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:	San Bernardino County
STATE OF ISSUE:	California
POLICY EFFECTIVE DATE:	July 29, 2023
POLICY ANNIVERSARY DATE:	July 29 of the following year and each July 29 thereafter

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

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

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

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

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

FIDELITY SECURITY LIFE INSURANCE COMPANY

Bryson Z. Jones — President

Bradford R. James — Secretary

This Policy is not major medical insurance and is not a substitute for major medical insurance. It does not qualify as minimum essential health coverage under the Federal Affordable Care Act.

GROUP VISION INSURANCE POLICY
THIS IS A LIMITED BENEFIT POLICY
Please read the Policy carefully.

THIRTY-DAY RIGHT TO EXAMINE: If the Policyholder is not satisfied for any reason, the Policyholder may return the Policy within 30 days after receipt. The premium will then be refunded. When returned, the Policy will be void from the beginning. The Policy must be returned to the Company at the Company's Home Office or to the Company's authorized agent.

PREMIUMS

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

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

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

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

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

Premium Rate Change. The Company has the right to change the premium rate on or after the fifth Policy Anniversary Date. The Company will provide written notice at least 150 days before the date of change.

Grace Period. A grace period of 60 days will be allowed to the Policyholder for the payment of each premium due after the first premium. The Policy will remain in force during the grace period. If the required premium is not paid by the end of the 60-day period, the Policy will terminate. The Policyholder will be required to pay premium for the grace period.

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

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

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

TERMINATION OF POLICY

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

1. any date on or after the third Policy Anniversary Date the Company requests termination. Written notice must be provided to the Policyholder at least 90 days prior to termination;
2. any date on or after the date the Company receives the Policyholder's written request for termination;
3. the date the number of persons covered under the Policy does not meet the minimum participation requirements of 10;
4. the date the required premium has not been paid, except as provided in the Grace Period provision; or
5. the date 100% of the eligible employees are not covered when a contribution is not required by the employee.

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

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

CERTIFICATE

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

ADDITIONAL INSUREDS

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

INCORPORATION PROVISION

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

Application for Vision Care Benefits

Underwritten by Fidelity Security Life Insurance Company
Kansas City, Missouri 64111

I. GROUP INFORMATION

Group Name: San Bernardino County Tax ID#: 95-6002748

DBA Name (If other than above): _____

Business Physical Address: 175 West 5th Street First Floor (Street Address) San Bernardino (City) CA (State) 92415 (Zip)

Mailing Address: _____ (Street Address) _____ (City) _____ (State) _____ (Zip)

Day-to-Day Contact Name: Sandra wakcher Title: Benefits Cheif

Phone Number: (909) 387-9676 E-Mail Address: sandra.wakcher@hr.

Type of Business: ☐ Proprietorship ☐ Corporation ■ Other (Specify): Government

PLEASE NOTE THE FOLLOWING TYPE BUSINESSES REQUIRE PRIOR CARRIER APPROVAL:

☐ MEWA ☐ PEO ☐ Trust ☐ Union ☐ VEBA ☐ Casino/Indian Tribe

Service Area: ☐ National *(U.S.– does not include Puerto Rico)* ☐ State Specific*
☐ National *(U.S.– does include Puerto Rico)*

If any subsidiary or affiliated companies are to be insured or any Employees/Members are working or residing in a state other than the business address above,* ***please list those states:* _____

Number of employees/members with language preferences other than English for oral or written communications:

Spanish _____ Oral _____ Written Chinese _____ Oral _____ Written Other _____ Oral _____ Written

GROUP DISPLAY NAME ***(Your Group Name as it should appear to your Employees/Members)***

Company Name: San Bernardino County

(Maximum of 40 characters, including capitalization, punctuation and spacing.)

II. GROUP BILLING

Billing Physical Address: 175 West 5th Street First Floor (Street Address) San Bernardino (City) CA (State) 92415 (Zip)

Primary Contact Name: Sandra Wakcher Title: Benefits Cheif

Phone Number: (909) 387-9676 E-Mail Address: sandra.wakcher@hr.sbcounty.gov

Do you have any additional subsidiaries, affiliated companies, or divisions that use another name and will be covered by this plan AND require separate billing invoices? ☐ Yes ☐ No If Yes, please attach and send a separate page signed by you with the following information: Name, Address, Billing Contact Name and Phone Number

III. PREMIUMS*

Please indicate the percentage of premium contributed by the Group and the Employee/Member for both the Employee/Member and Dependents; the total for each row must equal 100%.

	Group Contribution	Employee/Member Contribution
Employee/Members:	100 %	0 %
Dependents:	0-100 depends on unit %	0-100 depends on unit %

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

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

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

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

IV. ELIGIBILITY

Number of Eligible Employees/Members: 14,688

Will this plan replace any existing vision coverage? ☐ Yes ☐ No

If "Yes," name of existing insurer: _____

Eligible Class(es) of Employees/Members (please check all that apply):

☐ Active employees ☐ Retiree / Leave of Absence

■ COBRA–eligible employees ☐ Other: _____

Are the following covered under the plan:

Dependent Children Covered to Age*: ■ 26** ☐ Other _____

Dependent Children who are full-time students covered to age*: ☐ 27 ■ Other 26

Dependent Child Age Termination based on:

☐ Day Age is attained ☐ End of Month Age is attained ☐ End of Year Age is attained

**Unless state law has different requirements.*

***Dependent Children covered to age 26 regardless of financial dependency, residency, student status or marital status.*

