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-20

POLICYHOLDER: University of California Postdoctoral

POLICY EFFECTIVE DATE: January 1, 2019

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

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

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

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

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

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

FIDELITY SECURITY LIFE INSURANCE COMPANY

President Secretary

GROUP VISION INSURANCE CERTIFICATE
THIS IS A LIMITED BENEFIT CERTIFICATE
Please read the Certificate carefully.

THIS PLAN IS NOT MEDICARE SUPPLEMENT. If you are eligible for Medicare, please review "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare," available from the Company.

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

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DEFINITIONS

Benefit Frequency means the period of time in which a benefit is payable.

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

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

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

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

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

Medically Necessary Contact Lenses means:

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

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

Policy means the Policy issued to the Policyholder.

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

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

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

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

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

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

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

EFFECTIVE DATES

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

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

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

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

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

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

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

BENEFITS

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

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

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

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

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

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

LIMITATIONS

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

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

EXCLUSIONS

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

1. orthoptic or vision training, subnormal vision aids and associated supplemental testing; Aniseikonic lenses;
2. medical and/or surgical treatment of the eye, eyes or supporting structures;
3. any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear;
4. services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
5. plano (non-prescription) lenses;
6. non-prescription sunglasses;
7. two pair of glasses in lieu of bifocals;
8. services 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 a physically or mentally disabling injury, illness or condition that began before the age limit was reached; and
2. mainly dependent on the Insured for support.

The Company will notify the Insured that the Dependent child's coverage will terminate upon attainment of the limiting age at least 90 days prior to the termination. The Company may ask for proof of the eligible Dependent child's incapacity and dependency two months prior to the date the Dependent child would otherwise cease to be covered.

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

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

CLAIMS

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

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

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

Time Payment of Claims. Any benefit payable under the Policy will be paid immediately upon receipt of due written proof of loss.

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

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

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

GENERAL PROVISIONS

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

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

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

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

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

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

FIDELITY SECURITY LIFE INSURANCE COMPANY

Notice of Availability of Language Assistance Services

XXX-XXX-XXXX = 1-877-226-1115

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-877-226-1115. For more help call the CA Dept. of Insurance at 1-800-927-4357.

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-877-226-1115. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357.

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم XXX-XXX-XXXX. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357 Arabic.

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ XXX-XXX-XXXX համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

免費語言服務。您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 XXX-XXX-XXXX 與我們聯絡。欲取得其他協助，請致電1-800-927-4357 與加州保險部聯絡。Chinese

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis XXX-XXX-XXXX. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または XXX-XXX-XXXX までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ XXX-XXX-XXXX ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: XXX-XXX-XXXX 번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

خدمات جانبی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگرنید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره XXX-XXX-XXXX تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ XXX-XXX-XXXX 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или XXX-XXX-XXXX. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa XXX-XXX-XXXX. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc XXX-XXX-XXXX. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese.

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NOTICE

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

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

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

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

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Health Care Insurer Appeals Process Information Packet

Please read this notice carefully. This notice contains important information about how to appeal decisions made by your insurer.

1. Levels of Review

You may ask the insurer to review its decisions involving your requests for service or your request to have your claims paid. In general, the following four levels will be available to you.

Level 1	Expedited Medical Review.
Level 2	Informal Reconsideration.
Level 3	Formal Appeal.
Level 4	Independent Medical Review

These levels of review are discussed more fully below.

A. Expedited Medical Review (Level 1)

1. Eligibility

a. Claim for a covered service not yet provided:

You may obtain Expedited Medical Review of your denied request for a covered service that has not already been provided if:

* You have coverage with the insurer.
* Your insurer has denied your request for a covered service.
* Your physician or treating provider certifies in writing and provides supporting documentation that the time required to process your request through the Informal Reconsideration process could cause a significant negative change in your medical condition.

b. Claim for a covered service already provided but not paid for:

You may not obtain expedited medical review of your denied request for a covered service that has already been provided. Instead, you may start the review process by seeking Formal Appeal (Level 3).

