky

Tax ID: 61-600-1218

DBA Name (if other than above): _____

Business Address: 112 Scovell Hall City: Lexington State: KY Zip: 40506-0064

Mailing Address: 112 Scovell Hall City: Lexington State: KY Zip: 40506-0064

Primary Contact: Joey Payne Title: Director of Employee Benefits

Phone Number: 859 257-9185

Fax Number: 859 323-1095

E-mail Address: joey.payne@uky.edu

Type of Business: ☐ Proprietorship

☐ Corporation

☒ Other (Specify): governmental

university

Service Area: ☒ National (United States does not include Puerto Rico) ☐ State Specific (List) _____

PLEASE NOTE THE FOLLOWING TYPE BUSINESSES REQUIRE PRIOR CARRIER APPROVAL:

☐ MEWA

☐ PEO

☐ Trust

☐ Union

If any subsidiary or affiliated companies are to be insured or any Employees/Members are working at a location other than the address above, please explain. KCTCS, these employees were previously part of UK and have a legislated right to participate in UK benefit plans.

Billing Contact Name: Lora Dials Phone: 859 257-6604

Billing Address: 375 Peterson Service Building City: Lexington State: KY Zip: 40506-0005

If you have subsidiaries, affiliated companies, or divisions who use another name and will be covered by this plan, AND require separate billing invoices, please attach the following information on a separate sheet of paper signed by you: • Name • Address • Billing Contact & Phone Number

Will this plan replace any existing coverage?

☐ Yes ☒ No

If "Yes," indicate name and address of existing insurer:

Name: EyeMed Address: _____

City: _____ State: _____ Zip: _____

Effective date of existing coverage: _____

Termination date of existing coverage (if applicable): _____

If "Yes," are any Employees/Members on COBRA continuation?

☐ Yes ☐ No How many? _____

Do you intend to offer Employees/Members COBRA continuation?

☐ Yes ☐ No

II. PLAN SELECTION

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

A-01053KY

M-9083/M-9093

III. PREMIUMS

Contribution towards premium: ☐ Yes ☒ No

Group's Premium Contribution for: Employees/Members: ___% Dependents: ___%

Employee's/Member's Premium Contribution for: Employees/Members: 100% Dependents: 100%

Are Employee/Member and Dependent premiums paid through a Section 125 Plan? ☒ Yes ☐ No

Are Employee/Member and Dependent premiums collected via payroll deduction? ☒ Yes ☐ No

Premiums shall be payable at the rates included on the attached proposal page.

**If the Group's contribution percentage is changed or the number of eligible Employees/Members increases or decreases, premium may be adjusted as allowed under the Policy. The premium may be adjusted at the end of the calendar month in which the change occurred.*

IV. ELIGIBILITY

Number of Employees/Members: 17,000 Number Applying: _____

Number of Dependents: 14,000 Number of Retirees: 3,700

Are Domestic Partners covered under this Plan? ☒ Yes ☐ No

Same Sex**? ☒ Yes ☐ No Opposite Sex**? ☒ Yes ☐ No

Dependent Children Covered to Age** ☐ 19 ☐ 21 ☐ 25 ☒ Other 26

Dependent Children Covered if Full-Time Student** ☐ Yes ☒ No

If "Yes", Dependent Full-Time Student Covered to** ☐ 21 ☐ 25 ☐ 27 ☐ Other _____

*Except as required by state law.

**Unless state law has different requirements for Dependent Child status.

Eligibility Reporting Contact (produces the eligibility file): Bront Davis

Address (if different from group): _____

City: _____ State: _____ Zip: _____

E-mail Address: bront.davis@uky.edu Phone: 859 257-2372 Fax: 859 323-1095

Eligibility Authorization Contact (Benefits Administrator or Third Party Administrator responsible for verifying vision election for Employees/Members):

Name: Donna Henry Phone: 859 257-8830

Days/Hours of Availability: 8-5 E-mail Address: dkhenr2@email.uky.edu

PROBATIONARY PERIOD

For New Employees/Members: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days ☒ Other 1st day of month following hire date.

