## HOW TO USE YOUR IN-NETWORK BENEFITS

***Do I need to show an I.D. card to the provider to receive my benefits?***
Your Envolve Vision Plan ID card identifies you as a member covered by an Envolve Vision Plan and identifies the plan under which you are covered. It is recommended that you show the provider your I.D. card. However, you may receive services without the I.D. card. Simply identify yourself as an Envolve Vision member with proper personal identification, social security number and the name of your employer.

***Under what situations do I make payment directly to the in-network provider?***
You pay the in-network provider for the following: Your plan co-pay(s); any charges over and above your plan allowance; any service or item that is listed as non-covered by your routine vision plan.

***Do I need to bring any forms with me to the provider?***
There are no forms required for in-network services.

## HOW TO USE YOUR OUT-OF-NETWORK BENEFITS

***How do I make use of my benefit when using an out-of-network provider?***
First, see your provider and pay for your examination and/or materials. Second, complete the Envolve Vision Out-of-Network claim form (www.myvisionplan.com). Remember to sign and date the form. Third, attach the provider's "super bill" (or any other itemized billing or receipt, describing all of the services and materials that were provided to you) to the out-of-network claim form and Mail to: Envolve Vision, Inc., OON, P.O. Box 7548, Rocky Mount, NC 27804. You will be reimbursed according to the schedule of allowances for out-of-network services (typically 70¢ on the in network allowance dollar).

**What do I do if there are no in-network providers close to me, or if an appointment is not available within two weeks?**
If there is no in-network provider within the established standard for driving distance for your location (1 provider within 15 miles in an urban setting, or 1 provider within 45 miles from members home in a suburban/rural setting), or if you are unable to get an appointment within 2 weeks and you use an out-of-network provider, benefits will be paid as if you used an in-network provider. To receive in-network reimbursement, you must check the box on the out-of-network claim form indicating one of these reasons for filing an out-of-network claim.
If you simply choose to use an out-of-network provider even though an in-network provider is available, your claim will be paid at the out-of-network rates listed on the front of this brochure.
If you wish to nominate a provider to the panel, call (800) 368-4790 and give the representative the name, address, and telephone number of the provider you would like to see in the network. You can also fax this information to (800) 980-4002. Your nominated provider will be placed into consideration for panel membership.

***Can I use the Out-of-Network form to submit services that I receive from an in-network provider?***
No. In-network providers will submit the claim for you. This form is only to be utilized for services received from an out-of-network provider.

***How is my out-of-network benefit reimbursed?***
Exams are reimbursed at up to $38.50 and frames, ophthalmic lenses, contact lenses and contact lens fitting fees are reimbursed according to the schedule on the first page of this member brochure.

***Where do I get an Out-of-Network Claim form?***
An Out-of-Network claim form is included in your "member kit" or may be obtained from the Envolve Vision Plans website: www.myvisionplan.com.

## HOW TO GET DISCOUNTS ON EYEWEAR

***Do all providers offer discounts?***
No. Some providers choose to opt-out of our discount program. Please make sure your provider offers discounts prior to receiving services by calling (800) 368-4790 or visiting https://visionbenefits.envolvehealth.com/locate/grps/search.

### LIMITATION

Vision Examination and Vision Materials. Fees charged by providers for services other than Vision Examination or covered Vision Materials must be paid in full by the Insured Person to the Provider. Such fees or materials are not covered under the policy.

### EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from: I) orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) medical and/or surgical treatment of the eye, eyes or supporting structures; 3) any eye or Vision Examination, or any corrective eyewear, required by an Employer as a condition of employment and safety eyewear, unless specifically covered under the Policy; 4) services or supplies for the treatment of an occupational injury or sickness which are paid under North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement with the North Carolina Workers' Compensation Act; 5) Plano (non-prescription) lenses; 6) non-prescription sunglasses; 7) two pair of glasses in lieu of bifocals; 8) services or materials provided by any other group benefit plans providing vision care; or 9) certain name brands in which the manufacturer imposes a no discount policy. Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit Period when Vision Materials would next become available.

### TERMINATION OF INSURANCE

Coverage will end on the earliest of: the date the policy ends; the date the employee's employment ends; or the date the employee is no longer eligible; the end of the last period for which any required contribution has been made.