2. Decision:

After receiving the certification and the supporting documentation, the insurer has 24 hours to make a decision and orally communicate that decision to you or your health care provider. Written notice of the decision will also be mailed to you within one day after the decision has been orally communicated to you and/or your health care provider.

The written notice will include the criteria used, the clinical reasons for that decision and any references to supporting documentation. This notice will also be sent to your physician or treating provider.

a. Denial upheld

If your insurer agrees that the covered services should have been denied, you may ask for further review through the Formal Appeal process (Level 3) discussed below.

b. Denial reversed

If your insurer agrees that the covered service should have been provided, your insurer must authorize the service.

B. Informal Reconsideration (Level 2)

1. Eligibility

a. Claim for a covered service not yet provided:

If your insurer denies your request for a covered service that has not already been provided, and you do not qualify for an Expedited Medical Review (Level 1), you may ask for Informal Reconsideration (Level 2) of that denial by calling, writing or faxing your request to:

First American Administrators, Inc.
ATTN: Quality Assurance Department
4000 Luxottica Place
Mason, Ohio 45040
Or you may call the toll-free number at:
1-877-226-1115

b. Claim for a covered service already provided, but not paid for:

You may not obtain Informal Reconsideration of your denied request for the payment of a covered service. Instead, you may start the review process by seeking Formal Appeal (Level 3).

2. Deadlines Applicable to the Informal Reconsideration Process:

You have up to two years after your insurer denies your request for a covered service to request an Informal Reconsideration.

Within two business days after receiving your request for Informal Reconsideration, your insurer will send you a notice showing that your request was received. At that time, if the insurer does not have sufficient information to complete the Informal Reconsideration process, the insurer will advise you that it may not proceed with its review unless additional information is provided. The insurer agrees to assist you in gathering the necessary information. You will also receive another copy of this information packet with that notice.

3. Decision

Unless you or your health care provider agree in writing to an extension of up to 30 business days, your insurer has 30 days to make a decision and orally communicate that decision to you or your health care provider. Written notice of the decision will also be mailed to you within 5 business days after the decision has been orally communicated to you and/or your health care provider. This notice will also be sent to your physician or treating provider.

a. Denial upheld

If your insurer continues to agree that the covered service should have been denied, you will receive a notice of that decision. The notice will include a description of the criteria used, the clinical reasons for that decision and any references to supporting documentation.

You may ask for further review through the Formal Appeal process (Level 3) discussed below.

b. Denial reversed

If your insurer agrees that the covered service should have been provided, your insurer must authorize the service.

C. Formal Appeal (Level 3).

1. Eligibility

a. Claim for a covered service not yet provided:

If your insurer denies your request for a covered service after either the Expedited Medical Review (Level 1) or Informal Reconsideration (Level 2), you may send a written request for Formal Appeal within 60 days of the last denial to:

First American Administrators, Inc.
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 elect this option, you or your physician or treating provider must give the insurer any material justification or documentation to support your request for the service.

b. Claim for a covered service already provided, but not paid for:

If your insurer denies your claim for a covered service that has already been provided, you may send written request for Formal Appeal within two years of the last denial to:

First American Administrators, Inc.
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 elect this option, you or your physician or treating provider must give the insurer any material justification or documentation to support your request for the service.

2. Deadlines Applicable to the Formal Appeal Process:

Within five business days after receiving your request for Formal Appeal, your insurer will send you a notice showing that your request was received. You will also receive another copy of this information packet with that notice.

a. Claim for covered service not yet provided:

Your insurer has 30 days to make a decision and mail a notice of that decision to you, send you the written decision, a description of the criteria used, the clinical reasons for that decision and any references to supporting documentation. Your insurer will also send a copy of this information to your physician or treating provider.

b. Claim for a covered service already provided, but not paid for:

Your insurer has 30 days to make a decision and mail a notice of that decision to you, send you the written decision and a description of the supporting documentation. Your insurer will also send a copy of this information to your physician or treating provider.

3. Decision

a. Denial upheld

If your insurer continues to agree that the covered service or claim for a covered service should have been denied, you will receive a notice of that decision.

b. Denial reversed

If your insurer agrees that the covered service should have been provided, or that your claim should have been paid, your insurer must authorize the service or pay the claim.