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

Number of Employees/Members who have not yet completed the probationary period: 0

V. EFFECTIVE DATE

This plan will become effective at 12:01 a.m. Local Time at the Group's address herein, on the first day of July, 2011, provided all of the following have been completed prior to this effective date:

- A. This application has been received and accepted by the Company (must be submitted 30 days in advance of the effective date).

- B. EyeMed has been furnished a working file of all eligible Employees/Members, according to the layout guidelines. It is understood and agreed that EyeMed may rely on this information to provide services to individuals designated as eligible.

The Group hereby makes application to Fidelity Security Life Insurance Company for Vision Care Benefits. The Group agrees to maintain and furnish any records necessary to administer this plan and to forward premiums monthly.

All the information shown on this application and any attachments are correct and complete as of the date this application is signed. All statements by the Group shall be deemed to be representations and not warranties. The Group understands that the Company intends to rely on this information in determining whether or not the enrolling Employees/Members and their Dependents may become insured. It is further understood and agreed that **NO INSURANCE WILL BECOME EFFECTIVE UNTIL APPROVED BY THE COMPANY**, and that no field representative of the Company has the authority to modify any conditions of the application or the Policy by making any promise or representation. It is understood that the insurance as to any Employee/Member will not become effective on the date insurance should otherwise become effective if he or she is not at work on such date performing all duties of his or her occupation and otherwise meets the requirements of the Company.

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

Dated at: UK this 17 day of July, 2011

Signed for the Group: [Signature] Title: Director of Employee Benefits

VI. EMPLOYEE/MEMBER ID CARDS

Group will be receiving ID cards: ☒ Yes ☐ No

Company Name: University of Kentucky

(Maximum of 30 characters, including punctuation, spacing and any code.)

Delivery of ID cards mailed directly to Employee's/Member's home address.

ATTENTION: THE DEPARTMENT OF INSURANCE REQUIRES THAT ONLY THE BROKER AND/OR GENERAL AGENT WHO SOLD THE PRODUCT AND HOLDS A VALID LIFE AND HEALTH LICENSE MAY COMPLETE THE CERTIFYING STATEMENT.

WRITING BROKER'S CERTIFYING STATEMENT

I certify that I have accurately recorded on this application the information supplied by the applicant and I am properly licensed in the state in which the Group is domiciled.

Firm Name (print): The MPM Group, LLC Tax ID No.: 75-3052829

Broker Name (print): Dale E Baldwin

SS#: [REDACTED]

Address: 1010 Monarch Street, Suite 220 City: Lexington State: KY Zip: 40513

Phone: (859) 223-4973 Fax: (859) 224-1288

Primary Contact: Dale Baldwin Title: Manager E-mail Address: dabaldwin@msn.com

Secondary Contact: Nicole Jordan Title: Office Manager E-mail Address: mpmgroup@msn.com

Commission checks payable to: ☒ Firm ☐ Broker

Broker Signature: [Signature]

WRITING GENERAL AGENT'S CERTIFYING STATEMENT

I certify that I have accurately recorded on this application the information supplied by the applicant and I am properly licensed in the state in which the Group is domiciled.

Firm Name (print): _____ Tax ID No.: _____

General Agent Name (print): _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

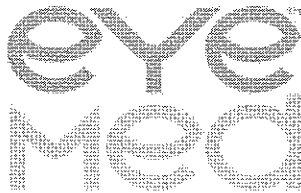
Phone: _____ Fax: _____

Primary Contact: _____ Title: _____ E-mail Address: _____

Secondary Contact: _____ Title: _____ E-mail Address: _____

Commission checks payable to: ☐ Firm ☐ General Agent

General Agent's Signature: _____



University of Kentucky EyePrefer

Version 6

V13

EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company
Fixed Fee Voluntary Insight

The innovation of EyePrefer allows employees to choose from two plan designs to maximize their household's benefit dollar.