MEMBERSHIP INFORMATION

Who will send enrollment for Active Employees/Members? ■ Group ☐ Group's TPA

If TPA, TPA Name: _____

Group/TPA Contact Name: Janet Rodriguez

Phone Number: (909) 387-5812 E-Mail Address: janet.rodriguez@hr.sbcounty.gov

Membership will be an electronic membership file? ☐ Yes ☐ No

Who will send enrollment for COBRA Employees/Members? ☐ Group ☐ Group's TPA

If TPA, TPA Name: _____

Group/TPA Contact Name: _____

Phone Number: ( ) _____ E-Mail Address: _____

Membership will be an electronic membership file? ☐ Yes ☐ No

PROBATIONARY PERIOD

For New Employees/Members: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days ☐ Other _____

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

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

V. PLAN SELECTION

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

VI. EFFECTIVE DATE

This Policy will become effective at 12:01 a.m. Local Time at the Group's address herein, on

7/29/2023 , provided all the following has been completed prior to this effective date:
MM/DD/YYYY

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

B. EyeMed has been furnished a working file of all eligible Employees/Members, in an agreed upon format. It is understood and agreed that EyeMed may rely on this information to provide services to individuals designated as eligible.

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

The Group certifies that all information shown on this application and any attachments is correct and complete to the best of the Group's knowledge and belief as of the date this application is signed. The Group understands that the Company intends to rely on this information in determining if the enrolling Employees/Members and their Dependents may become insured. It is further understood and agreed that **NO INSURANCE WILL BECOME EFFECTIVE UNTIL APPROVED BY THE COMPANY**; and that no field representative of the Company has the authority to modify any conditions of the application or the Policy by making any promise or representation.

The falsity of any statement in this application will not bar the right to recovery under the Policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the Company.

ELECTRONIC TRANSMISSION OF DOCUMENTS: The Group agrees to voluntarily receive all documents and correspondence electronically and that the Group can access the internet or the email address provided. Written notice of termination will be provided to the Group as shown in the Policy. The Group understands that the Group may revoke this authorization, report a change or correction to the email address provided or request specific paper documents without revoking this authorization by contacting the Company or EyeMed by mail, email, or by telephone at 800-648-8624.

☐ Yes Email Address: _____ ■ No

Dated at: San Bernardino CA (City) (State) this 15th (Day) day of May (Month), 2023 (Year)

Signed for the Group: ▶ DocuSigned by: Sandra Walker 55679295A8504B9... Title: Division Chief

Printed Name: Sandra Walker

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

WRITING BROKER'S CERTIFYING STATEMENT

I certify that I am properly licensed in the state in which the Group is domiciled and I have accurately recorded on this application the information supplied by the applicant, if such information has been provided directly to me for recording purposes, to the best of my knowledge and belief the information on the application is complete and accurate, that I explained in easy to understand language the risk to the applicant of providing inaccurate information and that the applicant understood the explanation and that if I willfully state as true any material fact I know to be false, that I shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars ($10,000). Any public prosecutor may bring a civil action to impose that civil penalty. These penalties shall be paid to the Insurance Fund.

Firm Name (print): Segal Western States Tax ID No.: 94-1503999

Mailing Address: 500 N Brand Blvd, Ste 1400 (Street Address) Glendale (City) CA (State) 91203 (Zip)

Day-to-Day Contact Name: _____ Title: _____

Day-to-Day Contact Phone Number: (818) 956-6700 Day-to-Day Contact E-Mail Address: _____

Commission checks payable to: ☐ Firm ☐ Broker

Broker Name (print): Robert Mitchell SS#: 94-1503999

Broker Phone Number: (818)956-6700 Broker E-mail Address: rmitchell@segalco.com

Broker Signature: ► _____

WRITING GENERAL AGENT'S CERTIFYING STATEMENT

I certify that I am properly licensed in the state in which the Group is domiciled and I have accurately recorded on this application the information supplied by the applicant, if such information has been provided directly to me for recording purposes, to the best of my knowledge and belief the information on the application is complete and accurate, that I explained in easy to understand language the risk to the applicant of providing inaccurate information and that the applicant understood the explanation and that if I willfully state as true any material fact I know to be false, that I shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars ($10,000). Any public prosecutor may bring a civil action to impose that civil penalty. These penalties shall be paid to the Insurance Fund.

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

Mailing Address: _____ (Street Address) (City) (State) (Zip)

