



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-146
POLICYHOLDER: Louisiana State University and Agricultural and Mechanical College
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.

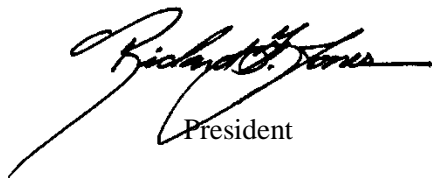
The Policy may be amended, changed, cancelled or discontinued without the consent of any Insured Person.

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

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

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

FIDELITY SECURITY LIFE INSURANCE COMPANY



Richard C. Jones
President



Bradford R. Jones
Secretary

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

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

TABLE OF CONTENTS

DEFINITIONS..... 3

EFFECTIVE DATES..... 4

BENEFITS..... 5

LIMITATIONS..... 5

EXCLUSIONS..... 5

TERMINATION OF INSURANCE..... 6

PREMIUMS..... 6

CLAIMS 7

GENERAL PROVISIONS 7

SCHEDULE OF BENEFITS Attached (1A)

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Policy means the Vision Insurance Policy issued to the Policyholder.

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

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

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

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

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

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

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

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

EFFECTIVE DATES

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

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

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

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

If the Insured and the Insured’s spouse 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 a greater number of days, if elected by the Policyholder. To continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period.

Adopted Children. If a Dependent child is placed with the Insured for adoption while the Insured’s coverage is in force, this child will be covered from the date of placement for 31 days or a greater number of days, if elected by the Policyholder.

To continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period. If proper notice has been given, coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement.

BENEFITS

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

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

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

LIMITATIONS

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

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

EXCLUSIONS

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

1. medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures;
2. Refraction, when not provided as part of a Comprehensive Eye Examination;
3. services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
4. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
5. any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment;
6. safety eyewear;
7. solutions, cleaning products or frame cases;
8. non-prescription sunglasses;
9. plano (non-prescription) lenses;
10. plano (non-prescription) contact lenses;
11. two pair of glasses in lieu of bifocals;
12. electronic vision devices;
13. services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or
14. lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.

TERMINATION OF INSURANCE

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

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 end of the month 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 an intellectual or physical disability 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 within 31 days of the date the Dependent child would otherwise cease to be covered.

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

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

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 on or after the fourth Policy Anniversary Date. Rates will not increase more than once on a six-month period thereafter. 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.

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

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

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

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

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

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

SCHEDULE OF BENEFITS

Louisiana State University and Agricultural and Mechanical College

<i>BENEFIT FREQUENCY</i>		
<u>Vision Examination</u>	once every plan year	Insured Person
<u>Vision Materials</u>		
Frame	once every plan year	Insured Person
Lenses and Lens Options	once every plan year	Insured Person
Contact Lenses	once every plan year	Insured Person

