**ATTACHMENT 1**
**CERTIFICATES OF COVERAGE**

# 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-108 |
| **POLICYHOLDER:** | SOUTHWEST FLORIDA WATER MGMT DISTRICT-OPTION 1 |
| **POLICY EFFECTIVE DATE:** | January 1, 2021 |
| **POLICY ANNIVERSARY DATE:** | January 1 of the following year and each January 1 thereafter |

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

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

The Certificate explains the plan of insurance. 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

**If you have a question or complaint about this insurance, please write to us at the following address or call us Toll free: 3130 Broadway, Kansas City, Missouri 64111-2406, (800) 648-8624.**

## 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.**

**This limited health benefits plan does not provide comprehensive medical coverage. It is a basic or limited benefits certificate and is not intended to cover all medical expenses. This plan is not designed to cover the costs of serious or chronic illness.**

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## SCHEDULE OF BENEFITS

Policyholder: SOUTHWEST FLORIDA WATER MGMT DISTRICT - Option 1

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:

| **Benefit** | **In-Network Provider** | | **Out-of-Network Provider** | **Benefit Frequency** |
|---|---|---|---|---|
| | **In-Network Provider – Wal-Mart Vision Centers** | **In-Network Provider** | | |
| **VISION EXAMINATION** | | | | |
| **Comprehensive Eye Examination** | $10.00 Copayment | $10.00 Copayment | up to $40 | 12 months |
| **Contact Lenses Fit and Follow-Up** | | | | 12 months |
| Standard Daily Wear | $0 Copayment | $0 Copayment | up to $20 | |
| Standard Extended Wear | $0 Copayment | $0 Copayment | up to $30 | |
| Specialty Wear | $0 Copayment | $0 Copayment | up to $50 | |
| **VISION MATERIALS** | | | | |
| ***Standard Plastic Lenses*** | | | | 12 months |
| Single Vision | $20 Copayment | $20 Copayment | up to $40 | |
| Bifocal | $20 Copayment | $20 Copayment | up to $60 | |
| Trifocal | $20 Copayment | $20 Copayment | up to $80 | |
| Lenticular | $20 Copayment | $20 Copayment | up to $100 | |
| ***Frames*** | $0 Copayment<br>Up to $61.00 retail Allowance | $0 Copayment<br>Up to $150.00 retail Allowance | up to $50 | 24 months |
| ***Contact Lenses (only one option available per Benefit Frequency)*** | | | | 12 months |
| Conventional | $0 Copayment<br>Up to $91.00 Allowance | $0 Copayment<br>up to $130.00 Allowance | up to $105 | |
| Medically Necessary | Paid in full | Paid in full | up to $225 | |
| ***Lens Options*** | | | | 12 months |
| Standard Polycarbonate | | | | |
| Single Vision | Paid in Full | Paid in Full | up to $25 | |
| Bifocal/Trifocal | Paid in Full | Paid in Full | up to $30 | |
| Tint Solid | | | | |
| Single Vision | Paid in Full | Paid in Full | up to $10 | |
| Bifocal/Trifocal | Paid in Full | Paid in Full | up to $10 | |
| Tint Gradient | | | | |
| Single Vision | Paid in Full | Paid in Full | up to $12 | |
| Bifocal/Trifocal | Paid in Full | Paid in Full | up to $12 | |
| Standard Scratch Coating | Paid in Full | Paid in Full | up to $10 | |

## DEFINITIONS

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

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

The Benefit Frequency begins on the Policy Effective Date. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

**Copayment** 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 an intermediate or 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;
2. each child from birth to age 25* who is living with the Insured and is primarily dependent upon the Insured or the Insured's spouse for support and maintenance;
3. each unmarried child to age 30* who does not have a dependent of his or her own and is a resident of Florida or a part-time or full-time student; or
4. each unmarried child 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.

Dependent includes stepchild, foster child, legally adopted child, child for whom the Insured is a party to a suit for adoption, child who has been placed in the Insured's home for adoption and child under the Insured's legal guardianship, if such child depends primarily on the Insured for support. Dependent also includes a child for whom the Insured is legally required to support due to court order or divorce decree. A student is one who is enrolled for credit in an accredited junior college, college or university, or trade school.