D. Independent Medical Review (Level 4)

1. Eligibility

If your insurer denies your request for a "disputed health care service" (see VI Definitions) under Levels 1 or 3, you may ask for Independent Medical Review under Level 4.

If an insurer or one of its contracting providers issues a decision denying, modifying or delaying health care services, based in whole or in part on a finding that the proposed health care services are not a covered benefit, the decision will clearly specify the provision of the contract that excludes that coverage. Independent Medical Review cannot be used for an insurer decision that is based on a coverage issue only.

All insured grievances involving a disputed health care service are eligible for review under Independent Medical Review (Level 4) if the requirements set forth in 2. below are met. If the Department of Insurance (Department) finds that an insured grievance involving a disputed health care service does not meet the requirements for Independent Medical Review, then the request for review will be treated as a request for the Department to review the grievance. The Department will have the final authority to determine whether the grievance is more properly resolved through Independent Medical Review.

2. Applying for Independent Medical Review

You may apply to the Department of Insurance for an Independent Medical Review (Level 4) when the following conditions are met:

a) Your physician or treating provider has recommended a health care service as medically necessary; or
b) You have received urgent care or emergency services that were determined by your physician or treating provider to be medically necessary; or
c) You have been seen by a physician or treating provider in the absence of a provider recommendation, for the diagnosis or treatment of the medical condition for which you seek Independent Medical Review;
d) The disputed health care service has been denied, modified or delayed by the insurer or by your physician or treating provider based in whole or in part on a decision that the health care service is not medically necessary;
e) You have filed a grievance with the insurer or your physician or treating provider and the disputed decision is upheld or the grievance remains unresolved after 30 days.

You may apply to the Department of Insurance for an Independent Medical Review (Level 4) within six months of any decision by your insurer. This deadline may be extended if the Department believes that circumstances of the case warrant an extension.

You will not have to pay an application or processing fee of any kind for this review.

You must fill out the application form N-00185CA and send it to the Department. An envelope addressed to the Department will be provided by the insurer for this purpose.

Upon notice from the Department that you have applied for an Independent Medical Review, the insurer must provide the Independent Review Organization (IRO) designated by the Department:

a) a copy of all of your medical records that are in their possession relating to your medical condition;
b) the services being provided;
c) the disputed health care services, requested by you, for the condition;
d) any newly developed or discovered relevant medical records in possession of the insurer after the initial documents are provided will be forwarded immediately;
e) a copy of all information provided to you concerning the decision reached by the insurer regarding your condition and care and a copy of any materials submitted to the insurer by you or your physician or treating provider in support of your request for disputed health care services, which will include a written response to the grievance;
f) a copy of any other relevant documents or information used by the insurer in determining whether disputed health care services should have been provided and any statements explaining the reasons for the decision to deny, modify or delay.

This information must be provided within 3 business days of the insurer's receipt of the Department's notice of your request for an Independent Medical Review.

3. Expedited Independent Review

If there is an "imminent and serious threat" to your health, all necessary information and documents must be delivered to an IRO within 24 hours of approval of the request for review. In reviewing the request, the Department may waive the requirement that you follow the appeals process where there is an extraordinary and compelling case and the Commissioner finds the insurer has acted reasonably.

The Department will review the expedited request and inform you, in writing, if the request is approved in whole or in part and if not approved, the reasons why. The insurer must notify you, after submitting all required material to the IRO, that you may request a copy of all documents submitted.

4. Decision

Upon receipt of information and documents related to a case, the IRO will conduct a review to determine if the disputed health care service was medically necessary based on your specific medical needs and on the following: peer reviewed scientific and medical evidence regarding the effectiveness of the disputed service, nationally recognized professional standards, expert opinion, generally accepted standards of medical practice, and treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

The IRO will complete its review and make its determination in writing within 30 days of receipt of the application for review (with supporting documentation).