<i>BENEFIT</i>	<i>In-Network</i>		<i>Out-of-Network Provider (Reimbursement up to)</i>
	<i>Plus In-Network Provider</i>	<i>In-Network Provider</i>	
<u>Vision Examination</u>			
Comprehensive Eye Examination	\$0 Copayment	\$0 Copayment	\$40
<u>Vision Materials</u>			
Frame	\$0 Copayment, up to \$200 Allowance	\$0 Copayment, up to \$150 Allowance	\$91
Contact Lenses Only one of the following Contact Lenses benefits may be used for the Contact Lenses benefit. Contact Lenses are in lieu of Lenses and Lens Options.			
Conventional	\$0 Copayment, up to \$130 Allowance	\$0 Copayment, up to \$130 Allowance	\$91
Disposable	\$0 Copayment, up to \$130 Allowance	\$0 Copayment, up to \$130 Allowance	\$91
Medically Necessary	Paid in Full	Paid in Full	\$210
Standard Plastic Lenses			
Single Vision	\$0 Copayment	\$0 Copayment	\$30
Bifocal	\$0 Copayment	\$0 Copayment	\$50
Trifocal	\$0 Copayment	\$0 Copayment	\$70
Lenticular	\$0 Copayment	\$0 Copayment	\$70
Progressive – Standard	\$0 Copayment	\$0 Copayment	\$50
Progressive – Premium Tier 1	\$0 Copayment	\$0 Copayment	\$50
Progressive – Premium Tier 2	\$95 Copayment	\$95 Copayment	\$50
Progressive – Premium Tier 3	\$110 Copayment	\$110 Copayment	\$50
Progressive – Premium Tier 4	\$175 Copayment	\$175 Copayment	\$50
Lens Options			
Anti-Reflective Coating – Standard	\$45 Copayment	\$45 Copayment	\$5
Anti-Reflective Coating – Premium Tier 1	\$57 Copayment	\$57 Copayment	\$5
Anti-Reflective Coating – Premium Tier 2	\$68 Copayment	\$68 Copayment	\$5
Anti-Reflective Coating – Premium Tier 3	\$85 Copayment	\$85 Copayment	\$5
Polycarbonate Lenses – Standard Dependent Children under 19 years of age	\$0 Copayment	\$0 Copayment	\$5
Scratch Coating – Standard Plastic	\$0 Copayment	\$0 Copayment	\$5
Tint (Solid and Gradient)	\$0 Copayment	\$0 Copayment	\$5
UV Treatment	\$0 Copayment	\$0 Copayment	\$5



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AMENDATORY RIDER REGARDING REPLACEMENT COVERAGE

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

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

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

Each such person will be insured under the Policy if:

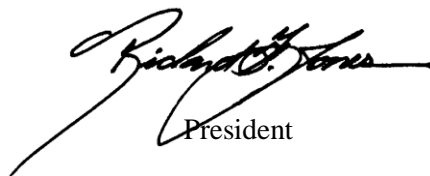
1. the person was insured under the prior plan, including coverage under the prior plan's extension of benefits provision, on the date the Policyholder's coverage with the prior plan ended;
2. the prior plan covered more than 15 people; and
3. the person is in a class of persons eligible for coverage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

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

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

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

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DOMESTIC PARTNER COVERAGE BENEFIT RIDER For California Residents Only

If the Policy/Certificate provides coverage for a Dependent spouse of an Insured, and if the Policy/Certificate contains existing domestic partner language, the following definition applies only to the extent the existing language does not meet the minimum requirements of California law:

The term "spouse" or "Spouse" is defined as follows:

Spouse means:

1. a person to whom you are legally married; or
2. the Insured's Domestic Partner. "Domestic Partner" means an individual recognized as such under California state law.

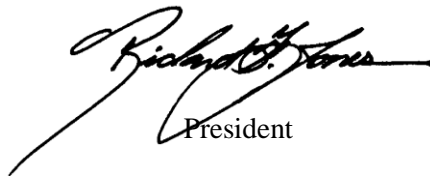
The following provision is added:

Termination of Coverage for Domestic Partner. When a domestic partnership is terminated, coverage will cease for the dependent Domestic Partner on the date any one of the following occurs:

1. six months after the filing of a Notice of Termination of Domestic Partnership with the California Secretary of State;
or
2. the domestic partnership is ended through dissolution, nullity, or legal separation the same as in a marriage.

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.