**(Until the end of the calendar year in which the child reaches the limiting age.)*

**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 the Insured Person is prescribed contact lenses and has been diagnosed with any of the following:

1. Keratoconus;
2. Anisometropia of 3.00 diopters spherical equivalent;
3. Aphakia following cataract surgery;
4. best corrected visual acuity with eyeglasses between 20/50 and 20/80 that can be corrected to 20/40 or better with contact lenses;
5. best corrected visual acuity with eyeglasses worse than 20/80 that can be improved by double the visual acuity with contact lenses;
6. any structural deformity, scar, postoperative irregularity or distortion of the cornea or iris as determined by the Provider that prevents the attainment of best corrected visual acuity with eyeglasses that can be improved by at least one line of vision with contact lenses;
7. any chronic pain, discomfort or photophobia due to chronic, persistent corneal, iris or lacrimal system inflammatory disease, injury, surgery or deformity as determined by the Provider that prevents the attainment of best corrected visual acuity with eyeglasses that can be improved by at least one line of vision with contact lenses;
8. any structural, neurologic or refractive ocular issues interfering with the normal development of expected levels of visual acuity, binocular function or both in a Dependent child that cannot be achieved with eyeglasses that can be achieved with contact lenses as determined by the Provider; or
9. refractive error equal to or greater than 12.00 diopters spherical equivalent in either eye.

**Out-of-Network Provider** means a Provider, located within the PPO Service Area, who is not an In-Network Provider and 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 the agreement between the PPO and a Provider who agrees to become an In-Network Provider. The Preferred Provider Agreement contains the rates and reimbursement methods for services and supplies furnished by an In-Network Provider.

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

**Provider** means a licensed physician or optometrist who is operating within the scope of his or her license 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 becomes eligible;
2. if the Policyholder requires the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured becomes eligible, provided:
   a. the Insured has given the Company the Insured's enrollment form (if required) on, prior to, or within 30 days of the date the Insured becomes eligible; and
   b. the Insured has agreed to pay the required premium contributions; and
3. if the Insured fails to meet the requirements of 2 a) and 2 b) within 30 days after becoming eligible, the Insured's coverage will not become effective until the Company has verified that the Insured has met these requirements. The Insured will then be advised of the Insured's effective date.

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

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

If the Insured and the Insured's spouse 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 in writing, 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. Coverage for a newborn child of a covered Dependent child will terminate 18 months after the birth of such newborn child.

**Adopted Children.** If a Dependent child is adopted or placed with the Insured for adoption while the Insured's coverage is in force, this child will be covered from the date of adoption or placement for 31 days or greater, if elected in writing, by the Policyholder. In case of a newborn child, coverage begins at the moment of birth if a written agreement to adopt such child has been entered into by the Insured prior to the child's birth unless the child is not ultimately placed in the Insured's residence. To continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be due for coverage beyond the initial 31-day period. If proper notice has been given, coverage will continue without additional premium during the 31-day period unless the placement is disrupted prior to legal adoption and the child is removed from placement. If the Insured does not give the Company written notice within 31 days of the birth or placement, the Company will charge the applicable premium for coverage of such child during this 31-day period. If notice is given within 60 days of the adoption, birth or placement of the child, the Company will not deny coverage for the child due to the Insured's failure to timely notify the Company of the adoption, birth or placement of the child. Coverage will end if 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 Copayment or any cost above the allowance shown in the Schedule of Benefits at the time the covered service is provided. Benefits will be paid to the In-Network Provider who will file a claim with the Company.

**Out-of-Network Provider Benefits.** The Insured Person must pay the Out-of-Network Provider the full cost at the time the covered service is provided and file a claim with the Company, unless the Out-of-Network Provider allows assignment of benefits. The Company will 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 , Contact Lenses Fit and Follow-Up benefits apply only for covered Contact Lenses.