Day-to-Day Contact Name: _____ Title: _____

Day-to-Day Contact Phone Number: ( ) Day-to-Day Contact E-Mail Address: _____

Commission checks payable to: ☐ Firm ☐ General Agent

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

General Agent Phone Number: ( ) General Agent E-mail Address: _____

General Agent Signature: ► _____

County of San Bernardino

Proposed Benefits

EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company

Option General 1 - Eye360

Exam & Materials

Select Network

Fully Insured

Employer Paid

Funded Benefits

Frequency

Examination
Once every plan year

Lenses (in lieu of contacts)
Once every plan year

Contacts (in lieu of lenses)
Once every plan year

Frame
Once every plan year

Terms

Contract Term
36 months

Rate Guarantee
60 months

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam at PLUS Providers	***$0 copay***	Up to $48
Exam	$0 copay	Up to $48
FRAME		
Any available frame at PLUS Providers	***$0 copay; 20% off balance over $170 allowance***	Up to $47
Frame	$0 copay; 20% off balance over $120 allowance	Up to $47
CONTACT LENSES		
(Contact Lens allowance includes materials only)		
Contacts - Conventional	$0 copay; 15% off balance over $120 allowance	Up to $85
Contacts - Disposable	$0 copay; 100% of balance over $120 allowance	Up to $85
Contacts - Medically Necessary	$0 copay; paid-in-full	Up to $250
STANDARD PLASTIC LENSES		
Single Vision	$0 copay	Up to $40
Bifocal	$0 copay	Up to $55
Trifocal	$0 copay	Up to $75
Lenticular	$0 copay	Up to $125
Progressive - Standard	$65 copay	Up to $70
Progressive - Premium Tier 1	$85 copay	Up to $70
Progressive - Premium Tier 2	$95 copay	Up to $70
Progressive - Premium Tier 3	$110 copay	Up to $70
Progressive - Premium Tier 4	$65 copay, 20% off retail price less $120 allowance	Up to $70
LENS OPTIONS		
Polycarbonate - Standard	$20 copay	Up to $14

RATES	MONTHLY	BI-WEEKLY
Per Subscriber Per Month	$4.98	$2.30

Monthly Rate is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies. The Plan reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866-939-3633.

PLAN DETAILS

Quote for group situsedin the State of CA and will be valid until the 07/29/2023 implementation date. Date Quoted 11/22/2022. Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group. Percentage discounts are not part of the insurance benefit. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. EyeMed is licensed in California as EyeMed Vision Care & Insurance Services, LLC. California License # 0F30752. Fidelity Security Life Policy number VC-146, form number M-9184. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

PLAN EXCLUSIONS/LIMITATIONS

No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; 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; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; 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 lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. 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. Some provisions, benefits, exclusions or limitations listed herein may vary by state.

By signing below, the Group agrees to receive all documents and correspondence electronically and that the Group can access the internet or the email address provided. The Group understands that the Group may revoke this authorization or request specific paper documents without revoking this authorization by contacting EyeMed by mail, email, or [illegible] Bernardino has chosen this benefit design, attach this document to the group application and sign here

DocuSigned by:
Sandra Wakcher
55679295A8504B9...

5/12/2023

Signature

Date

County of San Bernardino

Proposed Benefits

EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company

Option General 2 - Eye360

Exam & Materials

Select Network

Fully Insured

Employer Paid

Funded Benefits

Frequency

Examination
Once every plan year

Lenses (in lieu of contacts)
Once every plan year

Contacts (in lieu of lenses)
Once every plan year

Frame
Once every plan year

Terms

Contract Term
36 months

Rate Guarantee
60 months

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam at PLUS Providers	***$0 copay***	Up to $48
Exam	$0 copay	Up to $48
FRAME		
Any available frame at PLUS Providers	***$0 copay; 20% off balance over $170 allowance***	Up to $47
Frame	$0 copay; 20% off balance over $120 allowance	Up to $47
CONTACT LENSES		
(Contact Lens allowance includes materials only)		
Contacts - Conventional	$0 copay; 15% off balance over $120 allowance	Up to $85
Contacts - Disposable	$0 copay; 100% of balance over $120 allowance	Up to $85
Contacts - Medically Necessary	$0 copay; paid-in-full	Up to $250
STANDARD PLASTIC LENSES		
Single Vision	$0 copay	Up to $40
Bifocal	$0 copay	Up to $55
Trifocal	$0 copay	Up to $75
Lenticular	$0 copay	Up to $125
Progressive - Standard	$65 copay	Up to $70
Progressive - Premium Tier 1	$85 copay	Up to $70
Progressive - Premium Tier 2	$95 copay	Up to $70
Progressive - Premium Tier 3	$110 copay	Up to $70
Progressive - Premium Tier 4	$65 copay, 20% off retail price less $120 allowance	Up to $70
LENS OPTIONS		
Polycarbonate - Standard	$20 copay	Up to $14

RATES	MONTHLY	BI-WEEKLY
Subscriber	$4.89	$2.26
Subscriber + 1	$11.73	$5.42
Subscriber + Family	$23.99	$11.07

Monthly Rate is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies. The Plan reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866-939-3633.

PLAN DETAILS

Quote for group situsedin the State of CA and will be valid until the 07/29/2023 implementation date. Date Quoted 11/22/2022. Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group. Percentage discounts are not part of the insurance benefit. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. EyeMed is licensed in California as EyeMed Vision Care & Insurance Services, LLC. California License # 0F30752. Fidelity Security Life Policy number VC-146, form number M-9184. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

PLAN EXCLUSIONS/LIMITATIONS

No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; 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; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; 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 lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. 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. Some provisions, benefits, exclusions or limitations listed herein may vary by state.

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DocuSigned by:
Sandra Wakcher
55679295A8504B9...

5/12/2023

Signature

Date

County of San Bernardino

Proposed Benefits

EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company

Option Exempt 3 - Eye360

Exam & Materials

Select Network

Fully Insured

Employer Paid

Funded Benefits

Frequency

Examination
Once every plan year

Lenses (in lieu of contacts)
Once every plan year

Contacts (in lieu of lenses)
Once every plan year

Frame
Once every plan year

Terms

Contract Term
36 months

Rate Guarantee
60 months

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam at PLUS Providers	***$0 copay***	Up to $48
Exam	$0 copay	Up to $48
FRAME		
Any available frame at PLUS Providers	***$0 copay; 20% off balance over $185 allowance***	Up to $125
Frame	$0 copay; 20% off balance over $135 allowance	Up to $125
CONTACT LENSES		
(Contact Lens allowance includes materials only)		
Contacts - Conventional	$0 copay; 15% off balance over $135 allowance	Up to $125
Contacts - Disposable	$0 copay; 100% of balance over $135 allowance	Up to $125
Contacts - Medically Necessary	$0 copay; paid-in-full	Up to $250
STANDARD PLASTIC LENSES		
Single Vision	$0 copay	Up to $40
Bifocal	$0 copay	Up to $55
Trifocal	$0 copay	Up to $75
Lenticular	$0 copay	Up to $125
Progressive - Standard	$65 copay	Up to $70
Progressive - Premium Tier 1	$85 copay	Up to $70
Progressive - Premium Tier 2	$95 copay	Up to $70
Progressive - Premium Tier 3	$110 copay	Up to $70
Progressive - Premium Tier 4	$65 copay, 20% off retail price less $120 allowance	Up to $70
LENS OPTIONS		
Polycarbonate - Standard	$0 copay	Up to $28