Some Benefits, exclusions, provisions or limitations listed herein may vary depending on your state of residence.

envolve
Benefit Options

# Benefit Options

## Take advantage of our *secure* on-line Member Services!

## Getting started is easy! Simply follow the steps below:

1. Log on to www.visionbenefits.envolvehealth.com.
2. Select **Members**, then **Member Login**.
3. Click on the link below **First Time User?**.
4. Enter the following information:
    a. Social Security Number (SSN) – *You will need to enter this twice as confirmation.*
    b. Birth date
    c. PIN/Password – *This is created by you & will need to be entered twice as confirmation.*
    d. Group ID# - *This may be found on the letter that includes your member ID Cards and/or by contacting Customer Relations at (800) 368-4790.*
5. Select **Register**.
6. A handy form is provided at the bottom of this page for you to keep in a secure location.

## Available on-line services include:

- **Enroll** - To be completed during open enrollment as instructed by your HR Department.
- **Update Members** – Add/change information during open enrollment as instructed by your HR Department.
- **View Claims** – View and inquire about the status of a claim for services received.
- **Eligibility** – Check and print your benefit eligibility certificate. This certificate may be used in lieu of an ID Card in the event that it has been misplaced.
- **Order Contacts** – Envolve Vision has partnered with FramesDirect.com to offer a markdowns to Envolve Vision Members only. Your allowance may *not* be used for FramesDirect.com purchases.
- **Request New ID** – Misplaced your ID Card? No need to worry! Complete the form provided and fax it to our Enrollment Department.

## Questions? Please contact Customer Relations at (800) 368-4790.

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**Envolve Benefit Options Vision Plan**

1. Log on to www.visionbenefits.envolvehealth.com
2. Select Members.
3. Select Login.
4. Enter your specific Member Information.

Member ID: _____
Birth Date: _____
Pin Number: _____
Group Number: _____

**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
A STOCK COMPANY (Herein Called "the Company")

# Group Vision Insurance Certificate
## This Is A Limited Benefit Certificate
***Please read the Certificate carefully.***

### TABLE OF CONTENTS



This Certificate will take the place of any and all Certificates and Riders which may have been issued to You at a prior time under the Policy.

### GENERAL INFORMATION

**About Your Insurance.** This Certificate explains the plan of insurance which is underwritten by Fidelity Security Life Insurance Company. Read it closely to become familiar with Your plan. An individual identification card will be issued to You containing the name of the Policyholder and Your effective date.

**Important Notice.** Benefits are payable only for expenses incurred while this insurance is in force. No agent has the right to change the Policy or to waive any part of it. The Policy under which this Certificate is issued may at any time be amended or canceled as stated in its provisions. Such an action may be taken without the consent of or notice to any person who claims rights or benefits under the Policy. The insurance under the Policy does not take the place of nor does it affect any requirements for coverage by Workers' Compensation or a similar type of insurance. The benefits for Dependents which are described in this Certificate will be applicable to Your Dependents only if You make application to have Your Dependents insured.

### DEFINITIONS

The following terms have specific meaning as used in the Policy.

**Insured Person** means an employee meeting the eligibility requirements of the Policy who is covered for benefits. Insured Person will also include Your Dependents, if enrolled.

**Dependent** means any of the following persons: 1) Your lawful spouse; 2) each unmarried child from birth to age 19 who is primarily dependent upon You for support and maintenance; 3) each unmarried child at least 19 years of age to age 26 who is primarily dependent upon You for support and maintenance and who is a full-time student; or 4) each unmarried child at least 19 years of age: who is primarily dependent upon You for support and maintenance because the child is incapable of self-sustaining employment by reason of mental incapacity or physical handicap; who was so incapacitated and is an Insured Person under the Policy on his or her 19th birthday; and who has been continuously so incapacitated since his or her 19th birthday. Child includes stepchild, foster child, legally adopted child, child legally placed in Your home for adoption and child under Your legal guardianship. A full-time student is one who is enrolled at least 12 semester hours for credit in the case of an accredited junior college, college or university; and in the case of a trade school, is enrolled in a course requiring attendance of 20 or more hours weekly for six or more months.