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AMENDMENT RIDER For North Carolina Residents Only

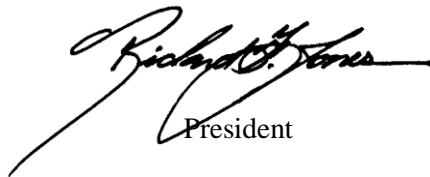
By attachment of this Rider, the Policy/Certificate is amended by the following:

ACCESS TO PREFERRED PROVIDERS

1. If you are unable to locate an In-Network Provider in your area, please contact us at the EyeMed Customer Care Center at (866-939-3633) or go to the EyeMed website at eyemedvisioncare.com/locator and, EyeMed, on our behalf, will provide a list of potential providers from which you can choose.
2. If you believe that no providers are within the driving distance standard or if you are unable to obtain an appointment within the appointment wait-time standard, please contact the EyeMed Customer Care Center for assistance to locate a provider and/or schedule an appointment. If it is determined that no In-Network Provider is available within these established standards and you obtain services from an Out-of-Network Provider, we will review and pay the eligible claims submitted as if you had visited an In-Network Provider. You may review the established accessibility standards for driving distance and appointment wait-times for this coverage in the Out-of-Network Claim Form found at the EyeMed website <https://eyemed.com/resource/blob/15642/7cfe717302c35ac9d6e54e5420dbba11/eyemed-out-of-network-claim-form-data.pdf> or visit eyemed.com and enter 'out of network claim form' in the search bar.

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.

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AMENDMENT RIDER For Residents of New Mexico

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

1. The face page of the Certificate is amended to add the following:

NOTICE TO CONSUMER: This is a limited benefits health plan. The benefits provided are supplemental to, and not a substitute for, major medical coverage, even in combination with other limited benefits plans. To apply for an individual or small-group major medical plan, please visit the website of the New Mexico Health Insurance Exchange at www.bewellnm.com or call 1-833-862-3935 (TTY: 711).

2. Any provision that provides coverage for a Dependent child is hereby amended as follows:
 - a. Coverage for an unmarried Dependent child will continue to the later of age 25 or the age shown in the Policy/Certificate, regardless of student status.
 - b. Coverage will be extended to an unmarried Dependent child who is mentally handicapped or physically incapable of earning his or her own living, provided proof of incapacity is furnished to the Company within 31 days of such child attaining age 25, but not more than once in any 12-month period after the initial two-year period following such child's attainment of age 25.
 - c. Coverage for a Dependent child will include coverage for a child of a non-custodial parent or a child for whom the Insured Person is legally required to provide support due to an administrative order.
3. Any provision that provides coverage for a Domestic Partner will include coverage for both a same-sex and opposite-sex Domestic Partner.
4. Any provision that provides a definition of an employee or Insured will include the following:

Employee also includes a regular part-time employee who works or is expected to work an average of at least 20 hours per week over a six-month period.
5. Any Pre-Existing Condition limitation or definition will be revised to change the following:
 - a. the time frame prior to the Insured Person's Effective Date for which medical treatment or advice was rendered or recommended is amended to the lesser of 12 months or the time frame shown in the Policy/Certificate; and
 - b. the time frame beginning with the Insured Person's Effective Date after which a Pre-Existing Condition will be paid is amended to the lesser of 12 months or the time frame shown in the Policy/Certificate.

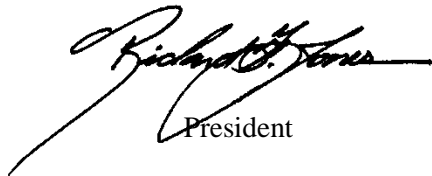
6. The **Premium Changes** provision is amended to provide a written notice by the Company of the greater of 60 days or the number of days shown in the Policy/Certificate.
7. The **Payment of Claims** provision is amended to add the following:

Benefits paid on behalf of an Insured Person will be paid to the Human Services Department when:

1. the Human Services Department has paid or is paying benefits on behalf of such Insured Person under the state's Medicaid program pursuant to Title XIX of the Federal Social Security Act, 42 U.S.C. 1396, et seq.;
2. payment for the services in question has been made by the Human Services Department to the Medicaid Provider; or
3. the Company is notified that such Insured Person receives benefits under the Medicaid program and that benefits must be paid directly to the Human Services Department.

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.