RATES	MONTHLY	BI-WEEKLY
Per Subscriber Per Month	$12.48	$5.76

Monthly Rate is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies. The Plan reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866-939-3633.

PLAN DETAILS

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DocuSigned by:
Sandra Wakcher
55679295A8504B9...

5/12/2023

Signature

Date

County of San Bernardino

Proposed Benefits

EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company

Option General 4 - Eye360

Exam & Materials

Select Network

Fully Insured

Employer Paid

Funded Benefits

Frequency

Examination
Once every plan year

Lenses (in lieu of contacts)
Once every plan year

Contacts (in lieu of lenses)
Once every plan year

Frame
Once every plan year

Terms

Contract Term
36 months

Rate Guarantee
60 months

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam at PLUS Providers	***$0 copay***	Up to $48
Exam	$0 copay	Up to $48
FRAME		
Any available frame at PLUS Providers	***$0 copay; 20% off balance over $170 allowance***	Up to $47
Frame	$0 copay; 20% off balance over $120 allowance	Up to $47
CONTACT LENSES		
(Contact Lens allowance includes materials only)		
Contacts - Conventional	$0 copay; 15% off balance over $120 allowance	Up to $85
Contacts - Disposable	$0 copay; 100% of balance over $120 allowance	Up to $85
Contacts - Medically Necessary	$0 copay; paid-in-full	Up to $250
STANDARD PLASTIC LENSES		
Single Vision	$0 copay	Up to $40
Bifocal	$0 copay	Up to $55
Trifocal	$0 copay	Up to $75
Lenticular	$0 copay	Up to $125
Progressive - Standard	$65 copay	Up to $70
Progressive - Premium Tier 1	$85 copay	Up to $70
Progressive - Premium Tier 2	$95 copay	Up to $70
Progressive - Premium Tier 3	$110 copay	Up to $70
Progressive - Premium Tier 4	$65 copay, 20% off retail price less $120 allowance	Up to $70
LENS OPTIONS		
Polycarbonate - Standard	$20 copay	Up to $14

RATES	MONTHLY	BI-WEEKLY
Per Subscriber Per Month	$10.61	$4.90

Monthly Rate is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies. The Plan reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866-939-3633.

PLAN DETAILS

Quote for group situsedin the State of CA and will be valid until the 07/29/2023 implementation date. Date Quoted 11/22/2022. Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group. Percentage discounts are not part of the insurance benefit. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. EyeMed is licensed in California as EyeMed Vision Care & Insurance Services, LLC. California License # 0F30752. Fidelity Security Life Policy number VC-146, form number M-9184. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

PLAN EXCLUSIONS/LIMITATIONS

No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; 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; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; 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 lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. 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. Some provisions, benefits, exclusions or limitations listed herein may vary by state.

By signing below, the Group agrees to receive all documents and correspondence electronically and that the Group can access the internet or the email address provided. The Group understands that the Group may revoke this authorization or request specific paper documents without revoking this authorization by contacting EyeMed by mail, email, n Bernardino has chosen this benefit design, attach this document to the group application and sign here

DocuSigned by:
Sandra Wakcher
55679295A8504B9...

5/12/2023

Signature

Date

FACTS

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

Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: ■ Social Security number and transaction history ■ medical information and insurance claim information ■ assets and checking account information When you are no longer our customer, we continue to share your information as described in this notice.
How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons Fidelity Security Life Insurance Company and Affiliates choose to share; and whether you can limit this sharing.

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

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

Who we are	
Who is providing this notice?	Fidelity Security Life Insurance Company and Affiliates including our Administrative, Insurance and Financial Service Providers.

What we do	
How does Fidelity Security Life Insurance Company and Affiliates protect my personal information?	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. 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 ■ apply for insurance or pay insurance premiums ■ file an insurance claim or give us your contact information ■ show your driver's license 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 ■ sharing for affiliates' everyday business purposes – information about your creditworthiness ■ affiliates from using your information to market to you ■ sharing for nonaffiliates to market to you 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. ■ *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. ■ *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. ■ *Our joint marketing partners include insurance agencies, broker dealers and investment advisor firms.*

Other important information

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: San Bernardino County

POLICY EFFECTIVE DATE: July 29, 2023

POLICY ANNIVERSARY DATE: July 29 of the following year and each July 29 thereafter

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

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

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

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

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

FIDELITY SECURITY LIFE INSURANCE COMPANY

Bryson T. Jones — President

Bradford R. James — Secretary

This Certificate is not major medical insurance and is not a substitute for major medical insurance. It does not qualify as minimum essential health coverage under the Federal Affordable Care Act.

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

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

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

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DEFINITIONS

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 July 29. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

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

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

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

1. the Insured's lawful spouse or Domestic Partner;
2. each child of the Insured or the Insured's spouse who is under 26 years of age;
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 a physically or mentally disabling injury, illness or condition.