## LIMITATIONS

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

Allowances provide no remaining balance for future use within the same Benefit Frequency. Any remaining Allowance may be used within the same Benefit Frequency. Where the Insured Person previously utilized an In-Network Provider, the remaining Allowance must be used with the same or any other In-Network Provider. Where the Insured Person previously utilized an Out-of-Network Provider, the remaining Allowance must be used with the same or any other Out-of-Network Provider.

## 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 pathological 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 payable under any Workers' Compensation law, any Occupational Disease law, any similar legislation, or any governmental agency or program, whether federal, state or a subdivision thereof;
5. plano (non-prescription) lenses and/or contact lenses;
6. non-prescription sunglasses;
7. two pair of eyeglasses in lieu of bifocals or trifocals;
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

1. lost or broken lenses, frames, eyeglasses, 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 earlier of:

1. the date the Policy ends;
2. the end of the last period for which any required premium contribution agreed to in writing has been made;
3. the 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 request it more than once a year after this coverage has been continued for two years. This continued coverage will end on the earlier of:

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

Termination of the insurance of any Insured Person will be without prejudice to any claim originating before the date of termination.

## PREMIUMS

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

**Premium Changes.** The Company has the right to change the premium rates on any premium due date as allowed in the Policy. The Company will provide written notice to the Policyholder at least 45 days before the date of the change. The premium rates also may be changed at any time the terms of the Policy are changed.

**Grace Period.** The Policy has a 31-day grace period for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. Coverage will terminate at the end of the grace period if all premiums due are not paid. The Company will require payment of all premiums for the period this coverage continues in

force, including the premiums for the grace period. The grace period will not apply if the Company receives written notice of the Policyholder's or the Insured's intent to terminate coverage.

**Unpaid Premium.** When a claim is paid during the grace period, any premium due and unpaid for the Insured Person will be deducted from the claim payment.

## CLAIMS

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

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

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

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

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

**Assignment.** Benefits under the Policy may be assigned to an In-Network Provider. Benefits under the Policy may not be assigned to an Out-of-Network Provider. Such Out-of-Network benefits will be paid directly to the Insured.

**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 within 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 the applicable statute of limitations 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 will be used in defense to a claim hereunder unless it is contained in a written instrument signed by the Policyholder, the Insured, the Insured's beneficiary or personal representative, a copy of which has been furnished to the Policyholder, the Insured, the Insured's beneficiary or personal representative.

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

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

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

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

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

# FIDELITY SECURITY LIFE INSURANCE COMPANY

3130 Broadway
Kansas City, Missouri 64111-2406
Phone 800-648-8624
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## AMENDATORY RIDER REGARDING REPLACEMENT COVERAGE

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

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

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

Each such person will be insured under the Policy if:

(a) the person was insured under the prior plan, including coverage under the prior plan's extension of benefits provision, on the date the Policyholder's coverage with the prior plan ended; and
(b) the person is in a class of persons eligible for coverage under the Policy.

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

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

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

FIDELITY SECURITY LIFE INSURANCE COMPANY

President Secretary

# 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:<br>■ Social Security number and transaction history<br>■ medical information and insurance claim information<br>■ assets and checking account information<br>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 |

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|---|---|
| **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? | 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.<br>These physical, electronic and procedural safeguards were created to protect your information. We also limit employee access as appropriate. |
| How does Fidelity Security Life Insurance Company and Affiliates collect my personal information? | We collect your personal information, for example, when you<br>■ apply for insurance or pay insurance premiums<br>■ file an insurance claim or give us your contact information<br>■ show your driver's license<br>We also collect your personal information from others, such as credit bureaus, affiliates, or other companies. |
| Why can't I limit all sharing? | Federal law gives you the right to limit only<br>■ sharing for affiliates' everyday business purposes – information about your creditworthiness<br>■ affiliates from using your information to market to you<br>■ sharing for nonaffiliates to market to you<br>State laws and individual companies may give you additional rights to limit sharing. |

| **Definitions** | |
|---|---|
| Affiliates | Companies related by common ownership or control. They can be financial and nonfinancial companies.<br>■ *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.* |
| Nonaffiliates | Companies not related by common ownership or control. They can be financial and nonfinancial companies.<br>■ *Fidelity Security Life Insurance Company does not share with nonaffiliates so they can market to you.* |
| Joint marketing | A formal agreement between nonaffiliated financial companies that together market financial products or services to you.<br>■ *Our joint marketing partners include insurance agencies, broker dealers and investment advisor firms.* |

| **Other important information** |
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# 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-108