If the disputed health care service has not been provided and your provider certifies in writing that an imminent and serious threat to your health may exist, then the analyses and determination of the reviewers will be rendered within three days of receipt of the information.

The IRO will provide you, the insurer and your provider with the analyses and determination of the medical professionals reviewing the case and a description of the medical professionals.

The Commissioner of Insurance will immediately adopt the determination of the IRO and will promptly issue a written decision to the parties that will be binding on the insurer.

II. Obtaining Medical Records

A. Requesting Medical Records

You have the right to ask for a copy of medical records. Your request must be in writing. Your request must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

B. Designated Decision Maker

If you have a designated health care decision maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision maker or a person designated in writing by your health care decision maker unless you limit access to your medical records only to yourself or your health care decision maker.

C. Confidentiality

Medical Records disclosed under any State Regulations remain confidential.

III. Documentation for an Appeal

If you decide to file an appeal, you must give the person who will be responsible for processing the appeal any material justification or documentation for the appeal at the time the appeal is filed. You must also give that person the address and phone number where you can be contacted.

IV. Confidentiality

If you participate in the review process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other person.

V. Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed" means your last known address.

VI. Definitions

A "disputed health care service" means any health care service eligible for coverage and payment that has been denied, modified or delayed by a decision of the insurer or by one of its contracting providers, in whole or in part due to a finding that the service was not medically necessary. A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage decision.

"Imminent and serious threat" means including but not limited to serious pain, the potential for loss of life, limb or major bodily function, or the immediate and serious deterioration of the health of the insured.

FIDELITY SECURITY LIFE INSURANCE COMPANY

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

INFORMATION AND INSTRUCTIONS REGARDING YOUR APPLICATION FOR INDEPENDENT MEDICAL REVIEW

Before you request an Independent Medical Review with the California Department of Insurance, you are required to first file an appeal/grievance with the insurance company in an effort to resolve the issue(s). If you do not receive a satisfactory response after 30 days, then complete the Application for Independent Medical Review, attach copies of any important papers that relate to your complaint and mail to California Department of Insurance at the address shown on the application form. You may also attach additional sheets as necessary to explain and/or describe the situation and disagreement with your insurance company. We consider this information necessary to our review and within the powers and duties expressed in the California Insurance Code, Section 12921.3 and Section 10169. Please review our privacy statement regarding information we obtain from you.

Please be aware that a copy of your Application for Independent Medical Review will be provided to the insurance company and the Independent Medical Review Organization.

You have the right to provide any information or documentation you believe will support your position in this review.

You may inspect the information you submit at any time as long as the department's case is maintained. All original documents will be returned to you upon completion of our handling.

APPLICATION FOR INDEPENDENT MEDICAL REVIEW MAY BE SUBMITTED TO THE DEPARTMENT OF INSURANCE FOR THE FOLLOWING TYPES OF PROBLEMS:

1. Denial of a claim due to the company's opinion that the treatment or service is not medically necessary or that it is experimental and excluded by a policy provision.

2. An offer of an amount less than that indicated in the policy due to the company's opinion of medical necessity.

3. Delay in settlement of a claim due to the disputed issue of medical necessity.

4. Denial of a claim for urgent or emergency services.

Under the Independent Medical Review process, one or more physicians will determine these issues and their decision will be binding on the insurance company.

N-00185(CA)-1

Fidelity Security Life Insurance Company
P.O. Box 418131 • 3130 Broadway
Kansas City, MO 64141-8131

Insurance Company Contact: First American Administrators, Inc.
ATTN: Quality Assurance Department
4000 Luxottica Place
Mason, Ohio 45040
Or you may call the toll-free number at:
1-877-226-1115

APPLICATION FOR INDEPENDENT MEDICAL REVIEW

Name _____ Work Phone: ( ) _____

Address _____ Home Phone: ( ) _____

City _____ Zip _____

Please be aware that a copy of this Application for Independent Medical Review will be provided to the insurance company. Also, please be advised that:

- **A decision not to participate in the independent review process may cause the forfeiture of any statutory right to pursue legal action against the insurer regarding the disputed health care service.**
- **Your consent to obtain any necessary medical records from the insurer, any of its contracting providers, and any out-of-plan provider the insured may have consulted on the matter, is necessary to be signed by you.**
- **You have the right to provide information or documentation, either directly or through your provider, regarding any of the following:**
  - **The provider's recommendation indicating that the disputed health care service is medically necessary for the insured's medical condition.**
  - **Medical information or justification that a disputed health care service, on an urgent care or emergency basis, was medically necessary for the insured's medical condition.**
  - **Reasonable information supporting your position that the disputed health care service is or was medically necessary for the medical condition, including all information provided to the insured by the insurer or any of its contracting providers, still in the possession of the insured, concerning an insurer or provider decision regarding disputed health care services, and a copy of any materials the insured submitted to the insurer, still in the possession of the insured, in support of the grievance, as well as any additional material that the insured believes is relevant.**

1. Complete name of insurance company and policy/certificate number:

   _____

2. Claim number and date(s) of medical service(s):

   _____

3. Have you contacted the company to request an Independent Medical Review?
   ☐ Yes ☐ No (Provide copies of all correspondence)

4. If there is an imminent and serious threat to the health of the insured or claimant, please check and indicate the diagnosis. ☐

   _____

5. Briefly describe the disputed medical service or expense that you want referred to the Independent Medical Review Organization and list the physicians who have treated you for this condition. Use additional paper as needed.

   _____

   _____

I hereby request Independent Medical Review of my dispute with the insurer. I authorize the release of any and all of my medical records and information, of any type, of or pertaining to the scope of this authorization including medical, mental health, substance abuse, HIV records, diagnostic imaging reports, and any other type of non-documentary records, as well as pertinent non-medical records and information. This authorizes release by and among all medical providers, the insurer, the California Department of Insurance and any Independent Medical Review Organization. Release and disclosure are authorized only to the extent any of those persons or entities may deem appropriate for a purpose consistent with the review of a complaint regarding health care services. This authorization will expire one year from the date below, except as regarding the Department's internal use or as otherwise allowed by law. The expiration will apply to all information not previously released pursuant to this authorization. This authorization may be revoked or withdrawn at any time. A revocation or withdrawal will apply to all information not previously released pursuant to this authorization. I attest that the information provided is accurate and truthful.

Signature _____ Date _____

Send a copy of this application to: California Department of Insurance
Claims Services Bureau – Attn: IMR
300 South Spring Street, South Tower, 11th Floor
Los Angeles, CA 90013
Fax: 213-897-5891

FIDELITY SECURITY LIFE INSURANCE COMPANY

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

CALIFORNIA CONTINUATION OF COVERAGE (Cal-COBRA)

CAL-COBRA applies to employer groups with 2 to 19 eligible Employees that are not offered continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1983 (COBRA).

DEFINITIONS

The definitions below are applicable to this Rider only:

1) **Continuation of Coverage** means extended coverage under the Group Benefit Plan under which an eligible Subscriber or eligible Dependent is currently covered, or, in the case of a termination of the Group Benefit Plan or an employer open enrollment period, extended coverage under the Group Benefit Plan currently offered by the Employer.
2) **Group Benefit Plan** means a vision plan as defined in Chapter 8 (commencing with Section 10700) of California law) to an employer with 2 to 19 eligible Employees.
3) **Qualified Beneficiary** means any individual who, on the day before the Qualifying Event, is covered under a Group Benefit Plan offered by a disability insurer and has a Qualifying Event as defined in subdivision (4).
4) **Qualifying Event** means any of the following events that, but for the election of Continuation Coverage as set forth herein, would result in a loss of coverage under the Group Benefit Plan to a Qualified Beneficiary.
   a) Death of the covered Employee.
   b) Termination of employment or reduction in hours of the covered Employee's employment for any reason other than for gross misconduct.
   c) Divorce or legal separation of the covered Subscriber from the covered Subscriber's spouse.
   d) The loss of dependent status by a Dependent enrolled in the Group Benefit Plan.
   e) With respect to a covered Dependent only, the covered Subscriber's entitlement to benefits under Title XVIII of the United States Social Security Act (Medicare).
5) **Employer** means any Employer that:
   a) Employed 2 to 19 eligible Employees on at least 50 percent of its working days during the preceding calendar year, or, if the Employer was not in business during any part of the preceding calendar year, employed 2 to 19 eligible Employees on at least 50 percent of its working days during the preceding calendar quarter;
   b) Has contracted for health care coverage through a group plan through a disability insurer; and
   c) Is not subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.