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

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

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 United States, which is 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 for and paid as a result of any Workers' Compensation law, or any other services provided by or required by any governmental agency or program whether federal, state or subdivisions thereof;
4. orthoptic or vision training, subnormal vision aids and 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 subject to the Grace Period;
3. the date the Insured is no longer eligible for insurance; or
4. the date the Insured's employment with the Policyholder ends. The Policyholder may, at the Policyholder's option, continue insurance for individuals whose employment has ended, if the Policyholder:
   a. does so without individual selection between Insureds; and
   b. continues to pay any premium contribution for those individuals.

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

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

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

1. not capable of self-sustaining employment due to a physically or mentally disabling injury, illness or condition that began before the age limit was reached; and
2. mainly dependent on the Insured for support.

The Company will notify the Insured 90 days prior to the termination of a child reaching the limiting age. The Company may ask for proof of the eligible Dependent child's incapacity and dependency two months prior to the date the Dependent child would otherwise cease to be covered.

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

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

PREMIUMS

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

Premium Changes. The Company has the right to change the premium rates on any premium due date as allowed in the Policy. The Company will provide written notice to the Policyholder at least 150 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 60-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 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 if the payment was made to the Provider or from the Insured if the payment was made to 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 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

San Bernardino County
Option General 1

BENEFIT FREQUENCY		
Vision Examinations	once every 12 months	Insured Person
Vision Materials	once every 12 months	Insured Person

BENEFIT	*In-Network*		*Out-of-Network Provider* *(Reimbursement up to)*
	Plus In-Network Provider	*In-Network Provider*	
Vision Examination			
Comprehensive Eye Examination	$0 Copayment	$0 Copayment	$48
Vision Materials			
Frame	$0 Copayment up to $170 Allowance	$0 Copayment up to $120 Allowance	$47
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 $120 Allowance	$0 Copayment up to $120 Allowance	$85
Disposable	$0 Copayment up to $120 Allowance	$0 Copayment up to $120 Allowance	$85
Medically Necessary	Paid in Full	Paid in Full	$250
Standard Plastic Lenses			
Single Vision	$0 Copayment	$0 Copayment	$40
Bifocal	$0 Copayment	$0 Copayment	$55
Trifocal	$0 Copayment	$0 Copayment	$75
Lenticular	$0 Copayment	$0 Copayment	$125
Progressive – Standard	$65 Copayment	$65 Copayment	$70
Progressive – Premium Tier 1	$85 Copayment	$85 Copayment	$70
Progressive – Premium Tier 2	$95 Copayment	$95 Copayment	$70
Progressive – Premium Tier 3	$110 Copayment	$110 Copayment	$70
Progressive – Premium Tier 4	$65 Copayment up to $120 Allowance	$65 Copayment up to $120 Allowance	$70

BENEFIT	***In-Network***		***Out-of-Network Provider*** *(Reimbursement up to)*
	Plus In-Network Provider	***In-Network Provider***	
Lens Options			
Polycarbonate Lenses – Standard	$20 Copayment	$20 Copayment	$14

SCHEDULE OF BENEFITS

San Bernardino County
Option General 2

BENEFIT FREQUENCY		
Vision Examinations	once every 12 months	Insured Person
Vision Materials	once every 12 months	Insured Person

BENEFIT	*In-Network*		*Out-of-Network Provider* *(Reimbursement up to)*
	Plus In-Network Provider	*In-Network Provider*	
Vision Examination			
Comprehensive Eye Examination	$0 Copayment	$0 Copayment	$48
Vision Materials			
Frame	$0 Copayment up to $170 Allowance	$0 Copayment up to $120 Allowance	$47
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 $120 Allowance	$0 Copayment up to $120 Allowance	$85
Disposable	$0 Copayment up to $120 Allowance	$0 Copayment up to $120 Allowance	$85
Medically Necessary	Paid in Full	Paid in Full	$250
Standard Plastic Lenses			
Single Vision	$0 Copayment	$0 Copayment	$40
Bifocal	$0 Copayment	$0 Copayment	$55
Trifocal	$0 Copayment	$0 Copayment	$75
Lenticular	$0 Copayment	$0 Copayment	$125
Progressive – Standard	$65 Copayment	$65 Copayment	$70
Progressive – Premium Tier 1	$85 Copayment	$85 Copayment	$70
Progressive – Premium Tier 2	$95 Copayment	$95 Copayment	$70
Progressive – Premium Tier 3	$110 Copayment	$110 Copayment	$70
Progressive – Premium Tier 4	$65 Copayment up to $120 Allowance	$65 Copayment up to $120 Allowance	$70

BENEFIT	***In-Network***		***Out-of-Network Provider*** *(Reimbursement up to)*
	Plus In-Network Provider	***In-Network Provider***	
Lens Options			
Polycarbonate Lenses – Standard	$20 Copayment	$20 Copayment	$14

SCHEDULE OF BENEFITS

San Bernardino County
Option Exempt 3

BENEFIT FREQUENCY		
Vision Examinations	once every 12 months	Insured Person
Vision Materials	once every 12 months	Insured Person