**POLICYHOLDER:** SOUTHWEST FLORIDA WATER MGMT DISTRICT-OPTION 2

**POLICY EFFECTIVE DATE:** January 1, 2021

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## SCHEDULE OF BENEFITS

Policyholder: SOUTHWEST FLORIDA WATER MGMT DISTRICT – Option 2

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:

| **Benefit** | **In-Network Provider** | | **Out-of-Network Provider** | **Benefit Frequency** |
|---|---|---|---|---|
| | **In-Network Provide Wal-Mart Vision Centers** | **In-Network Provider** | | |
| **VISION EXAMINATION** | | | | |
| **Comprehensive Eye Examination** | $10.00 Copayment | $10.00 Copayment | up to $40 | 12 months |
| **Contact Lenses Fit and Follow-Up** | | | | 12 months |
| Standard Daily Wear | $0 Copayment | $0 Copayment | up to $20 | |
| Standard Extended Wear | $0 Copayment | $0 Copayment | up to $30 | |
| Specialty Wear | $0 Copayment | $0 Copayment | up to $50 | |
| **VISION MATERIALS** | | | | |
| ***Standard Plastic Lenses*** | | | | 12 months |
| Single Vision | $20 Copayment | $20 Copayment | up to $40 | |
| Bifocal | $20 Copayment | $20 Copayment | up to $60 | |
| Trifocal | $20 Copayment | $20 Copayment | up to $80 | |
| Lenticular | $20 Copayment | $20 Copayment | up to $100 | |
| ***Frames*** | $0 Copayment<br>Up to $95.00 retail Allowance | $0 Copayment<br>Up to $225.00 retail Allowance | up to $51 | 12 months |
| ***Contact Lenses (only one option available per Benefit Frequency)*** | | | | 12 months |
| Conventional | $0 Copayment<br>Up to $158.00 Allowance | $0 Copayment<br>up to $225.00 Allowance | up to $105 | |
| Medically Necessary | Paid in full | Paid in full | up to $225 | |
| ***Lens Options*** | | | | 12 months |
| Standard Polycarbonate | | | | |
| Single Vision | Paid in Full | Paid in Full | up to $25 | |
| Bifocal/Trifocal | Paid in Full | Paid in Full | up to $30 | |
| Tint Solid | | | | |
| Single Vision | Paid in Full | Paid in Full | up to $10 | |
| Bifocal/Trifocal | Paid in Full<br>{ | Paid in Full | up to $10 | |
| Tint Gradient | | | | |
| Single Vision | Paid in Full | Paid in Full | up to $12 | |
| Bifocal/Trifocal | Paid in Full | Paid in Full | up to $12 | |
| Standard Scratch Coating | Paid in Full | Paid in Full | up to $10 | |
| Progressives – Tier 1 | Paid in Full | Paid in Full | Up to $50 | |

## DEFINITIONS

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

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

The Benefit Frequency begins on the Policy Effective Date. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

**Copayment** 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 an intermediate or 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;
2. each child from birth to age 25* who is living with the Insured and is primarily dependent upon the Insured or the Insured's spouse for support and maintenance;
3. each unmarried child to age 30* who does not have a dependent of his or her own and is a resident of Florida or a part-time or full-time student; or
4. each unmarried child 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.

Dependent includes stepchild, foster child, legally adopted child, child for whom the Insured is a party to a suit for adoption, child who has been placed in the Insured's home for adoption and child under the Insured's legal guardianship, if such child depends primarily on the Insured for support. Dependent also includes a child for whom the Insured is legally required to support due to court order or divorce decree. A student is one who is enrolled for credit in an accredited junior college, college or university, or trade school.

