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: Johns Hopkins University

POLICY EFFECTIVE DATE: January 1, 2023

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

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

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

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

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

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

FIDELITY SECURITY LIFE INSURANCE COMPANY

Bryson T. Jones — President

Bradford R. James — Secretary

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

This plan is not designed to fill the gaps of Medicare.

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

TABLE OF CONTENTS

DEFINITIONS

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

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

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

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

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

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

1. the Insured's lawful spouse 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 mental or physical incapacity.

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

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 each contributes to some extent to the other individual's maintenance and support with the intention of remaining in the relationship indefinitely. 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, as determined by the Provider. 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.

Non-physician Specialist means a Provider who:

1. is not a physician;
2. is licensed or certified under the Health Occupations article; and
3. is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of the license or certification of the health care provider.

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

Policy means the Vision Insurance Policy issued to the Policyholder.

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

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

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

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

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

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, including a grandchild in the court-ordered custody of the Insured and a minor child in the custody of the Insured as a result of guardianship, other than temporary guardianship of less than 12 months' duration. 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.

If the spouse of the Insured dies or the spouse of the Insured loses coverage under another group policy due to involuntary termination of the Insured's spouse's employment and the Insured's Dependent children were covered under such policy, the Insured may add the Insured's spouse and Dependent children to the coverage under the Policy without evidence of insurability. The Insured must notify the Policyholder and the Company within six months after the date of death of the Insured's spouse or termination date of the Insured's spouse's coverage. Involuntary termination does not mean termination for cause.

If the Insured is required due to court order to provide coverage for a Dependent child, the Company will allow the Insured to enroll, regardless of enrollment period restrictions.

If the Insured is enrolled, but does not include the Dependent child in the enrollment, the Company will:

1. allow the non-insuring parent, child support enforcement agency, or Maryland Department of Health to apply for enrollment on behalf of the Dependent child; and
2. include the Dependent child, regardless of enrollment period restrictions.

If a Dependent child's coverage is through the Insured, the Company will:

1. provide to the non-insuring parent ID cards, claims forms, and any other information necessary for the Dependent child to obtain benefits through the Policy; and
2. process the claims forms and make appropriate payment to the non-insuring parent, Provider, or Maryland Department of Health if the non-insuring parent incurs expenses for covered vision care provided to the Dependent child.

Coverage will not terminate for the Dependent child unless written evidence is provided to the entity that:

1. the court order is no longer in effect;
2. the Dependent child has been or will be enrolled under other reasonable vision insurance coverage that will take effect on or before the effective date of the termination;
3. the employer has eliminated family health coverage for all Insureds; or
4. the Insured is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), when coverage under the Policy terminates.

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

BENEFITS

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

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

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

LIMITATIONS

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

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

EXCLUSIONS

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

1. medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures;
2. Refraction, when not provided as part of a Comprehensive Eye Examination;
3. services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof. This exclusion does not apply to Medicaid;
4. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
5. any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment;
6. safety eyewear;
7. solutions, cleaning products or frame cases;
8. non-prescription sunglasses;
9. plano (non-prescription) lenses;
10. plano (non-prescription) contact lenses;
11. two pair of glasses in lieu of bifocals;
12. electronic vision devices;

13. services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order;
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; or
15. payment of any claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral.

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 last day of the grace period, if the premium due is not paid by the last day of 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 last day of the grace period, if the premium due is not paid by the last day of 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 mental or physical incapacity that began before the age limit was reached; and
2. mainly dependent on the Insured for support.

The Company may ask for proof of the eligible Dependent child's incapacity and dependency on 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.

If the Insured Person's coverage terminates and the Insured Person has ordered Vision Materials, the Company will provide benefits in accordance with the Policy for the Vision Materials if the Insured Person receives the Vision Materials within 30 days after the date ordered.