BENEFIT	***In-Network***		***Out-of-Network Provider*** *(Reimbursement up to)*
	Plus In-Network Provider	***In-Network Provider***	
Vision Examination			
Comprehensive Eye Examination	$0 Copayment	$0 Copayment	$48
Vision Materials			
Frame	$0 Copayment up to $185 Allowance	$0 Copayment up to $135 Allowance	$125
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 $135 Allowance	$0 Copayment up to $135 Allowance	$125
Disposable	$0 Copayment up to $135 Allowance	$0 Copayment up to $135 Allowance	$125
Medically Necessary	Paid in Full	Paid in Full	$250
Standard Plastic Lenses			
Single Vision	$0 Copayment	$0 Copayment	$40
Bifocal	$0 Copayment	$0 Copayment	$55
Trifocal	$0 Copayment	$0 Copayment	$75
Lenticular	$0 Copayment	$0 Copayment	$125
Progressive – Standard	$65 Copayment	$65 Copayment	$70
Progressive – Premium Tier 1	$85 Copayment	$85 Copayment	$70
Progressive – Premium Tier 2	$95 Copayment	$95 Copayment	$70
Progressive – Premium Tier 3	$110 Copayment	$110 Copayment	$70
Progressive – Premium Tier 4	$65 Copayment up to $120 Allowance	$65 Copayment up to $120 Allowance	$70

BENEFIT	***In-Network***		***Out-of-Network Provider*** *(Reimbursement up to)*
	Plus In-Network Provider	***In-Network Provider***	
Lens Options			
Polycarbonate Lenses – Standard	$0 Copayment	$0 Copayment	$28

SCHEDULE OF BENEFITS

San Bernardino County
Option General 4

BENEFIT FREQUENCY		
Vision Examinations	once every 12 months	Insured Person
Vision Materials	once every 12 months	Insured Person

BENEFIT	*In-Network*		*Out-of-Network Provider* *(Reimbursement up to)*
	Plus In-Network Provider	*In-Network Provider*	
Vision Examination			
Comprehensive Eye Examination	$0 Copayment	$0 Copayment	$48
Vision Materials			
Frame	$0 Copayment up to $170 Allowance	$0 Copayment up to $120 Allowance	$47
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 $120 Allowance	$0 Copayment up to $120 Allowance	$85
Disposable	$0 Copayment up to $120 Allowance	$0 Copayment up to $120 Allowance	$85
Medically Necessary	Paid in Full	Paid in Full	$250
Standard Plastic Lenses			
Single Vision	$0 Copayment	$0 Copayment	$40
Bifocal	$0 Copayment	$0 Copayment	$55
Trifocal	$0 Copayment	$0 Copayment	$75
Lenticular	$0 Copayment	$0 Copayment	$125
Progressive – Standard	$65 Copayment	$65 Copayment	$70
Progressive – Premium Tier 1	$85 Copayment	$85 Copayment	$70
Progressive – Premium Tier 2	$95 Copayment	$95 Copayment	$70
Progressive – Premium Tier 3	$110 Copayment	$110 Copayment	$70
Progressive – Premium Tier 4	$65 Copayment up to $120 Allowance	$65 Copayment up to $120 Allowance	$70

BENEFIT	***In-Network***		***Out-of-Network Provider*** *(Reimbursement up to)*
	Plus In-Network Provider	***In-Network Provider***	
Lens Options			
Polycarbonate Lenses – Standard	$20 Copayment	$20 Copayment	$14

F I D E L I T Y S E C U R I T Y L I F E I N S U R A N C E C O M P A N Y®
3130 Broadway • Kansas City, Missouri 64111-2406
Phone: (800) 648-8624 Fax: (816) 968-0657
A STOCK COMPANY (herein Called "the Company")

OUTLINE OF COVERAGE
GROUP VISION INSURANCE POLICY
THIS IS A LIMITED BENEFIT POLICY

Policy Form M-9184CA

Read Your Certificate Carefully—This Outline of Coverage provides a very brief description of the important features of your coverage. This is not the insurance Policy and only the actual Policy provisions will control. The Policy itself sets forth in detail, the rights and obligations of both you and the Company. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY!

BENEFITS

VISION EXAMINATION AND VISION MATERIALS

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

VISION EXAMINATION AND VISION MATERIALS

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

VISION EXAMINATION AND VISION MATERIALS

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 for and paid as a result of any Workers' Compensation law, or any other services provided by or required by any governmental agency or program whether federal, state or subdivisions thereof;
4. orthoptic or vision training, subnormal vision aids and 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 subject to the Grace Period;
3. the date the Insured is no longer eligible for insurance; or
4. the date the Insured's employment with the Policyholder ends. The Policyholder may, at the Policyholder's option, continue insurance for individuals whose employment has ended, if the Policyholder:
   a. does so without individual selection between Insureds; and
   b. continues to pay any premium contribution for those individuals.

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

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

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

1. not capable of self-sustaining employment due to a physically or mentally disabling injury, illness or condition that began before the age limit was reached; and
2. mainly dependent on the Insured for support.

The Company will notify the Insured 90 days prior to the termination of a child reaching the limiting age. The Company may ask for proof of the eligible Dependent child's incapacity and dependency two months prior to the date the Dependent child would otherwise cease to be covered.

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

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

PREMIUMS

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 60 days before the date of the change. The premium rates also may be changed at any time the terms of the Policy are changed.

FIDELITY SECURITY LIFE INSURANCE COMPANY®

3130 Broadway
Kansas City, Missouri 64111-2406
Phone 800-648-8624
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(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:

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.

FIDELITY SECURITY LIFE INSURANCE COMPANY

Bryson Z. Jones — President

Bradford R. James — Secretary

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CONTINUATION OF COVERAGE (Cal-COBRA) AMENDMENT RIDER

Employers with 20 or more Full-time Employees Only
For California Residents Only

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

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

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

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

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

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

5. the date the Policy is terminated.