Vision Care Services

Exam with Dilatation as Necessary
Exam Options:
Standard Contact Lens Fit and Follow-Up:
Premium Contact Lens Fit and Follow-Up:
Frames:
Any available frame at provider location
Standard Plastic Lenses
Single Vision
Bifocal
Trifocal
Standard Progressive Lens
Premium Progressive Lens
Lens Options:
UV Treatment
Tint (Solid and Gradient)
Standard Plastic Scratch Coating
Standard Polycarbonate - Adults
Standard Polycarbonate - Kids under 19
Standard Anti-Reflective Coating
Polarized
Photocromatic / Transitions Plastic
Premium Anti-Reflective
Other Add-Ons
Contact Lenses
Contact lens allowance includes materials only
Conventional
Disposable
Medically Necessary
Laser Vision Correction
Laser or PRK from U.S. Laser Network
Owned and operated by LCA Vision
Additional Pairs Benefit:

ESSENTIAL	
Member Cost	Out-of-Network Reimbursement
\$10 Copay	\$40
Up to \$40	N/A
10% off Retail Price	N/A
\$0 Copay; \$130 Allowance, 20% off balance over \$130	\$55
\$10 Copay	\$40
\$10 Copay	\$60
\$10 Copay	\$80
\$75 Copay	\$60
See attached Fixed Premium Progressive price list	\$60
\$15	N/A
\$15	N/A
\$15	N/A
\$40	N/A
\$0 Copay	\$30
\$45	N/A
20% off Retail Price	N/A
\$75	N/A
See attached Fixed Premium Anti-Reflective Coating price list	N/A
20% off Retail Price	N/A
\$0 Copay; \$130 allowance, 15% off balance over \$130	\$100
\$0 Copay; \$130 allowance, plus balance over \$130	\$100
\$0 Copay, Paid-in-Full	\$200
15% off Retail Price or 5% off promotional price	N/A
Members also receive a 40% discount off complete pair eyeglass purchases	N/A

ENTRAINED	
Member Cost	Out-of-Network Reimbursement
\$0 Copay	\$42
\$0 Copay, Paid-in-full fit and two follow-up visits	\$40
\$0 Copay, 10% off retail prices, then apply \$40 allowance	\$40
\$0 Copay; \$160 Allowance, 20% off balance over \$160	\$80
\$10 Copay	\$40
\$10 Copay	\$60
\$10 Copay	\$80
\$10 Copay	\$83
See attached Fixed Premium Progressive price list	\$83
\$0 Copay	\$12
\$0 Copay	\$12
\$0 Copay	\$12
\$0 Copay	\$30
\$0 Copay	\$30
\$0 Copay	\$34
20% off Retail Price	N/A
\$75	N/A
See attached Fixed Premium Anti-Reflective Coating price list	\$34
20% off Retail Price	N/A
\$0 Copay; \$160 allowance, 15% off balance over \$160	\$128
\$0 Copay; \$160 allowance, plus balance over \$160	\$128
\$0 Copay, Paid-in-Full	\$210
15% off Retail Price or 5% off promotional price	N/A
Members also receive a 40% discount off complete pair eyeglass purchases	N/A

Frequency	
Examination	Once every 12 months
Frame	Once every 24 months
Lenses	Once every 12 months
OR	
Contact Lenses	Once every 12 months

Frequency	
Examination	Once every 12 months
Frame	Once every 12 months
Lenses	Once every 12 months
OR	
Contact Lenses	Once every 12 months

Monthly Rate
Subscriber
Subscriber + Spouse
Subscriber + Child(ren)
Subscriber + Family

Premium
\$8.50
\$16.00
\$15.20
\$21.40

Premium
\$21.40
\$40.00
\$38.00
\$53.60

Additional Plan Details

Member receives a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers.

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

Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group.

Rates assume at least 80% employee contribution for employees and dependents.

Insured Plans are underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York.

Policy number VC-19/VC-20, form number M-9083

Rates are valid for groups domiciled in the State of KY.