PREMIUMS

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

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

Grace Period. The Policy has a 30-day grace period for the payment of each premium due after the first premium, unless the Company does not intend to renew the Policy beyond the period for which premium has been accepted and notice of the Company's intention not to renew is delivered to the Policyholder at least 45 days before the premium is due. 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, but not more than 30 days. The grace period will not apply if the Company receives written notice of the Policyholder's or the Insured's intent to terminate coverage.

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. Failure to provide notice within the time required will not invalidate or reduce any claim if it was not reasonably possible to give notice within that time, if such notice is provided as soon as reasonably possible.

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

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

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

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

Assignment. Benefits under the Policy may be assigned. The Company will not directly reimburse an Out-of-Network Provider if:

1. the Company receives notice of the assignment after the time the Company has paid the benefits to the Insured;
2. the Company, due to an inadvertent administrative error, has previously paid the Insured;
3. the Insured withdraws the assignment before the Company has paid the benefits to the Out-of-Network Provider; or
4. the Insured paid the Out-of-Network Provider the full amount due at the time of service.

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

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

GENERAL PROVISIONS

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

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

Entire Contract. The Policy, including any endorsements and riders, the Certificate, the Policyholder's application, which is attached to the Policy when issued, the Insured's individual enrollment form, if any, and the eligibility file, if any, are the entire contract between the parties. A copy of the Policy may be examined at the office of the Policyholder during normal business hours.

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, which will be attached to the Policy. 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.

Contestability of Coverage. After the Policy has been in force for two years from its date of issue, 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. Absent fraud, each statement made by an applicant, Policyholder or an Insured person is considered to be a representation and not a warranty. A statement made to effectuate insurance may not be used to avoid the insurance or reduce benefits under the Policy unless the statement is contained in a written instrument signed by the Policyholder or Insured Person and a copy of the statement is given to the Policyholder, Insured Person or beneficiary of the Insured Person. This provision does not preclude the assertion at any time of defenses based upon the Insured Person's ineligibility for coverage under the Policy or upon other provisions in the Policy.

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

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

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

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®
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SCHEDULE OF BENEFITS

Johns Hopkins University

BENEFIT FREQUENCY		
Vision Examination	once every calendar year	Insured Person
Vision Materials		
Frame	once every calendar year	Insured Person
Lenses and Lens Options	once every calendar year	Insured Person
Contact Lenses	once every calendar year	Insured Person

BENEFIT	*In-Network Provider*	*Out-of-Network Provider (Reimbursement up to)*
Vision Examination	$10 Copayment	$40
Vision Materials		
Frame	$0 Copayment up to $150 Allowance	$66
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 $150 Allowance	$150
Disposable	$0 Copayment $150 Allowance	$150
Medically Necessary	Paid in Full	$210
Standard Plastic Lenses		
Single Vision	$20 Copayment	$40
Bifocal	$20 Copayment	$60
Trifocal	$20 Copayment	$80
Lenticular	$20 Copayment	$80
Progressive – Standard	$75 Copayment	$60
Progressive – Premium Tier 1	$105 Copayment	$60
Progressive – Premium Tier 2	$115 Copayment	$60
Progressive – Premium Tier 3	$130 Copayment	$60
Progressive – Premium Tier 4	$195 Copayment	$60
Lens Options		
Anti-Reflective Coating – Standard	$45 Copayment	$5
Anti-Reflective Coating – Premium Tier 1	$57 Copayment	$5
Anti-Reflective Coating – Premium Tier 2	$68 Copayment	$5
Anti-Reflective Coating – Premium Tier 3	$85 Copayment	$5

BENEFIT	***In-Network Provider***	***Out-of-Network Provider*** *(Reimbursement up to)*
Polycarbonate Lenses – Standard Dependent Children under 19 years of age	$0 Copayment	$32
Scratch Coating – Standard Plastic	$0 Copayment	$12
Tint (Solid and Gradient) – Standard	$0 Copayment	$12
UV Treatment	$0 Copayment	$12

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VISION EXAMINATION BENEFIT RIDER
For Insured Persons with Type 1 or Type 2 Diabetes with Diabetic Retinopathy