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

FIDELITY SECURITY LIFE INSURANCE COMPANY

Bryson T. Jones — Bradford R. James

President — Secretary

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AMENDMENT RIDER

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

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

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

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Bryson Z. Jones — President

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NOTICE

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

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

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

California Department of Insurance
Consumer Services Division
300 S. Spring Street, 14th Floor
Los Angeles, CA 90013
800-927-4357 (Inside California)
213-897-8921 (Outside California and Area Codes 213, 310, and 818)
TDD: 800-482-4TDD (4833)
https://www.insurance.ca.gov/01-consumers/

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NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**
  Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**
  The basic coverage protections provided by the Association are as follows.

  - **Life Insurance, Annuities and Structured Settlement Annuities**
    For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

    - Life Insurance
      80% of death benefits but not to exceed $300,000
      80% of cash surrender or withdrawal values but not to exceed $100,000

    - Annuities and Structured Settlement Annuities
      80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

    The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

  - **Health Insurance**
    The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract.
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society.
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual.
- Employer and association plans, to the extent they are self-funded or uninsured.
- A policy or contract providing any health care benefits under Medicare Part C or Part D.
- An annuity issued by an organization that is only licensed to issue charitable gift annuities.
- 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 certain investment elements of a variable life insurance policy or a variable annuity contract.
- Any policy of reinsurance unless an assumption certificate was issued.
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1067.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O Box 16860
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

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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.

FIDELITY SECURITY LIFE INSURANCE COMPANY

Notice of Non-Discrimination and Availability of Disability Accessibility Assistance

Your plan complies with applicable State and Federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

For people with disabilities, we offer free aids and services, such as sign language interpreters, large print, audio and accessible electronic formats. Please contact your administrator at its customer service phone number 1-888-249-5194, or email address www.eyemed.com for assistance.

If you believe that your plan has failed to provide you these services or discriminated against you on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a complaint with the State Department of Health Care Services, Office of Civil Rights at:

P.O. Box 997413, MS 0009
Sacramento, CO 95899-7413
(916) 440-7370
civilrights@dhcs.ca.gov

You are entitled to obtain the administrator representative's name, address, phone and email during your contact to provide the department so the department may contact that person about your complaint.

Notice of Availability of Language Assistance Services

English:
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-888-249-5194. For more help call the CA Dept. of Insurance at 1-800-927-4357.

Spanish:
Servicios de idiomas sin costo. Puede tener acceso a un intérprete para que le lea los documentos en su idioma. También podemos enviarle algunos documentos traducidos. Para obtener ayuda, llámenos al número en su tarjeta de asegurado o al 1-888-249-5194. Si necesita ayuda adicional, comuníquese con el Departamento de Seguros de California al 1-800-927-4357.

Arabic:
الخدمات اللغوية المجانية. يُمكنك الحصول على خدمات أحد المترجمين الفوريين. كما يمكنك الاستعانة بخدمات أحد المتخصصين لقراءة بعض الوثائق وإرسال بعضها إليك بلغتك. وللحصول على المساعدة، اتصل بنا على الأرقام المدرجة على بطاقة الهوية الخاصة بك أو على 1-888-249-5194. وللحصول على مزيد من المساعدة، اتصل بإدارة كاليفورنيا للتأمين الصحي على الرقم 1-800-927-4357.

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են ընթերցել ձեզ համար և ուղարվել դրանք ձեզ ձեր լեզվով: Օգնության համար զանգահարեք ձեր ինքնության (ID) քարտի վրա նշված հեռախոսահամարով կամ 1-888-249-5194 հեռախոսահամարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆորնիայի Ապահովագրության բաժանմունք՝ 1-800-927-4357 հեռախոսահամարով:

Chinese
免費語言服務。您可以獲得口譯員的協助。發給您的文件可提供閱讀服務，部分文件可提供您使用的語言版本。如需協助，請撥打 ID 卡上載明的號碼或 1-888-249-5194 與我們連絡。如需其他協助，請撥打 1-800-927-4357 與加州保險局連絡。

Hindi
□बना लागत क□ भाषा सेवाएँ। आप दुभा□षया प◌ुर◌ा कर सकते ह□। आप दस◌ुताव ◌ुताव ◌ुतावे◌ पढ़वा सकते ह□ और कुछ दस◌ुताव ◌ुताव ◌ुतावे◌ आपको आपक□ भाषा म□ भेजे जा सकते ह□। मदद के □लए, हम□ अपने ID काडर पर सूचीबद नंबर पर या 1-888-249-5194 पर कॉल कर□। अ□धक मदद के □लए 1-800-927-4357 पर CA बीमा □वभाग कोकॉल कर□।

Hmong
Muaj Cov Kev Pab Txhais Lus Pub Dawb. Koj tuaj yeem tau txais ib tus neeg txhais lus. Koj tuaj yeem tau txais kev pab muab cov ntaub ntawv nyeem rau koj mloog thiab muab qee cov xa tuaj rau koj ua koj hom lus. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob saum koj daim npav ID lossis 1-888-249-5194. Yog xav paub ntxiv, hu rau CA Dept. of Insurance ntawm 1-800-927-4357.

