Fidelity Security Life Insurance Company® of New York

A STOCK COMPANY
(Herein Called "the Company")

Home Office:
162 Prospect Hill Road, Suite 101B
Brewster, New York 10509-2374
Phone: 845-363-1635

Administrative Office:
2600 Grand Blvd., Suite 900
Kansas City, Missouri 64108-4626
Phone: 888-968-0054

POLICY NUMBER: VCN-19

POLICYHOLDER: FanDuel Group, Inc.

POLICY EFFECTIVE DATE: January 1, 2022

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

Fidelity Security Life Insurance Company of New York 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 of New York at Brewster, New York on the Policy Effective Date.

FIDELITY SECURITY LIFE INSURANCE COMPANY OF NEW YORK

Bradford R. James
President

Martha E. Madden
Secretary

The insurance evidenced by this Certificate provides limited benefits health insurance only. It does NOT provide basic hospital, basic medical, major medical, Medicare supplement, long term care insurance, nursing home insurance only, home care insurance only or nursing home and home care insurance as defined by the New York State Department of Financial Services.

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

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

TABLE OF CONTENTS

DEFINITIONS 3

EFFECTIVE DATES 5

BENEFITS 6

LIMITATIONS 6

EXCLUSIONS 6

SERVICES AND MATERIALS NOT COVERED 6

TERMINATION OF INSURANCE 7

PREMIUMS 8

CLAIMS 8

GENERAL PROVISIONS 9

SCHEDULE OF BENEFITS ..... Attached (1A)

DEFINITIONS

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

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

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

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

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

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

1. the Insured's lawful spouse, which includes a same sex partner to whom the Insured is legally married, 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 to 27 years of age who is primarily dependent upon the Insured or the Insured's spouse for support and maintenance and who is a full-time student; or
4. each unmarried child at least 26 years of age who is chiefly 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 illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap. Proof of such incapacity and dependency must be furnished to the Company 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.

Coverage for an unmarried Dependent child who is a full-time student will continue if such Dependent child, due to illness, is required to take a leave of absence from school due to such illness. Continuation of insurance under the Policy will terminate 12 months after the last day of attendance in school or until the coverage would have otherwise lapsed pursuant to the terms and conditions of the Policy, whichever occurs first. The Company may require the Dependent student's attending Physician to certify to the Company, in writing, that the need for leave of absence is medically necessary.

Dependent includes a step-child, foster child, legally adopted child, child for whom the Insured is a party to a suit for adoption, child who has been placed in the Insured's home for adoption and child under the Insured's legal guardianship, if such child depends primarily on the Insured for support. Dependent will also include a child for whom the Insured is legally required to support due to court order or divorce decree. A full-time student is one who is actively attending at least the minimum number of hours of class a week the school considers as full-time status.

Domestic Partner means an adult who has registered as the Insured's Domestic Partner or civil union partner in a state that allows such registration. Domestic Partner also includes an adult who is in a committed relationship with the Insured and the Insured and the Domestic Partner are mutually responsible for one another financially and otherwise. To qualify as a Domestic Partner or Dependent under the Policy, all of the following conditions must be met:

1. the Domestic Partner and Insured are over the age of 18 and are mentally competent to enter into contracts;
2. the Domestic Partner and Insured reside in the same household;
3. the Domestic Partner and Insured have a committed relationship with each other for no less than six months, intend to continue the relationship indefinitely and have no such relationship with any other person;
4. the Domestic Partner and Insured are not related by blood in a manner that would bar marriage under the laws of the state of New York;
5. the Domestic Partner and Insured are not married to or in a domestic partner relationship with any third party;
6. the Domestic Partner and Insured are of the same sex or opposite sex; and
7. the Domestic Partner and Insured are not claiming Dependent status for the primary purpose of gaining insurance coverage under the Policy.

Proof of mutual financial dependency can be demonstrated by evidence of two or more of the following: joint bank account; joint credit or charge card; joint obligation on a loan; status as authorized signatory on the partner's bank account, credit card or charge card; joint ownership or holding of investments; joint ownership of residence; joint ownership of real estate other than residence; listing of both partners as tenants on lease; shared rental payments; shared household expenses; shared household budget for purposes of receiving government benefits; joint ownership of major items of personal property; joint ownership of a motor vehicle; joint responsibility for child care; shared child-care expenses; execution of wills naming each other as executor, beneficiary or both; designation as beneficiary under the other's life insurance policy or retirement benefits account; mutual grant of durable power of attorney; mutual grant of authority to make health care decisions; affidavit by creditor or other individual able to testify to partners' financial interdependence; or other items of sufficient proof to establish economic interdependency under the circumstances of the particular case. The term "spouse," wherever used, will include a Domestic Partner.