**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.**

**IMPORTANT CANCELLATION INFORMATION - PLEASE READ THE PROVISION ENTITLED, "TERMINATION OF INSURANCE," FOUND ON PAGE 4.**
**THIS CERTIFICATE IS RENEWABLE AT THE OPTION OF THE COMPANY.**

**Employee** means a non-seasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on part-time, temporary or substitute basis. An "employee" includes employees of a single employer, the officers, managers, and employees of the employer and of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, and employees of individuals and firms of which the business is controlled by the insured employer through stock ownership, contract or otherwise.

**Policy** means the Policy issued to the Policyholder.

**Policyholder** means the employer named as the Policyholder on the face of the Policy.

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

**Vision Examination** means a comprehensive ophthalmological service as defined in the Current Procedural Technology (CPT) and the Documentation Guidelines listed under "Eyes-examination items". Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated by examination: biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

**Vision Materials** mean corrective lenses and/or frames or contact lenses.

**The Company** means Fidelity Security Life Insurance Company (the Insurer).

**You, Your, Yours** means the employee covered under the Policy.

## DEFINITIONS
## (PPO and Non-PPO)

**Preferred Agreement** means a contract between the PPO and a Provider concerning the rates and reimbursement methods for services and supplies provided by such Provider.

**Non-Preferred Provider** means a Provider, located within the PPO Service Area, who has not signed a Preferred Agreement with the PPO.

**Preferred Provider** means a Provider who has signed a Preferred Agreement with the PPO.

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

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

## EFFECTIVE DATES

**Effective Date of Employee's Insurance.** Your insurance will be effective as follows: 1) if the Policyholder does not require You to contribute towards the premium for this coverage, Your insurance will be effective on the date You became eligible; 2) if the Policyholder requires You to contribute towards the premium for this coverage, Your insurance will be effective on the date You became eligible provided: a) You have given the Company Your enrollment form (if required) on, prior to or within 30 days of the date You became eligible; and b) You have agreed, in writing, to pay the required contributions; 3) if You fail to meet the requirements a) and b) within 30 days after becoming eligible, Your coverage will not become effective until the Company has verified that You have met these requirements. You will then be advised of Your effective date.

**Effective Date of Dependent's Insurance.** Coverage for Dependents becomes effective on the later of: 1) the date Dependent coverage is first included in Your coverage; or 2) the premium due date on or after the date the person first qualifies as Your Dependent. If an enrollment form is required, You must provide such form and agree to pay any premium contribution that may be required prior to coverage becoming effective.

**Newborn Children.** If a Dependent is covered under Your Certificate, a dependent child born while this Certificate is in force shall be covered from the moment of birth for 31 days. If additional premium is required, You must enroll the newborn child, the child placed for adoption, or the adopted child and furnish the required premium within 31 days after birth, placement, or adoption. If premium is not furnished within that period, coverage as to such child will terminate at the end of this 31-day period.

**Adopted Children/Foster Children.** If a dependent child is placed with You as a foster child or for adoption while Your Certificate is in force, such child will be covered from the date of placement for 31 days. In order to continue coverage beyond this 31-day period, You must send notice and agree to pay any premium contributions that may be required by the Policyholder within this 31-day 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.

## SCHEDULE OF BENEFITS

Insured Persons have the right to obtain vision care from the Provider of their choice. However, payment of the Benefit varies depending on the type of Provider chosen. Benefits are payable as shown in the following Schedule:

| **Benefit** | **Preferred Provider*** ** | **Non-Preferred Provider*** (Up to a Maximum Dollar Amount of):** |
|---|---|---|
| Vision Examination: | $10 copayment | $10 copayment, up to $38.50 |
| Vision Materials Copayment: | $10 | $10 |
| | *(Only one Materials copayment due at time of service.)* | |
| Lenses | | |
| Single | Paid in Full | up to $37.50 |
| Bifocal | Paid in Full | up to $55.00 |
| Trifocal | Paid in Full | up to $90.00 |
| Lenticular | Paid in Full | up to 90.00 |
| Frames | $175 allowance | up to $122.50 |
| Contact Lenses* | | |
| Elective | $150 allowance | up to $105.00 |
| Medically Necessary | Paid in Full | up to $210.00 |

*Contact Lenses Allowance includes fit, follow-up and Materials.