**(Until the end of the calendar year in which the child reaches the limiting age.)*

**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 the Insured Person is prescribed contact lenses and has been diagnosed with any of the following:

1. Keratoconus;
2. Anisometropia of 3.00 diopters spherical equivalent;
3. Aphakia following cataract surgery;
4. best corrected visual acuity with eyeglasses between 20/50 and 20/80 that can be corrected to 20/40 or better with contact lenses;
5. best corrected visual acuity with eyeglasses worse than 20/80 that can be improved by double the visual acuity with contact lenses;
6. any structural deformity, scar, postoperative irregularity or distortion of the cornea or iris as determined by the Provider that prevents the attainment of best corrected visual acuity with eyeglasses that can be improved by at least one line of vision with contact lenses;
7. any chronic pain, discomfort or photophobia due to chronic, persistent corneal, iris or lacrimal system inflammatory disease, injury, surgery or deformity as determined by the Provider that prevents the attainment of best corrected visual acuity with eyeglasses that can be improved by at least one line of vision with contact lenses;
8. any structural, neurologic or refractive ocular issues interfering with the normal development of expected levels of visual acuity, binocular function or both in a Dependent child that cannot be achieved with eyeglasses that can be achieved with contact lenses as determined by the Provider; or
9. refractive error equal to or greater than 12.00 diopters spherical equivalent in either eye.

**Out-of-Network Provider** means a Provider, located within the PPO Service Area, who is not an In-Network Provider and 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 the agreement between the PPO and a Provider who agrees to become an In-Network Provider. The Preferred Provider Agreement contains the rates and reimbursement methods for services and supplies furnished by an In-Network Provider.

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

**Provider** means a licensed physician or optometrist who is operating within the scope of his or her license 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 becomes eligible;
2. if the Policyholder requires the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured becomes eligible, provided:
   a. the Insured has given the Company the Insured's enrollment form (if required) on, prior to, or within 30 days of the date the Insured becomes eligible; and
   b. the Insured has agreed to pay the required premium contributions; and
3. if the Insured fails to meet the requirements of 2 a) and 2 b) within 30 days after becoming eligible, the Insured's coverage will not become effective until the Company has verified that the Insured has met these requirements. The Insured will then be advised of the Insured's effective date.

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

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

If the Insured and the Insured's spouse 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 in writing, 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. Coverage for a newborn child of a covered Dependent child will terminate 18 months after the birth of such newborn child.

**Adopted Children.** If a Dependent child is adopted or placed with the Insured for adoption while the Insured's coverage is in force, this child will be covered from the date of adoption or placement for 31 days or greater, if elected in writing, by the Policyholder. In case of a newborn child, coverage begins at the moment of birth if a written agreement to adopt such child has been entered into by the Insured prior to the child's birth unless the child is not ultimately placed in the Insured's residence. To continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be due for coverage beyond the initial 31-day period. If proper notice has been given, coverage will continue without additional premium during the 31-day period unless the placement is disrupted prior to legal adoption and the child is removed from placement. If the Insured does not give the Company written notice within 31 days of the birth or placement, the Company will charge the applicable premium for coverage of such child during this 31-day period. If notice is given within 60 days of the adoption, birth or placement of the child, the Company will not deny coverage for the child due to the Insured's failure to timely notify the Company of the adoption, birth or placement of the child. Coverage will end if 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 Copayment or any cost above the allowance shown in the Schedule of Benefits at the time the covered service is provided. Benefits will be paid to the In-Network Provider who will file a claim with the Company.

**Out-of-Network Provider Benefits.** The Insured Person must pay the Out-of-Network Provider the full cost at the time the covered service is provided and file a claim with the Company, unless the Out-of-Network Provider allows assignment of benefits. The Company will 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 , Contact Lenses Fit and Follow-Up benefits apply only for covered Contact Lenses.

## LIMITATIONS

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

Allowances provide no remaining balance for future use within the same Benefit Frequency. Any remaining Allowance may be used within the same Benefit Frequency. Where the Insured Person previously utilized an In-Network Provider, the remaining Allowance must be used with the same or any other In-Network Provider. Where the Insured Person previously utilized an Out-of-Network Provider, the remaining Allowance must be used with the same or any other Out-of-Network Provider.