Fees quoted will be valid until the 7/1/2017 plan implementation date. Date quoted: 1/12/2017.

Plan Exclusions

1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Anisokonia lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) 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; 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

Base Rate Guarantee and ACA Fee

All plans are based on a 48-month contract term and 48-month rate guarantee. Premium is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies.

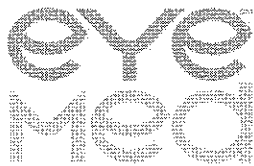
If University of Kentucky has chosen this benefit design, attach this document to the group application and sign here:

Signature

PROLIMINARY AUTHORIZATION

Date

3/30/17



University of Kentucky

Progressive and Anti-Reflective Member Cost Schedule

PROGRESSIVE MEMBER COST SCHEDULE*		ESSENTIAL	ENHANCED
Standard Progressive		Member Cost	Member Cost
		\$75 copay	\$10 Copay
Premium Progressives as Follows:			
Tier 1		\$95 Copay	\$30 Copay
Tier 2		\$105 Copay	\$40 Copay
Tier 3		\$120 Copay	\$55 Copay
Tier 4		\$75 Copay, 80% of charge less \$120 Allowance	\$10 copay, 80% of charge less \$120 Allowance
ANTI-REFLECTIVE MEMBER COST SCHEDULE*			
Standard Anti-Reflective Coating		\$45	\$0 Copay
Premium Anti-Reflective Coatings as Follows:			
Tier 1		\$57	\$12 Copay
Tier 2		\$68	\$23 Copay
Tier 3		80% of charge	\$0 copay, 80% of charge less \$45 allowance
OTHER ADD-ONS PRICE LIST			
Photochromic (Plastic)		\$75	\$75
Polarized		80% of charge	80% of charge

EyeMed Vision Care reserves the right to make changes to the products within each tier and the member out-of-pocket costs.
 *Fixed pricing is reflective of brands at the listed product level. Providers are not required to carry all brands in all tiers. Please consult your provider for what is available.

If this benefit design is chosen, attach this document to the group application and sign here:

Signature PRELIMINARY AUTHORIZATION Date 3/30/17

For a current listing of brands by tier, go to:
<http://www.eyemedvisioncare.com/theme/pdf/microsite-template/eyemedlenslist.pdf>

FACTS

WHAT DOES Fidelity Security Life Insurance Company, Fidelity Security Life Insurance Company of New York (NY Only) and Affiliates DO WITH YOUR PERSONAL INFORMATION?

Why?

Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.

What?

The types of personal information we collect and share depend on the product or service you have with us. This information can include:

- Social Security number and transaction history
- medical information and insurance claim information
- assets and checking account information

When you are no longer our customer, we continue to share your information as described in this notice.

How?

All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons Fidelity Security Life Insurance Company and Affiliates choose to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Fidelity Security Life share?	Can you limit this sharing?
For our everyday business purposes – such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes – to offer our products and services to you	Yes	No
For joint marketing with other financial companies	Yes	No
For our affiliates' everyday business purposes – information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes – information about your creditworthiness	No	We don't share
For our affiliates to market to you	No	We don't share
For nonaffiliates to market to you	No	We don't share

Questions?