**Benefit Period**:
12 month benefit period for Vision Examination
24 month benefit period for Frame Vision Materials
12 month benefit period for Lenses Vision Materials
12 month benefit period for Contact Lenses Vision Materials

***Differentials will not exceed 30%.**

Non-Preferred Provider expenses do not apply toward Preferred Provider expenses and Preferred Provider expenses do not apply toward Non-Preferred Provider expenses.

Any services which cannot be obtained by a Preferred Provider within the PPO Service Area because: 1) due to their specialized nature, there is no Preferred Provider located within the PPO Service Area; 2) the services are provided by a Provider not in the PPO Service Area; and 3) the services are specifically authorized in advance by the Insured Person's Provider and approved by the Company; shall be paid in accordance with the Schedule of Benefits, without further deductions, subject to all the Policy maximums, limitations, conditions and exclusions.

**Benefit Period for Vision Examination** is shown in the Schedule of Benefits and begins on the Policyholder's Effective Date.

**Benefit Period for Vision Materials** is shown in the Schedule of Benefits and begins on the Policyholder's Effective Date.

**Vision Examination Benefit.** An Insured Person is eligible for one Vision Examination in each successive Benefit Period.

**Vision Materials Benefit.** If a Vision Examination results in an Insured Person needing corrective Vision Materials for their visual health and welfare, those Vision Materials prescribed by Providers will be supplied, subject to certain limitations and exclusions of the Policy, as follows:

- Lenses - up to two lenses provided one time in each successive Benefit Period.
- Frame - one frame provided one time in each successive Benefit Period.
- Contact Lenses – up to two Contact Lenses provided in lieu of lenses and/or frame, one time in each successive Benefit Period.

## LIMITATION

**Vision Examination and Vision Materials.** Fees charged by a Provider for services other than Vision Examination or covered Vision Materials must be paid in full by the Insured Person to the Provider. Such fees or materials are not covered under the Policy.

## EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from: 1) orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) medical and/or surgical treatment of the eye, eyes or supporting structures; 3) any eye or Vision Examination, or any corrective eyewear, required by an Employer as a condition of employment and safety eyewear, unless specifically covered under the Policy; 4) services or supplies for the treatment of an occupational injury or sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement with the North Carolina Workers' Compensation Act; 5) Plano (non-prescription) lenses; 6) non-prescription sunglasses; 7) two pair of glasses in lieu of bifocals; 8) services or materials provided by any other group benefit plans providing vision care; or 9) certain name brands in which the manufacturer imposes a no discount policy.

Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit Period when Vision Materials would next become available.

## TERMINATION OF INSURANCE

**For all Insured Persons.** All Insured Persons' insurance will end automatically on the earliest of the following dates: 1) the date the Policy ends; 2) the end of the last period for which any required contribution agreed to in writing has been made; 3) the date You are no longer eligible for insurance; or 4) the date Your employment with the employer ends. Your coverage will end on the last day of the month in which employment ends. The employer may, at its option, continue insurance for individuals whose employment has ended if the employer: a) does so without individual selection between employees; and b) if the employer continues making premium payments for those individuals.

**For Dependents.** A Dependent's insurance will automatically stop on the earlier of: 1) the date Your coverage ends; 2) the end of the month in which the Dependent ceases to be Your Dependent; or 3) the end of the last period for which any required contribution has been made.

A dependent child will not cease to be a Dependent solely because of age if the child is: 1) not capable of self-sustaining employment due to mental incapacity or physical handicap that began before the age limit was reached; and 2) mainly dependent on You for support.

Proof of the eligible child's incapacity and dependency must be provided to the Company within 31 days of the date the Dependent would otherwise cease to be covered.

The Company may require the same proof again, but the Company will not ask for it more than once a year. This continued coverage will end: a) on the date the Policy ends; b) the date the incapacity or dependency ends; c) the last day of the month for which required premium for the child is paid; or d) 60 days after the date the Company requests proof which is not given to the Company.

## CLAIMS

**Notice Of Claim.** Written notice of claim must be given: 1) within 30 days after a covered loss begins; or 2) as soon as reasonably possible after that. Notice may be given to the Company at the Company's Home Office or to any authorized agent of the Insurer or to the Company's Administrator. Notice should include the Insured Person's name and the Policy and Certificate numbers.