Japanese
無料の言語サービス。メンバーは通訳者を通じて連絡を取ることができます。また、お望みの言語で通訳者に文書を呼んでもらったり、送付するよう依頼することも可能です。ヘルプについては、ID カードに記載されている番号、または 1-888-249-5194 までお電話ください。詳細については、カリフォルニア保険局（1-800-927-4357）までお問い合わせください。

Khmer:
សេវាភាសាអត់អស់ថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់ម្នាក់។ អ្នកអាចឱ្យគេអានឯកសារនានាឱ្យអ្នកស្តាប់ និងបញ្ជូនឱ្យអ្នកនូវឯកសារមួយចំនួនជាភាសារបស់អ្នកបាន។ ដើម្បីទទួលបានជំនួយ សូមហៅទូរសព្ទមកយើងខ្ញុំតាមរយៈលេខដែលមានចុះនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក ឬ 1-888-249-5194 ។ ដើម្បីរកបានជំនួយច្រើនទៀត សូមហៅទូរសព្ទទៅផ្នែក CA នៃក្រុមហ៊ុនធានារ៉ាប់រងតាមរយៈលេខ 1-800-927-4357។

Korean:
무료 통역/번역 서비스 제공 통역 서비스를 이용하실 수 있습니다. 원하는 언어로 문서 내용을 듣고 일부 내용은 문서로 받으실 수도 있습니다. 관련하여 도움이 필요하시면 ID 카드에 안내된 번호 또는 1-888-249-5194 번으로 연락주시기 바랍니다. 더 자세한 안내가 필요하시면 CA Dept. of Insurance (1-800-927-4357) 로 문의해 주세요.

Persian:
خدمات زبانی رایگان می توانید از خدمات یک مترجم لفظی بهره مند شوید. می توانید بخواهید تا مدارک برای شما خوانده شود و بعضی از آنها به زبان تان به شما ارسال شود. برای دریافت کمک، از طریق شماره مندرج در کارت شناسایی تان 1-888-249-5194با ما تماس بگیرید. برای دریافت کمک مکمل، با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید.

Punjabi:
ਬਿਨਾਂ ਲਾਗਤ ਦੇ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਹਾਨੂੰ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਮਿਲ ਸਕਦਾ ਹੈ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ ਅਤੇ ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ID ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਜਾਂ 1-888-249-5194 'ਤੇ ਸਾਨੂੰ ਕਾਲ ਕਰੋ। ਹੋਰ ਮਦਦ ਲਈ, ਕੈਲੀਫੋਰਨੀਆ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 'ਤੇ ਕਾਲ ਕਰੋ।

Russian:
Бесплатные услуги перевода. Вам могут предоставить переводчика. Вам могут зачитать документы на вашем родном языке, а также отправить некоторые из них в переводе на нужный вам язык. Чтобы получить помощь, позвоните нам по номеру, указанному на вашей карте участника плана, или по номеру 1-888-249-5194. Кроме того, вы можете обратиться за помощью в Департамент страхования Калифорнии, позвонив по номеру 1-800-927-4357.

Tagalog:
Mga Serbisyo sa Wika na Walang Bayad. Maaari kang makakuha ng interpreter. Maaari mong ipabasa ang mga dokumento sa iyo o ipapadala ang mga ito sa iyo sa iyong wika. Para sa tulong, tumawag sa amin sa numerong nakalista sa iyong ID card o sa 1-888-249-5194. Para sa higit pang tulong, tumawag sa CA Dept. of Insurance sa 1-800-927-4357.

Thai
ไม่มีค่าบริการเกี่ยวกับภาษา ท่านสามารถขอใช้บริการล่ามได้
ท่านสามารถขอให้เจ้าหน้าที่อ่านเอกสารได้ท่านฟังและเอกสารบางอย่างจะส่งถึงท่านโดยใช้ภาษาของท่าน
หากต้องการความช่วยเหลือ โปรดโทรหาเราตามหมายเลขที่ระบุอยู่บนบัตรประจำตัวของท่านหรือที่หมายเลข 1-888-249-5194
หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดตามแผนก CA Dept. of Insurance ที่หมายเลข 1-800-927-4357

Vietnamese:
Các dịch vụ ngôn ngữ miễn phí. Bạn có thể có một phiên dịch viên. Bạn có thể được nghe hoặc nhận tài liệu bằng ngôn ngữ của bạn. Để nhận hỗ trợ, hãy gọi cho chúng tôi qua số điện thoại trên thẻ ID hoặc qua 1-888-249-5194. Để nhận thêm hỗ trợ, hãy gọi tới Cơ quan Bảo hiểm của CA qua số 1-800-927-4357.

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

California Notice of Right to Request Confidential Communications

Pursuant to Cal. Ins. Code § 791.29(b), you have the right to request that Fidelity Security Life Insurance Company® (FSL) through its Administrator, send all "Confidential Communications" regarding your vision insurance to you at an alternative address. For purposes of this Notice, "Confidential Communications" refer to all communications that disclose your medical information or provider name and address related to your Vision insurance and related medical services.

Examples of Confidential Communications may include all bills and attempts to collect payment, notice of adverse benefits determinations, explanation of benefits notices, requests for additional information concerning a claim, notices of contested claims, names and addresses of providers, descriptions of services provided, any information related to a visit, and any other written, oral, or electronic communication containing medical information related specifically to your vision insurance.

FSL's designated administrator will respond to your request and provide directions and a form to complete no later than 7 business days after the date of receipt of a request by email. The Confidential Communication request will be valid until you submit a revocation of the request, or a new Confidential Communication request is submitted.

To request to receive Confidential Communications at an alternative address please submit your name and address, your policy/certificate number shown on your Vision Insurance ID card, and your phone and/or email address to the following:

EyeMed Vision Care, L.L.C.
Email to: privacyoffice@eyemed.com