Call 800-648-8624 or go to www.fslins.com or www.ftj.com

Who we are	
Who is providing this notice?	Fidelity Security Life Insurance Company and Affiliates including our Administrative, Insurance and Financial Service Providers.
What we do	
How does Fidelity Security Life Insurance Company and Affiliates protect my personal information?	<p>To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings.</p> <p>These physical, electronic and procedural safeguards were created to protect your information. We also limit employee access as appropriate.</p>
How does Fidelity Security Life Insurance Company and Affiliates collect my personal information?	<p>We collect your personal information, for example, when you</p> <ul style="list-style-type: none"> ■ apply for insurance or pay insurance premiums ■ file an insurance claim or give us your contact information ■ show your driver's license <p>We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.</p>
Why can't I limit all sharing?	<p>Federal law gives you the right to limit only</p> <ul style="list-style-type: none"> ■ sharing for affiliates' everyday business purposes – information about your creditworthiness ■ affiliates from using your information to market to you ■ sharing for nonaffiliates to market to you <p>State laws and individual companies may give you additional rights to limit sharing.</p>
Definitions	
Affiliates	<p>Companies related by common ownership or control. They can be financial and nonfinancial companies.</p> <ul style="list-style-type: none"> ■ <i>Our affiliates include Fidelity Security Life Insurance Company of New York, Forrest T. Jones & Company, Inc., Forrest T. Jones Consulting Company and National Pension & Group Consultants, Inc.</i>
Nonaffiliates	<p>Companies not related by common ownership or control. They can be financial and nonfinancial companies.</p> <ul style="list-style-type: none"> ■ <i>Fidelity Security Life Insurance Company does not share with nonaffiliates so they can market to you.</i>
Joint marketing	<p>A formal agreement between nonaffiliated financial companies that together market financial products or services to you.</p> <ul style="list-style-type: none"> ■ <i>Our joint marketing partners include insurance agencies, broker dealers and investment advisor firms.</i>
Other important information	



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POLICYHOLDER: University of Kentucky
POLICY EFFECTIVE DATE: July 1, 2011
POLICY ANNIVERSARY DATE: July 1 of the following year and each July 1 thereafter

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

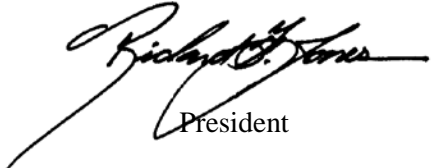
The Policy may be amended, changed, cancelled or discontinued without the consent of any Insured Person.


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

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

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

FIDELITY SECURITY LIFE INSURANCE COMPANY


President


Secretary

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.....	3
EFFECTIVE DATES.....	4
BENEFITS.....	5
LIMITATIONS.....	6
EXCLUSIONS.....	6
TERMINATION OF INSURANCE.....	6
CLAIMS	7
GENERAL PROVISIONS	8
SCHEDULE OF BENEFITS	Attached (1A)

DEFINITIONS

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

The Benefit Frequency begins on the later of the Insured Person's effective date or last date services were provided to the Insured Person. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

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

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

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

1. the Insured's lawful spouse or Domestic Partner;
2. each unmarried child from birth to age 19 who is primarily dependent upon the Insured or the Insured's spouse for support and maintenance;
3. each unmarried child at least 19 years of age to 25 years of age who is primarily dependent upon the Insured or the Insured's spouse for support and maintenance and who is a full-time student; or
4. each unmarried child at least 19 years of age: who is primarily dependent upon the Insured or the Insured's spouse for support and maintenance because the child is incapable of self-sustaining employment by reason of mental incapacity or physical handicap; who was so incapacitated and is an Insured Person under the Policy on his or her 19th birthday; and who has been continuously so incapacitated since his or her 19th birthday.

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

Domestic Partner means an adult who is in a committed relationship with the Insured, and the Insured and the Domestic Partner are mutually responsible for one another financially and otherwise. To qualify as a Domestic Partner or Dependent under the Policy, all of the following conditions must be met:

1. the Domestic Partner and the Insured are over the age of 18 and are mentally competent to enter into contracts;
2. the Domestic Partner and the Insured reside in the same household;
3. the Domestic Partner and the Insured have a committed relationship with each other for no less than six months; intend to continue the relationship indefinitely and have no such relationship with any other person;
4. the Domestic Partner and the Insured are not related by blood;
5. the Domestic Partner and the Insured are not married to any third party;
6. the Domestic Partner and the Insured are of the same sex or opposite sex; and
7. the Domestic Partner and the Insured are not claiming Dependent status for the primary purpose of gaining insurance coverage under the Policy.

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

Formulary means a list, provided by the Company, of Vision Materials covered under the Policy.