**Claim Forms.** When the Company receives notice of claim, the Company will send the claimant forms for filing proof of loss within 15 days. If claim forms are not supplied within this 15-day period, a claimant may submit proof in writing, setting forth the nature and extent of the loss.

**Proof Of Loss.** Proof of loss must be furnished to the Company within 180 days after the date of loss. The Company will not deny or reduce a claim if it was not reasonably possible to give the Company proof within the time allowed. In any event, the Insured Person must give the Company proof within one year after it is due unless the Insured Person is legally incapacitated.

**Time Of Payment Of Claims.** Immediately after receiving written proof of loss, the Company will pay all benefits then due an Insured Person.

**Payment Of Claims.** All claims will be paid to You, unless the Company has the obligation to pay the facility or Provider directly. However, in the event a Benefit becomes payable to Your estate, the Company may pay such Benefit, up to an amount equal to $1,000, to any relative by blood or connection by marriage who the Company deems to be equitably entitled thereto. Payment made in good faith fully discharges the Company to the extent of any payments made.

**Legal Actions.** No legal actions may be brought to recover under the Policy: 1) within 60 days after written proof of loss has been furnished as required; or 2) after three years (five years in Kansas and six years in South Carolina) from when written proof of loss is required.

**Claim Appeal Procedure.** If the Company partially or fully denies a claim for benefits submitted by an Insured Person and the Insured Person disagrees or does not understand the reasons for this denial, the Insured Person may appeal this decision and they have the right to: 1) request a review of the denial; 2) review pertinent plan documents; and 3) submit in writing any data, documents or comments which are relevant to the Company's review of this denial.

The Insured Person's appeal must be submitted in writing within 180 days of receiving written notice of denial. The Company will review all information and send written notification within 60 days of the Insured Person's request.

## GENERAL PROVISIONS

**Entire Contract.** The Policy is a legal contract. It is between the Policyholder and the Company. The entire contract consists of: 1) the Policy, the Certificate, endorsements and attachments, if any; 2) the Policyholder's application; and 3) the employees' enrollment forms, if any. Any statement made by the Policyholder or by an Insured Person in an application or enrollment form will, in the absence of fraud, be deemed a representation and not a warranty. No such statement will void the coverage or reduce the benefits or be used in defense to a claim unless it is in writing and a copy of the application or enrollment form is furnished to the Insured Person.

**Modification Of The Policy.** The Policy may be modified at any time by agreement between the Policyholder and the Company without consent of any employee. No modification will be valid unless approved by one of the Company's officers: 1) the President; 2) a Vice President; or 3) the Secretary. The approval must be endorsed on or attached to the Policy. No agent has authority to modify the Policy or waive any of the Policy's provisions to extend the time for premium payment by making any promise or representation.

**Incontestability.** The validity of the Policy shall not be contested except for non-payment of premiums or material misrepresentations after it has been in force for two years. Coverage under this Certificate shall not be contested except for non-payment of premiums or material misrepresentation after it has been in force for two years.

**Fraud.** If You or the Policyholder commits fraud pertaining to an employee against the Company, as determined by a court of competent jurisdiction, Your coverage will end automatically without notice.

**Misstatement Of Age.** If an Insured Person's age has been misstated, the benefits will be those which the premium paid would have bought for the correct age. If an Insured Person's correct age was over the maximum issue age, coverage will be voided and the premiums paid for such Insured Person will be refunded.

**Assignment Of Benefits.** You may assign Your benefits. However, an assignment is not binding until the Company has received and acknowledged in writing the original or a copy of the assignment before payment of the benefit. The Company does not guarantee the legal validity or effect of such assignment.

**Grace Period.** A grace period of 31 days will be allowed for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. If the premium is not paid within the grace period, coverage will terminate as of the premium due date. The grace period will not apply if the Insured Person gives written notice to the Company of the Insured Person's intent not to continue this coverage.

FIDELITY SECURITY LIFE INSURANCE COMPANY

President Secretary

# FIDELITY SECURITY LIFE INSURANCE COMPANY

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


## AMENDMENT RIDER

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

Any provision of the Policy/Certificate that provides coverage for a Dependent child up to a certain age is amended to cover such child to age 26, regardless of financial dependency, residency, student status, or marital status.