EXEMPTION TO COVERAGE

The continuation coverage requirement of CAL-COBRA does not apply to the following individuals:

1) Individuals who are entitled to Medicare benefits or become entitled to Medicare benefits.
2) Individuals who have other hospital, medical or surgical coverage, or who are covered or become covered under another Group Benefit Plan, including a self-insured employee welfare benefit plan, that provides coverage for individuals and that does not impose any exclusion or limitation with respect to any pre-existing condition of the individual, other than a pre-existing condition limitation or exclusion that does not apply to or is satisfied by the qualified beneficiary.
3) Individuals who are covered, become covered, or are eligible for federal COBRA coverage.
4) Individuals who are covered, become covered, or are eligible for coverage pursuant to Chapter 6A of the Public Health Service Act, 42 U.S.C. Section 300bb- 1 et seq.
5) Qualified Beneficiaries who fail to give notification of a Qualifying Event or election of continuation coverage within the specified time limits as hereinafter set forth.
6) Qualified Beneficiaries who fail to submit the correct premium amount as hereinafter set forth, or fail to satisfy other terms and conditions of this Policy or contract.

CONTINUATION PROVISIONS

An Insured may elect Continuation of Coverage:

1) Upon a Qualifying Event without evidence of insurability, and upon such an election, the Insured shall continue his/her coverage under the Group Benefit Plan, subject to the Plan's terms and conditions. Unless otherwise provided, Continuation of Coverage shall be provided under the same terms and conditions that apply to similarly situated individuals under the Group Benefit Plan:
2) If his or her Continuation Coverage is terminated under the Group Benefit Plan pursuant California law, subdivision (b) of Section 10128.57, prior to any other termination date specified in said Section 10128.57; or who elects coverage through the insurer during any employer sponsored open enrollment, and the Employer has contracted with the disability insurer to provide coverage to the Employer's active Employees. This Continuation Coverage shall be provided only for the balance of the period that the Qualified Beneficiary would have remained covered under the prior Group Benefit Plan had the Employer not terminated the contract with the previous insurer or health care service plan.
3) For any child who is born to a former Employee who is a Qualified Beneficiary who has elected Continuation Coverage pursuant to this Rider, or a child who is placed for adoption with a former Employee who is a Qualified Beneficiary who has elected Continuation Coverage pursuant to this Rider and is a Qualified Beneficiary entitled to receive benefits pursuant to this Rider for the remainder of the period that the former Employee is covered pursuant to this Rider, if the child is enrolled under a Group Benefit Plan as a Dependent of that former Employee who is a Qualified Beneficiary within thirty (30) days of the child's birth or placement for adoption.
4) If the Insured becomes a Qualified Beneficiary pursuant to this Rider, he or she shall continue to receive coverage pursuant to this Rider until Continuation of Coverage is terminated at the Qualified Beneficiary's election or pursuant to Termination of Continuation Coverage, whichever comes first, even if the Policyholder becomes subject to **ERISA**.

ELECTION

1) A Qualified Beneficiary shall notify the Company, in writing, of a Qualifying Event. Within 14 days of receipt of notice of a Qualifying Event, We will provide a Qualified Beneficiary with all necessary benefit information, premium information, enrollment forms, and the appropriate disclosures needed by the Qualified Beneficiary to elect continuation coverage. The Qualified Beneficiary must then give notice to the Company of the Qualifying Beneficiary's election of Continuation Coverage. Failure to provide said notice, within sixty (60) days will disqualify the Qualified Beneficiary from receiving Continuation of Coverage. The Notice must:
   a) Be in writing;
   b) Be delivered by first-class mail or other reliable means of delivery to the Company;
   c) Be delivered within sixty (60) days of the later of the following:
      i. The date the Insured's coverage under the Group Benefit Plan terminated or will terminate by reason of a Qualifying Event; or
      ii. The date that the Insured was sent notice of his ability to continue coverage under the Group Benefit Plan.

