



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: State of Tennessee
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



President

Secretary

READ THE CERTIFICATE CAREFULLY – THIS CERTIFICATE PROVIDES A VERY BRIEF DESCRIPTION OF THE IMPORTANT FEATURES OF THE POLICY. THE INSURED PERSON'S FULL RIGHTS AND BENEFITS ARE EXPRESSED IN THE ACTUAL POLICY THAT IS AVAILABLE TO THE INSURED PERSON UPON REQUEST TO THE COMPANY.

THIRTY-DAY RIGHT TO EXAMINE: If the Insured is not satisfied for any reason, the Insured may return the 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.

**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.

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SCHEDULE OF BENEFITS 1A

DEFINITIONS

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

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

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

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

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

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

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

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

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

Insured means an employee of the Policyholder who meets the eligibility requirements as shown in the Policyholder's application, and whose coverage under the Policy is in force and has not ended. Employee also includes a regular part-time employee who works or is expected to work an average of at least 20 hours per week over a six-month period.

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.

Low Vision means a severe visual loss that is not correctable with standard lenses and:

1. when the best-corrected acuity is 20/200 or less in the better eye with best conventional spectacle or contact lenses prescription; or
2. when there can be a demonstrated constriction of the peripheral fields in the better eye to 10 degrees or less from the fixation point or the widest diameter subtends an angle less than 20 degrees in the better eye.

Low Vision Aids are classified as follows:

1. Spectacle-mounted magnifiers - A magnifying lens is mounted in spectacles (this type of system is called a microscope) or on a special headband. This allows use of both hands to complete the close-up task, such as reading;
2. Handheld or spectacle-mounted telescopes - These miniature telescopes are useful for seeing longer distances, such as across the room to watch television, and can also be modified for near (reading) tasks;
3. Handheld and stand magnifiers - These magnifiers can serve as supplements to other specialized systems and are convenient for short-term reading of such things as price tags, labels and instrument dials. Both types of magnifiers can be equipped with lights; or
4. Video magnification - Table-top (closed-circuit television) or head-mounted systems enlarge reading material on a video display. Some systems can be used for distance viewing tasks. These are portable systems and can be used with a computer or Computer Display. Image brightness, image size, contrast, foreground/background color and illumination can be customized.

Low Vision Supplemental Examination means diagnostic evaluation beyond the Comprehensive Eye Examination and includes a history of functional difficulties that involves such things as reading, activities in the kitchen, glare problems, mobility, the workplace, television viewing, school requirements, hobbies and interests. Preliminary tests may include assessment of ocular functions such as color vision and contrast sensitivity. Measurements will be taken for visual acuity using special low vision test charts, which include a larger range of letters or numbers to more accurately determine a starting point for assessing the level of impairment. Visual fields may also be evaluated. A specialized Refraction must be performed with each eye thoroughly examined. The Provider may prescribe various treatment options, including Low Vision Aids, as well as assist with identifying other resources for vision and lifestyle rehabilitation.

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

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

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

Policy means the Vision Insurance Policy issued to the Policyholder.

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

PPO Service Area means the geographical area within the state of New Mexico.

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. This Certificate offers Vision Examination and Vision Materials, including lenses, frames and Medically Necessary Contact Lenses.

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

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

LIMITATIONS

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

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

EXCLUSIONS

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

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

TERMINATION OF INSURANCE

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

For All Insureds. The Insureds' insurance will cease on the earlier of:

1. the date the Policy ends;
2. the end of the last period for which any required premium contribution agreed to in writing has been made;
3. the date the Insured is no longer eligible for insurance; or
4. the date the Insured's employment with the Policyholder ends. The Policyholder may, at the Policyholder's option, continue insurance for individuals whose employment has ended, if the Policyholder:
 - a. does so without individual selection between Insureds; and
 - b. continues to pay any premium contribution for those individuals.

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

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

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

1. not capable of self-sustaining employment due to mental incapacity or physical disability that began before the age limit was reached; and
2. mainly dependent on the Insured for support.

The Company may ask for proof of the eligible Dependent child's incapacity and dependency within 31 days of the date the Dependent child would otherwise cease to be covered.

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

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

PREMIUMS

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

Premium Changes. The Company has the right to change the premium rates on any premium due date 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.

Grace Period. The Policy has a 31-day grace period for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. Coverage will terminate at the end of the grace period if all premiums due are not paid. The Company will require payment of all premiums for the period this coverage continues in force, including the premiums for the grace period. The grace period will not apply if the Company receives written notice of the Policyholder's or the Insured's intent to terminate coverage.

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

CLAIMS

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

Claim Forms. The Company will furnish claim forms to the Insured Person within 15 days after notice of claim is received. If the Company does not provide the forms within that time, the Insured Person making such claim will be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting 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.

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

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

Assignment. Benefits under the Policy may be assigned.