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

President

Secretary

# NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted *in the box* below, this protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

**The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.**

**Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.**

**Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.**

**The North Carolina Life and Health Insurance Guaranty Association**
**Post Office Box 10218**
**Raleigh, North Carolina 27605-0218**

**North Carolina Department of Insurance, Consumer Services Division**
**1201 Mail Service Center**
**Raleigh, North Carolina 27699-1201**

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. *On the back of this page* is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

## COVERAGE

Generally, individuals will be protected by the life and health guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

## EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy by a group contractholder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered;
- A policy or contract commonly known as Medicare Part C or Part D or any regulations issued pursuant thereto.

## LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

(1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
(2) Except as provided in (3), (4) and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.
(3) The guaranty association will pay a maximum of $500,000 with respect to basic hospital, medical and surgical insurance and major medical insurance.
(4) The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.
(5) The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.

# FIDELITY SECURITY LIFE INSURANCE COMPANY

3130 Broadway
Kansas City, Missouri 64111-2406
Phone 800-648-8624
A STOCK COMPANY
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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 Envolve Vision, Inc. to provide administrative services for your insurance plan. As administrator, Envolve Vision, Inc., may be authorized to market, underwrite, bill and collect premiums, process claims payment, and perform other services, according to the terms of its agreement with the insurance company. Envolve Vision, 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.

If Envolve Vision, 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 Envolve Vision, Inc. than would otherwise be afforded to you by law.

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Kansas City, Missouri 64111-2406
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## HIPAA Notice of Privacy Practices

## THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes how we protect personal health information we have about you which relates to our medical, dental, vision and prescription drug coverage. Protected Health Information ("PHI") is individually identifiable information about you. All of the following are examples of PHI: demographic information like your name, address and social security number; medical information that relates to your past, present or future physical or mental health that is collected, created or received from you, a health care provider, a health plan, employer or a health care clearinghouse; the providing of health care; or the past, present or future payment for providing health care to you.

### Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your PHI. We are also required to give You this notice about our privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect June 1, 2013 or the date coverage became effective for you, whichever is later, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all PHI that we maintain, including PHI we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and send the new notice to our Insureds at the time of change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

### Uses and Disclosures of Your PHI

In conducting our business we will create records regarding you and the insurance services we provide you. The main reasons for which we may use and may disclose your PHI are to evaluate and process any requests for medical coverage and claims for benefits you may make. The following describe these and other uses and disclosures, together with some examples:

**Treatment:** We may use or disclose your PHI to facilitate medical treatment by providers. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to treat you. We may request the services of a business associate to assist us in these activities.

**Payment:** We may use and disclose your PHI to facilitate payment of benefits under your insurance coverage. For example, we might disclose your PHI to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain payments and to issue explanations of benefits. We also may use your PHI to obtain payment from third parties that may be responsible for your premium payments, such as family members.

**Health Care Operations:** We may use and disclose your PHI as necessary, and as permitted by law, to operate our business. Health care operations include: (i) rating our risk and determining our premiums for your insurance; (ii) conducting quality assessment and improvement activities; (iii) conducting or arranging for medical review, legal services, audit services, fraud and abuse detection and compliance programs; and (iv) business planning and development.

**On Your Authorization:** You may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this notice. We would also need to obtain your prior written authorization if your PHI were to be used for marketing or sales purposes.

**To Your Family and Friends:** We may disclose your PHI to a family member, friend, or other person to the extent necessary to help with your health care or for payment of your health care. We may use or disclose your name, location and general condition or death to notify, or assist in the notification, of (including identifying or locating) a person involved in your care.

Before we disclose your PHI to a person involved with your health care or payment for your health care, we will provide you with an opportunity to object to such uses or disclosures. If you are not present, or in the event of your incapacity or an emergency, we will disclose your PHI based on our professional judgment of whether the disclosure would be in your best interest.