PREMIUM PAYMENT

1) A Qualified Beneficiary shall pay, through his/her Employer, premium to the Company as follows:
   a) Not more than 110% of the applicable rate charged, for a covered Employee or a covered Employee's Dependent, to a similarly situated individual under the Group Benefit Plan.
   b) Not more than 150% of the group rate after the first eighteen (18) months of Continuation Coverage for a Qualified Beneficiary who is determined disabled under Title II or Title XVI of the United States Social Security Act.
   c) The first premium payment shall be delivered, through his or her Employer, to the Company by first-class mail or other reliable means of delivery within forty-five (45) days of the date the Qualified Beneficiary provided written notice to the Company or his or her Employer of the election to continue coverage.
   d) The first premium must equal an amount sufficient to pay all required premiums and all premiums due. Failure to submit the correct premium amount within the forty-five (45) days, of the date that the Company received notice of the Continuation of Coverage election from the Qualified Beneficiary, will disqualify the Qualified Beneficiary from receiving Continuation Coverage.
   e) On or before the date that the premium is due; but not more often than on a monthly basis.
2) If, the Group Benefit Plan coverage of a prior carrier is terminated prior to the date that Continuation of Coverage under said prior plan, a Qualified Beneficiary may elect Continuation Coverage under this Plan for the balance of the period that the Qualified Beneficiary would have been eligible for Continuation Coverage under the prior plan. In order to obtain this benefit, the Qualified Beneficiary must enroll in and pay premiums to the Company within thirty (30) days of receiving notice of termination of the prior plan.

TERMINATION OF CONTINUATION COVERAGE

1) Continuation Coverage shall terminate on the first to occur of the following:
   a) Thirty-six (36) months for a Qualified Beneficiary whose benefits under this Plan would otherwise have terminated because of termination of employment or reduction in hours of the covered Employee's employment for any reason other than for gross misconduct.
   b) The end of the period for which premium was paid if the Qualified Beneficiary fails to make timely payments or ceases to make payment of required premium.
   c) Thirty-six (36) months for a Qualified Beneficiary whose benefits under this Plan would otherwise have terminated by reason of:
      i. Death of the covered Employee;
      ii. Divorce or legal separation of the covered Employee from the covered Employee's spouse;
      iii. The loss of dependent status by a Dependent enrolled in the Group Benefit Plan; or
      iv. With respect to a covered Dependent only, the covered Employee's entitlement to benefits under Title XVIII of the United States Social Security Act (Medicare).
   d) The Qualified Beneficiary becomes subject to the Exemption of Coverage provisions previously set forth in this Rider.

e) Thirty-six (36) months for a Qualified Beneficiary whose benefits under this Plan would otherwise have been terminated because of termination of employment or reduction in hours of the covered Employee's employment for any reason other than for gross misconduct provided said Qualified Beneficiary is determined by Social Security to be disabled any time during the first sixty (60) days of Continuation Coverage, and the spouse or Dependent thirty-six (36) months after the Qualified Beneficiary's benefits would otherwise have terminated because of a Qualified Event. The Qualified Beneficiary shall notify the Company of the social security determination within sixty (60) days of the date of the determination letter and prior to the end of the original thirty-six (36) month Continuation of Coverage period. If the Qualified Beneficiary is no longer disabled, the benefits under this paragraph shall terminate on the later of the date provided in paragraph (a) above, or the month that begins more than thirty-one (31) days after the date of the determination by Social Security that the Qualified Beneficiary is no longer disabled. The Qualified Beneficiary entitled to thirty-six (36) months shall give the Company notice of the determination letter stating that the Qualified Beneficiary is no longer disabled within thirty (30) days of receipt of said determination letter.