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

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

GENERAL PROVISIONS

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

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

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

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

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

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

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

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

SCHEDULE OF BENEFITS

State of Tennessee – Basic Plan

<i>BENEFIT FREQUENCY</i>		
<u>Vision Examination</u>		
Comprehensive Eye Examination	once every calendar year	Insured Person
Low Vision Supplemental Examination	once every 2 calendar years	Insured Person
<u>Vision Materials</u>		
Frame	once every 2 calendar years	Insured Person
Lenses and Lens Options	once every calendar year	Insured Person
Contact Lenses	once every calendar year	Insured Person
Low Vision Aids	once every 2 calendar years	Insured Person

<i>BENEFIT</i>	<i><u>In-Network Provider</u></i>	<i><u>Out-of-Network Provider</u></i> <i>(Reimbursement up to)</i>
<u>Vision Examination</u>		
Comprehensive Eye Examination	\$10 Copayment	\$40
Low Vision Supplemental Examination	\$0 Copayment, up to \$300 Allowance	\$300
<u>Vision Materials</u>		
Frame	\$0 Copayment, up to \$105 Allowance	\$55
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 \$105 Allowance	\$75
Disposable	\$0 Copayment, up to \$105 Allowance	\$75
Medically Necessary	\$0 Copayment, up to \$155 Allowance	\$80
Standard Plastic Lenses *		
Single Vision	\$20 Copayment	\$55
Bifocal	\$20 Copayment	\$55
Trifocal	\$20 Copayment	\$55
Lenticular	\$20 Copayment	\$90
Progressive – Standard	\$90 Copayment	\$55
Progressive – Premium Tier 1	\$110 Copayment	\$55
Progressive – Premium Tier 2	\$140 Copayment	\$55
Progressive – Premium Tier 3	\$200 Copayment	\$55
Progressive – Premium Tier 4	\$225 Copayment	\$55
<u>Lens Options</u>		
Polycarbonate Lenses – Standard Dependent Children under 19 years of age	\$0 Copayment	\$10
Low Vision Aids	\$0 Copayment, up to \$300 Allowance	\$300

* The Insured Person is eligible for additional Lenses 30 days after the initial prescription, if prescription has changed by 0.50 diopter sphere/cylinder >20 degrees axis, or visual acuity improvement by two lines on standard chart in the same Benefit Frequency.



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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.

FIDELITY SECURITY LIFE INSURANCE COMPANY



President

Secretary



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NOTICE

THIS NOTICE is to advise you that in the event a complaint should arise about this insurance, please contact First American Administrators, Inc. for complaint resolution or the appeals process:

First American Administrators, Inc.
4000 Luxottica Place
Mason, OH 45040
1-877-226-1115

If First American Administrators, Inc. fails to provide a reasonable and adequate resolution, please contact our Customer Service Department at:

Fidelity Security Life Insurance Company
3130 Broadway
Kansas City, MO 64111-2406
800-648-8624, Extension 1100
<https://www.fslins.com/>

If we at Fidelity Security Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact the Office of the Superintendent of Insurance with any questions regarding the appeals process:

New Mexico Office of Superintendent of Insurance
Consumer Assistance Bureau
1120 Paseo De Peralta, 4th Floor
Santa Fe, New Mexico 87501
855-427-5674
<https://www.osi.state.nm.us/index.php/consumers/consumer-assistance/>



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NOTICE OF PROTECTION PROVIDED BY NEW MEXICO LIFE INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the New Mexico Life Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under New Mexico law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that 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 Association will typically arrange to continue coverage and pay claims, in accordance with New Mexico law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
 - \$300,000 in death benefits
 - \$100,000 in cash surrender or withdrawal values
- Health Insurance
 - \$500,000 in hospital, medical and surgical insurance benefits
 - \$300,000 in disability income insurance benefits
 - \$300,000 in long-term care insurance benefits
 - \$100,000 in other types of health insurance benefits
- Annuities
 - \$250,000 in present value of annuity benefits

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000 (\$500,000 for hospital, medical and surgical insurance policies).

Note to benefit plan trustees or other holders of unallocated annuities covered under the act: For unallocated annuities that fund certain governmental retirement plans, the limit is \$250,000 in present value of annuity benefits per plan participant. For covered unallocated annuities that fund other plans, a special limit of \$5,000,000 applies to each contract holder, regardless of the number of contracts held or number of persons covered.

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 New Mexico law.

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

New Mexico Life Insurance
Guaranty Association
PO Box 2880
Santa Fe, NM 87504-2880
505-820-7355

Insurance Division
Public Regulation Commission
PO Box 1269
Santa Fe, NM 87504-1269
888-427-5772

Insurance companies and agents are not allowed by New Mexico law to use the existence of the Association or its coverage to 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 New Mexico law, then New Mexico 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.



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LIMITED BENEFIT HEALTH PLANS NOTICE TO CONSUMER

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