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

SCHEDULE OF BENEFITS

BENEFIT FREQUENCY		
Vision Examinations		
Medical Follow-Up Eye Examination	once every 6 months	Insured Person
Fundus Photography Examination	once every 6 months	Insured Person
Extended Ophthalmoscopy, initial and subsequent	once every 6 months	Insured Person
Gonioscopy	once every 6 months	Insured Person
Scanning Laser	once every 6 months	Insured Person

BENEFIT	***In-Network Provider***	***Out-of-Network Provider*** *(Reimbursement up to)*
Vision Examinations		
Medical Follow-Up Eye Examination	$0 Copayment	$77
Fundus Photography Examination	$0 Copayment	$50
Extended Ophthalmoscopy, initial and subsequent	$0 Copayment	$15
Gonioscopy	$0 Copayment	$15
Scanning Laser	$0 Copayment	$33

DEFINITIONS

Diabetes Mellitus or **Diabetes** means a metabolic disease in which a person has high blood sugar, either because the body does not produce enough insulin or because cells do not respond to the insulin that is produced.

Diabetic Retinopathy means damage to the retina caused by complications of Diabetes Mellitus.

Extended Ophthalmoscopy means an examination of the interior of the eye, focusing on the posterior segment of the eye, including the lens, retina, and optic nerve, by direct or indirect ophthalmoscopy, and includes a retinal drawing with interpretation and report.

Gonioscopy means an eye examination of the front part of the eye (anterior chamber) to check the angle where the iris meets the cornea with a gonioscope or with a contact prism lens.

Fundus Photography Examination means photographing portion(s) of or the complete retina surface and structures, with interpretation and report.

Medical Follow-Up Eye Examination means an office visit for diabetic vision care after the initial Comprehensive Eye Examination.

Scanning Laser means a computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report.

Type 1 Diabetes means a condition that results from the body's failure to produce insulin. It is also referred to as insulin-dependent Diabetes Mellitus or juvenile Diabetes.

Type 2 Diabetes means a condition in which cells fail to use insulin properly, sometimes combined with an absolute insulin deficiency.

BENEFITS

Benefits are payable as shown in the Schedule of Benefits for expenses incurred while this Rider is in force for each Insured Person who has Type 1 or Type 2 Diabetes and has been diagnosed with Diabetic Retinopathy.

Extended Ophthalmoscopy. An Insured Person is eligible for one initial Extended Ophthalmoscopy examination and one subsequent Extended Ophthalmoscopy examination for diabetic vision care in each Benefit Frequency. The Extended Ophthalmoscopy must provide information not available from the standard evaluation services and/or information that will demonstrably affect the treatment plan. The Extended Ophthalmoscopy is not covered if Fundus Photography Examination was provided within the previous six-month period.

Gonioscopy. An Insured Person is eligible for one Gonioscopy for diabetic vision care in each Benefit Frequency.

Medical Follow-Up Eye Examination. An Insured Person is eligible for one Medical Follow-Up Eye Examination for diabetic vision care in each Benefit Frequency.

Fundus Photography Examination. An Insured Person is eligible for one Fundus Photography Examination for diabetic vision care in each Benefit Frequency. The Fundus Photography Examination is not covered if an Extended Ophthalmoscopy was provided within the previous six-month period.

Scanning Laser. An Insured Person is eligible for one Scanning Laser in each Benefit Frequency.

EXCLUSIONS

In addition to the Exclusions in the Policy/Certificate, no benefits are payable for services connected with or charges arising from:

1. any Vision Materials;
2. orthoptic or vision training, subnormal vision aids and any associated supplemental testing;
3. medical, pathological and/or surgical treatment of the eye, eyes or supporting structures;
4. any Vision Examination required by a Policyholder as a condition of employment; or
5. services, supplies, prescription medication or treatment for diabetes, except as specifically included in this Rider.