f) Thirty-six (36) months for a Qualified Beneficiary whose benefits under this Plan would otherwise have terminated because of termination of employment or reduction in hours of the covered Employee's employment for any reason other than for gross misconduct provided that:
   i. The Qualified Beneficiary has another Qualifying Event as set forth in paragraph c above within thirty-six (36) months of the date of the first Qualifying Event; and
   ii. The Qualified Beneficiary notifies the Company of the second Qualifying Event within sixty (60) days of the date of the second Qualifying Event.

g) Until the Employer ceases to provide any Group Benefit Plan to his or her Employees.

h) Until the Qualified Beneficiary moves out of the Company's service area, or the Qualified Beneficiary commits fraud or deception in the use of benefits.

NOTICES

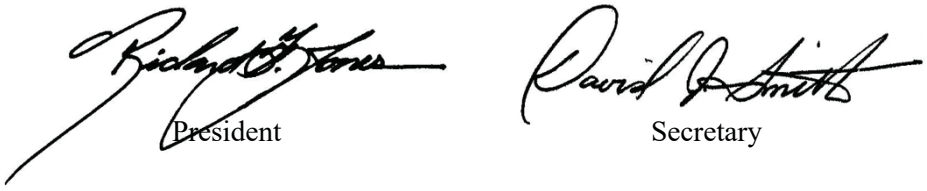
The Employer shall:

1) Notify the Plan in writing of any Employee who has had a Qualifying Event within 30 days of the Qualifying Event.
2) Notify in writing the Plan within 30 days of the date when the Employer becomes subject to Section 4980B of the Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29. U.S.C. Sec. 1161 et. seq.
3) Notify Qualified Beneficiaries currently receiving Continuation of Coverage, whose Continuation of Coverage will terminate under one group benefit plan prior to the end of the period the Qualified Beneficiary would have remained covered, of the ability for the Qualified Beneficiary to continue coverage under a new group benefit plan for the balance of the period the Qualified Beneficiary would have remained covered under the prior benefit plan. This notice shall be provided either 30 days prior to the termination or when all enrolled Employees are notified, whichever is later. The Company shall provide the Employer or said Employer's agent or broker, within 15 days of any written request, information in the Company's possession reasonably needed to administer the requirements of this subsection and subsection 4 below.
4) Notify the successor plan in writing of the Qualified Beneficiaries currently receiving Continuation of Coverage so that said successor plan, or the Employer or administrator, may provide those Qualified Beneficiaries with the necessary premium information, enrollment forms, and instructions consistent with the disclosures required by California law. This information shall be sent to all Qualified Beneficiaries at their last known address.
5) Within 14 days of receiving a notice of a Qualifying Event, provide the Qualified Beneficiary the necessary benefits information, premium information, enrollment forms, and disclosures consistent with the notice requirements contained in subdivisions (b) and (c) of Section 1366.24 of the California law. This information shall be sent to the Qualifying Beneficiary's last known address.

6) Within 180 days of the date that Continuation of Coverage ended, Employer shall notify a Qualified Beneficiary, who has elected Continuation of Coverage, of the date that his or her coverage will terminate, and shall notify the Qualified Beneficiary of any conversion coverage available to that Qualified Beneficiary. This requirement shall not apply when the Continuation of Coverage is terminated because the group contract between the plan and the Employer is terminated.

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

FIDELITY SECURITY LIFE INSURANCE COMPANY



President Secretary

FIDELITY SECURITY LIFE INSURANCE COMPANY

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

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

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

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

1. 36 months from the date the Insured Person's continuation coverage began under COBRA;

2. the end of the period for which the required premium has not been made;

3. the date the Insured Person is entitled to or becomes entitled to Medicare benefits;

4. the date the Insured Person is covered or becomes covered under another health insurance policy, other than a group conversion policy; or

5. the date the Policy is terminated.

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

FIDELITY SECURITY LIFE INSURANCE COMPANY

President Secretary

R-02984CA

FIDELITY SECURITY LIFE INSURANCE COMPANY

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

NOTICE OF ADMINISTRATOR'S CAPACITY

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

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

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

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

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

N-00120

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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

R-02959