**Your Employer or Organization Sponsoring Your Health Plan:** We may disclose your PHI and the PHI of others enrolled in your group insurance plan to the employer or other organization that sponsors your group insurance plan to permit the plan administrator to perform plan administration functions. We may also disclose summary information about the enrollees in your group insurance plan to the plan administrator to use to obtain premium bids for the health insurance coverage offered through your group insurance plan or to decide whether to modify, amend or terminate your group insurance plan. The summary information we may disclose will summarize claims history, claims expenses, or types of claims experienced by the enrollees in your group insurance plan. The summary information will be stripped of demographic information about the enrollees in the group insurance plan, but the plan administrator may still be able to identify you or other participants in your group health plan from the summary information. We may also disclose enrollment and disenrollment information to either the plan administrator or plan sponsor of your group insurance plan.

**Underwriting:** We may receive your PHI for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. We will not use or further disclose your PHI for any other purpose, except as required by law, unless the contract of health insurance or health benefits is placed with us, or where we disclose such information to MIB, Inc., a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. In those cases, our use and disclosure of your PHI will only be as described in this notice. We are also prohibited from using genetic information for underwriting.

**Public Benefit:** We may use or disclose your PHI without your authorization when required or permitted by law for the following purposes deemed in the public interest or benefit:

- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to organ procurement organizations;
- to avert a serious threat to health and safety;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

**Business Associates:** Certain aspects and components of our business are preformed through contracts with outside persons or organizations. Examples of these outside persons and organizations include our duly appointed insurance agents, third party administrators, financial auditors, actuarial and underwriting services, reinsurers, legal services, enrollment and billing services, claim payment and medical management services and collection agencies. At times it may be necessary for us to provide your PHI to one or more of these outside persons or organizations who assist us with our payment or health care operations. In all cases, we disclose only the minimum information necessary for these business associates to perform their responsibilities, and we require them to appropriately safeguard the privacy of your information.

## Individual Rights

**Access**: In most cases, you have the right to inspect and/or obtain an electronic or hard copy of the PHI that we maintain about you. You may also send a written request designating another individual to receive your PHI on your behalf. Written requests must be signed and dated by you or your personal representative using the "Contact Information" provided at the end of this Notice. The request must clearly identify the individual to receive your PHI. We may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. However, certain types of PHI will not be made available for inspection and copying. This includes psychotherapy notes and PHI collected by us in connection with, or in reasonable anticipation of any claim or legal proceeding. In very limited circumstances we may deny your request to inspect and obtain a copy of your PHI. If we do, you may request that the denial be reviewed. The review will be conducted by an individual chosen by us who was not involved in the original decision to deny your request. We will comply with the outcome of that review.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your PHI for purposes other than for treatment, payment, health care operations or as otherwise authorized by you during the six years prior to the date the accounting is requested. For example, we would account for your PHI or demographic information we disclose during an audit by an insurance department or pursuant to a court order. You must make your request in writing using the "Contact Information" provided at the end of this Notice. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Restriction:** You have the right to request a restriction or limitation on PHI we use or disclose about you for treatment, payment or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, we are not required to agree to it. If we do agree to it, we will comply with your request. To request a restriction, you must make your request in writing using the "Contact Information" provided at the end of this Notice. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). We will not agree to restrictions on PHI uses or disclosures that are legally required, or which are necessary to administer our business.

**Unauthorized Access:** You are entitled to receive notification of unauthorized access to your PHI. We maintain physical, electronic and procedural safeguards that are compliant with applicable federal and state privacy laws. However, if your PHI is ever compromised, we will notify you of the incident.

**Confidential Communications:** You have the right to request that we communicate with you about PHI in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing using the "Contact Information" provided at the end of this Notice and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

**Amendment:** If you believe that your PHI is incorrect or that an important part of it is missing, you have the right to ask us to amend your PHI while it is kept by or for us. You must provide your request and your reason for the request in writing using the "Contact Information" provided at the end of this Notice. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend PHI that: (i) is accurate and complete; (ii) was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment; (iii) is not part of the PHI kept by or for us; or (iv) is not part of the PHI which you would be permitted to inspect and copy.

**Right to File a Complaint**: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, submit your complaint using the "Contact Information" provided at the end of this Notice. All complaints must be submitted in writing. You will not be retaliated against for filing a complaint.

**Contact Information:** If you have questions regarding this Notice or need further assistance regarding this Notice, please contact us at:

Contact Office: Fidelity Security Life Insurance Company, HIPAA Customer Service
Telephone: 800-648-8624 Fax: 816-968-0660
Address: 3130 Broadway, Kansas City, MO 64111-2406