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

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AMENDATORY RIDER REGARDING REPLACEMENT COVERAGE

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

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

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

Each such person will be insured under the Policy if:

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

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

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

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

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NOTICE OF PROTECTION PROVIDED BY MARYLAND LIFE AND HEALTH INSURANCE GUARANTY CORPORATION

This notice provides a brief summary of the Maryland Life and Health Insurance Guaranty Corporation (the Corporation) and the protection it provides for policyholders and contract holders. This safety net was created under Maryland law, which determines who and what is covered and the amounts of coverage.

The Corporation is not a department or unit of the State of Maryland and the liabilities or debts of the Life and Health Insurance Guaranty Corporation are not liabilities or debts of the State of Maryland.

The Corporation was established to provide protection in the unlikely event that your health maintenance organization or your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Corporation will typically arrange to continue coverage and pay claims, in accordance with Maryland law, with funding from assessments paid by other insurance companies and health maintenance organizations.

The basic protections provided by the Corporation are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance or Health Benefit Plans
  - $500,000 for coverage provided by health benefit plans
  - $300,000 for disability insurance
  - $300,000 for long-term care insurance
  - $100,000 for a type of health insurance not listed above, including any net cash surrender and net cash withdrawal values under the types of health insurance listed above
- Annuities
  - $250,000 in the present value of annuity benefits, including net cash withdrawal values and net cash surrender values
  - With respect to each payee under a structured settlement annuity, or beneficiary of the payee, $250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is:

- $300,000 in aggregate for all types of coverage listed above, with the exception of coverage provided by health benefit plans
- $500,000 in aggregate for of coverage provided by health benefit plans

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Maryland law.

To learn more about the above protections, please visit the Corporation's website at www.mdlifega.org or contact:

Maryland Life and Health Insurance Guaranty Corporation
6210 Guardian Gateway , Suite 195APG
Aberdeen, Maryland 21005
410-248-0407

Insurance companies, health maintenance organizations, and insurance producers are not allowed by Maryland law to use the existence of the Corporation or its coverage to encourage you to purchase any form of insurance or health benefit plan. When selecting an insurance company or health maintenance organization, you should not rely on Corporation coverage. If there is any inconsistency between this notice and Maryland law, then Maryland law will control.

FIDELITY SECURITY LIFE INSURANCE COMPANY®

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

NOTICE OF ADMINISTRATOR'S CAPACITY

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

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

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

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

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

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HEALTH COVERAGE OPTIONS FOR CHILDREN TURNING AGE 18

This Notice provides you with information about how a child may remain covered under your health coverage after the child reaches age 18. Your child may remain covered under your current Policy as a dependent beyond age 18, under the following options:

Option to Remain Covered Under Parent's Coverage - The Policy automatically provides for coverage beyond age 18 in certain circumstances. Refer to the definition of 'Dependent' in your Policy for a description of these dependent age limitations.

COBRA Continuation Option - This option applies only if your child's current health coverage is under your employer's group plan and your employer has 20 or more employees. If your child does not satisfy the option above, your child's only option to continue coverage under your group Policy beyond the limiting age is by electing the COBRA continuation option. Under this option, your child will no longer be covered as a dependent under your coverage. The premium for the child selecting this option will be the full adult premium, plus a two percent administrative fee. Generally, employers do not contribute any premium for individuals who select COBRA continuation coverage.

Incapacitated Child Coverage - If your child, at the time of reaching the limiting age in the Policy, is incapable of self-support due to a mental or physical incapacity, the child may remain covered under your Policy as long as the child remains:

- unmarried;
- chiefly dependent on you for support;
- incapable of self-support due to the mental or physical incapacity; and
- if the child is your grandchild or an individual for whom guardianship is granted by court or testamentary appointment, in your custody.

Information Available from the Maryland Insurance Administration - The Maryland Insurance Administration has information available regarding health coverage that you might find helpful. The information includes a Consumer Guide for Health Insurance, as well as a list of all the carriers who sell individual health insurance or individual HMO coverage in Maryland, including contact information. The Maryland Insurance Administration's website is *www.mdinsurance.state.md.us*. Their telephone number is 1-800-492-6116.