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CONSUMER COMPLAINT NOTICE

If you are a resident of New Mexico, your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If you have concerns regarding a claim, premium, or other matters relating to this coverage, you may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at:

<https://sbs.naic.org/solar-web/pages/public/onlineComplaintForm/onlineComplaintForm.jsf?state=NM&dswid=6452>



FIDELITY SECURITY LIFE INSURANCE COMPANY

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

SUMMARY OF THE LOUISIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

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

DISCLAIMER

The Louisiana Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent.

COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is generally conditioned upon residence in this state. Other conditions may also preclude coverage.

Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

LLHIGA
P.O. Box 3337
Baton Rouge, LA 70821

Department of Insurance
P.O. Box 94214
Baton Rouge, LA 70804-9214

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law (the law), and is set forth at R.S. 22:2081 et seq. The following is a brief summary of this Law's coverages, exclusions and limits. This summary does not cover all provisions of the Law; nor does it in any way change any person's rights or obligations under the Law or the rights or obligations of LLHIGA.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a covered life, health, or annuity policy, plan or contract issued by an insurer (including a health maintenance organization) authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons may also be protected as well, even if they live in another state unless they are afforded coverage by the guaranty association of another state, or other circumstances described under the Law are applicable.

EXCLUSIONS FROM COVERAGE

A person who holds a covered life, health, or annuity policy, plan or contract is not protected by LLHIGA if:

- (1) He is eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.);
- (2) The insurer was not authorized to do business in this state;
- (3) His policy was issued by a profit or nonprofit hospital or medical service organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, an organization that issues charitable gift annuities as is defined in R.S. 22:952(A)(3), or any entity similar to any of these.

LLHIGA also does not provide coverage for:

- (1) Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- (2) Any policy of reinsurance (unless an assumption certificate was issued);
- (3) Interest rate or crediting rate yields, or similar factors employed in calculating changes in value, that exceed an average rate;
- (4) Dividends, premium refunds, or similar fees or allowances described under the Law;
- (5) Credits given in connection with the administration of a policy by a group contract holder;
- (6) Employers', associations' or similar entities' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured;
- (7) Unallocated annuity contracts (which give rights to group contract holders, not individuals), except unallocated annuity contracts and defined contribution government plans qualified under section 403(b) of the United States Internal Revenue Code (26 U.S.C. §403(b));
- (8) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policy owner or contract owner, including but not limited to, claims described under the Law;
- (9) A policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to "Medicare Part A Coverage", "Medicare Part B Coverage", "Medicare Part C Coverage", "Medicare Part D Coverage", or "Medicaid" and any regulations issued pursuant to those parts;
- (10) Interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNTS OF COVERAGE

The Louisiana Life and Health Insurance Guaranty Association Law also limits the amount that LLHIGA is obligated to pay out. The benefits for which LLHIGA may become liable shall in no event exceed the lesser of the following:

- (1) LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not an impaired or an insolvent insurer.
- (2) For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of \$300,000 in life insurance death benefits, but not more than \$100,000 in net cash surrender and net cash withdrawal values for life insurance.
- (3) For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of \$500,000 in health insurance benefits, and LLHIGA will pay a maximum of \$250,000 in present value of annuities, including net cash surrender and cash withdrawal values.

In no event, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages, LLHIGA shall not be liable to expend more than \$500,000 in the aggregate with respect to any one individual.



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NOTICE OF ADMINISTRATOR'S CAPACITY

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

1. Fidelity Security Life Insurance Company (FSL) has, by agreement, arranged for First American Administrators, Inc. to provide administrative services for your insurance plan. As administrator, First American Administrators, Inc., is authorized to process claim payments, and perform other services, according to the terms of its agreement with the insurance company. First American Administrators, Inc. is not the insurance company or the policyholder.
2. The policyholder is the entity to whom the insurance policy has been issued. The policyholder is identified on either the face page or schedule page of the policy or certificate.
3. Fidelity Security Life Insurance Company is liable for the funds to pay your insurance claims.

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