## 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 pathological 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 payable under any Workers' Compensation law, any Occupational Disease law, any similar legislation, or any governmental agency or program, whether federal, state or a subdivision thereof;
5. plano (non-prescription) lenses and/or contact lenses;
6. non-prescription sunglasses;
7. two pair of eyeglasses in lieu of bifocals or trifocals;
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
1. lost or broken lenses, frames, eyeglasses, 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 earlier of:

1. the date the Policy ends;
2. the end of the last period for which any required premium contribution agreed to in writing has been made;
3. the 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 request it more than once a year after this coverage has been continued for two years. This continued coverage will end on the earlier of:

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

Termination of the insurance of any Insured Person will be without prejudice to any claim originating before the date of termination.

## PREMIUMS

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

**Premium Changes.** The Company has the right to change the premium rates on any premium due date as allowed in the Policy. The Company will provide written notice to the Policyholder at least 45 days before the date of the change. The premium rates also may be changed at any time the terms of the Policy are changed.

**Grace Period.** The Policy has a 31-day grace period for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. Coverage will terminate at the end of the grace period if all premiums due are not paid. The Company will require payment of all premiums for the period this coverage continues in

force, including the premiums for the grace period. The grace period will not apply if the Company receives written notice of the Policyholder's or the Insured's intent to terminate coverage.

**Unpaid Premium.** When a claim is paid during the grace period, any premium due and unpaid for the Insured Person will be deducted from the claim payment.

## CLAIMS

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

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

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

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

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

**Assignment.** Benefits under the Policy may be assigned to an In-Network Provider. Benefits under the Policy may not be assigned to an Out-of-Network Provider. Such Out-of-Network benefits will be paid directly to the Insured.

**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 within 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 the applicable statute of limitations 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 will be used in defense to a claim hereunder unless it is contained in a written instrument signed by the Policyholder, the Insured, the Insured's beneficiary or personal representative, a copy of which has been furnished to the Policyholder, the Insured, the Insured's beneficiary or personal representative.

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

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

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

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

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

# FIDELITY SECURITY LIFE INSURANCE COMPANY

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


## AMENDATORY RIDER REGARDING REPLACEMENT COVERAGE

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

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

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

Each such person will be insured under the Policy if:

(a) the person was insured under the prior plan, including coverage under the prior plan's extension of benefits provision, on the date the Policyholder's coverage with the prior plan ended; and
(b) the person is in a class of persons eligible for coverage under the Policy.

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

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

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

FIDELITY SECURITY LIFE INSURANCE COMPANY

President Secretary

# 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:<br>■ Social Security number and transaction history<br>■ medical information and insurance claim information<br>■ assets and checking account information<br>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? | 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.<br>These physical, electronic and procedural safeguards were created to protect your information. We also limit employee access as appropriate. |
| How does Fidelity Security Life Insurance Company and Affiliates collect my personal information? | We collect your personal information, for example, when you<br>■ apply for insurance or pay insurance premiums<br>■ file an insurance claim or give us your contact information<br>■ show your driver's license<br>We also collect your personal information from others, such as credit bureaus, affiliates, or other companies. |
| Why can't I limit all sharing? | Federal law gives you the right to limit only<br>■ sharing for affiliates' everyday business purposes – information about your creditworthiness<br>■ affiliates from using your information to market to you<br>■ sharing for nonaffiliates to market to you<br>State laws and individual companies may give you additional rights to limit sharing. |

| **Definitions** | |
|---|---|
| Affiliates | Companies related by common ownership or control. They can be financial and nonfinancial companies.<br>■ *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.* |
| Nonaffiliates | Companies not related by common ownership or control. They can be financial and nonfinancial companies.<br>■ *Fidelity Security Life Insurance Company does not share with nonaffiliates so they can market to you.* |
| Joint marketing | A formal agreement between nonaffiliated financial companies that together market financial products or services to you.<br>■ *Our joint marketing partners include insurance agencies, broker dealers and investment advisor firms.* |

| **Other important information** |
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| |