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

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

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

Medically Necessary Contact Lenses means:

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

Out-of-Area Provider means a Provider that is utilized by the Insured Person when there is no In-Network Provider within 30 minutes or 30 miles of the Insured Person's residence or work.

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

Policy means the Policy issued to the Policyholder.

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

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

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

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

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

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

Vision Materials means those materials shown in the Schedule of Benefits.

EFFECTIVE DATES

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

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

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

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

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

Newborn Children. A Dependent child born while the Insured's coverage is in force will be covered from the moment of birth for 31 days or greater, if elected by the Policyholder. In order to continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period.

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

BENEFITS

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

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

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

Out-of-Area. An Insured Person who does not have access to an In-Network Provider within 30 minutes or 30 miles of the Insured Person's residence or work may receive services from an Out-of-Area Provider. The Insured Person must pay the full cost at the time the covered service is provided and file a claim with the Company. The Insured Person must pay any In-Network Co-payment or any cost above the In-Network allowance shown in the Schedule of Benefits.

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

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

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

LIMITATIONS

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

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

EXCLUSIONS

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

1. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
2. medical and/or surgical treatment of the eye, eyes or supporting structures;
3. any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear;
4. services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
5. plano (non-prescription) lenses;
6. non-prescription sunglasses;
7. two pair of glasses in lieu of bifocals;
8. services or materials provided by any other group benefit plan providing vision care;
9. 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
10. lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

TERMINATION OF INSURANCE

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

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

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

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

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

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

1. not capable of self-sustaining employment due to mental incapacity 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 ask for it more than once a year after this coverage has been continued for two years. This continued coverage will end:

1. on the date the Policy ends;
2. on the date the incapacity or dependency ends;
3. on the end of the last period for which any required premium contribution for the Dependent child has been made; or
4. 60 days following the date the Company requests proof and such proof is not provided to the Company.

CLAIMS

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

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

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

Time Payment of Claims. Any benefit payable under the Policy will be paid immediately, 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.

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

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

Claim Appeal Procedure. If the Company partially or fully denies a claim for benefits submitted by an Insured Person and the Insured Person disagrees or does not understand the reasons for this denial, the Insured Person, an authorized person or a provider acting on behalf of the Insured Person may appeal this decision and such person has the right to:

1) request a review of the denial; 2) review pertinent plan documents; and 3) submit in writing any data, documents or comments which are relevant to the Company's review of this denial. The appeal must be submitted in writing within 60 days of receiving written notice of denial. The Company will review all information and send written notification within 30 days of the request.

GENERAL PROVISIONS

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

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

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

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

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

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

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

<u>Benefit</u>	<u>In-Network Cost</u>	<u>Out-of-Network Reimbursement</u>	<u>Benefit Frequency</u>
VISION EXAMINATION			
Comprehensive Eye Examination	\$10 Co-payment	up to \$40	12 months
Contact Lenses Fit And Follow-Up			12 months
Standard	\$0 Co-payment, Paid in full fit and two follow-up visits	up to \$40	
Premium	\$0 Co-payment, up to \$160 allowance	up to \$40	
VISION MATERIALS			
Standard Plastic Lenses			12 months
Single Vision	\$10 Co-payment	up to \$40	
Bifocal	\$10 Co-payment	up to \$60	
Trifocal	\$10 Co-payment	up to \$80	
Frames	\$0 Co-payment, up to \$130 retail allowance	up to \$55	24 months
Contact Lenses (only one option available per Benefit Frequency)			12 months
Conventional	\$0 Co-payment, up to \$130 allowance	up to \$100	
Disposable	\$0 Co-payment, up to \$130 allowance	up to \$100	
Medically Necessary	Paid in full	up to \$200	
Lens Options			12 months
Standard Polycarbonate (For covered Dependent children under { 18-27 } years of age.)	\$0 Co-payment	up to \$30	
Standard Progressive Lenses (add on to Bifocal)	\$75 Co-payment	up to \$60	
Premium Progressive Lenses (add on to Bifocal)			
Tier 1	\$95 Co-payment	up to \$60	
Tier 2	\$105 Co-payment	up to \$60	
Tier 3	\$120 Co-payment	up to \$60	
Tier 4	\$75 Co-payment, Less \$120 allowance	up to \$60	

SCHEDULE OF BENEFITS

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

<u>Benefit</u>	<u>In-Network Cost</u>	<u>Out-of-Network Reimbursement</u>	<u>Benefit Frequency</u>
VISION EXAMINATION			
Comprehensive Eye Examination	\$0 Co-payment	up to \$42	12 months
Contact Lenses Fit And Follow-Up			12 months
Standard	\$0 Co-payment, Paid in full fit and two follow-up visits	up to \$40	
Premium	\$0 Co-payment, up to \$160 allowance	up to \$40	
VISION MATERIALS			
Standard Plastic Lenses			12 months
Single Vision	\$10 Co-payment	up to \$40	
Bifocal	\$10 Co-payment	up to \$60	
Trifocal	\$10 Co-payment	up to \$80	
Frames	\$0 Co-payment, up to \$160 retail allowance	up to \$80	12 months
Contact Lenses (only one option available per Benefit Frequency)			12 months
Conventional	\$0 Co-payment, up to \$160 allowance	up to \$128	
Disposable	\$0 Co-payment, up to \$160 allowance	up to \$128	
Medically Necessary	Paid in full	up to \$210	
Lens Options			12 months
Standard Polycarbonate	\$0 Co-payment	up to \$30	
Standard Polycarbonate (For covered Dependent children under { 18-27} years of age.)	\$0 Co-payment	up to \$30	
UV Treatment	\$0 Co-payment	up to \$12	
Tint {Solid} or {Gradient}	\$0 Co-payment	up to \$12	
Standard Plastic Scratch Coating	\$0 Co-payment	up to \$12	
Standard Progressive Lenses (add on to Bifocal)	\$10 Co-payment	up to \$83	
Premium Progressive Lenses (add on to Bifocal)			
Tier 1	\$30 Co-payment	up to \$83	
Tier 2	\$40 Co-payment	up to \$83	
Tier 3	\$55 Co-payment	up to \$83	
Tier 4	\$10 Co-payment, Less \$120 allowance	up to \$83	
Standard Anti-Reflective Coating	\$0 Co-payment	up to \$34	
Premium Anti-Reflective Coating	Tier 1 - \$12 Co-payment Tier 2 - \$23 Co-payment Tier 3 - \$0 Co-payment, Less \$45 allowance	up to \$34	

REVISED 7-1-17



FIDELITY SECURITY LIFE INSURANCE COMPANY

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

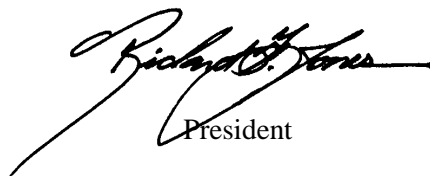
AMENDMENT RIDER

By attachment of this Rider, the third paragraph of the **PREMIUMS** section in the Policy is amended to add the following:

5. if a government action, including fees, taxes and assessments, or change in law or regulation materially affects the Company's risk, premium may be adjusted and will be effective upon written notification from the Company at least 31 days before the date of change.

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

FIDELITY SECURITY LIFE INSURANCE COMPANY


President


Secretary



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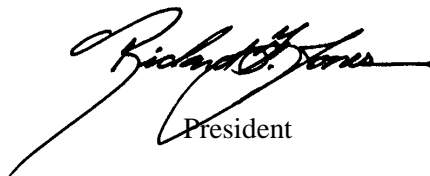
AMENDMENT RIDER

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

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

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

FIDELITY SECURITY LIFE INSURANCE COMPANY


President


Secretary



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NOTICE OF ADMINISTRATOR'S CAPACITY

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

1. Fidelity Security Life Insurance Company (FSL) has, by agreement, arranged for 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.