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

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

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

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

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

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

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

Policy means the Vision Insurance Policy issued to the Policyholder.

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

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

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

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

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

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

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

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

EFFECTIVE DATES

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

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

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

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

If the Insured and the Insured's spouse are both Insureds, one Insured may request to be a Dependent spouse of the other. A Dependent child may not be covered by more than one Insured.

Newborn Children. A Dependent child born while the Insured's coverage is in force will be covered from the moment of birth for 31 days or a greater number of days, if elected by the Policyholder. To continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period.

Adopted Children. If a Dependent child is placed with the Insured for adoption while the Insured's coverage is in force or if the Insured takes physical custody of a newborn child upon such child's release from the hospital and files a petition for adoption within 30 days, this child will be covered from the date of placement for 31 days or a greater number of days, if elected by the Policyholder. A proposed adopted child is eligible for coverage on the same basis as any natural child during any waiting period prior to the finalization of the child's adoption. 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 services provided as a result of any state or Federal workers' compensation, employers' liability or occupational disease law.

SERVICES AND MATERIALS NOT COVERED

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. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
4. any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment;
5. safety eyewear;
6. solutions, cleaning products or frame cases;
7. non-prescription sunglasses;
8. plano (non-prescription) lenses;
9. plano (non-prescription) contact lenses;
10. two pair of glasses in lieu of bifocals;

11. electronic vision devices;
12. services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or
13. 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

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

1. the date the Policy is terminated. If the Company decides to stop offering a particular class of group policies, without regard to claims experience, to which the Certificate belongs, the Company will provide the Policyholder and Insureds at least 30 days' prior written notice;
2. the Policyholder has failed to pay premiums within 30 days of when premiums are due. Coverage will terminate as of the last day for which premiums were paid;
3. the date the Insured ceases to meet the eligibility requirements as defined by the Policyholder;
4. the Insured's death;
5. the end of the month during which the Policyholder or Insured provides written notice to the Company requesting termination of coverage, or on such later date requested for such termination by the notice;
6. if the Insured has performed an act that constitutes fraud or made a misrepresentation of material fact in writing on the Insured's enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by the Company to the Insured;
7. the Policyholder has performed an act or practice that constitutes fraud or made a misrepresentation of material fact under the terms of the coverage;
8. the Policyholder has failed to comply with a material plan provision relating to group participation rules. The Company will provide written notice to the Policyholder at least 30 days prior to when the coverage will cease;
9. the Policyholder ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage. The Company will provide written notice to the Policyholder and Insured at least 30 days prior to when the coverage will cease; or
10. the date there is no longer any enrollee who lives, resides, or works in the PPO Service Area.

Termination of the insurance of any Insured Person will be without prejudice to any covered service incurred before the date of termination.

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;
3. the end of the last period for which any required premium contribution has been made;
4. for Dependent spouses in cases of divorce, the date of the divorce;
5. upon the Insured's death, the last day of the month for which the premium has been paid; or
6. If the Insured has performed an act that constitutes fraud or made a misrepresentation of material fact in writing on the Insured's enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by the Company to the Insured. If termination is a result of the Insured's action, coverage will terminate for the Insured and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.

Extension of Benefits. Upon termination of insurance, whether due to termination of eligibility, or termination of the Policy or Certificate, an extension of benefits will be provided for Vision Materials ordered before the date of termination and received within 31 days of the date of termination.

Consolidated Omnibus Reconciliation Act Of 1985 (COBRA). The Company will continue coverage under the Policy for COBRA beneficiaries as requested by the Policyholder. An Insured or Insured Person who wishes continuation of coverage must request continuation in writing and remit the first premium payment within the 60-day period following the later of: the date of termination or the date the Insured is sent notice by first class mail of the right to continuation by the Policyholder.

Continuation of Coverage for Service in the Uniformed Services (USERRA). The Company will continue coverage under the Policy for Service in the Uniformed Services (USERRA) as requested by the Policyholder. The temporary continuation benefits terminate upon the earlier of 24 months from when the absence begins or the day after the date on which the Insured or Insured Person fails to apply for or return to a position of employment.

Provided the Insured or Insured Person serves more than 31 days the group can charge up to 102% of the group premium for the continued coverage.

No exclusion or waiting period may be imposed for any condition unless the condition arose during the period of active duty and the condition has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty or a waiting period had been imposed and was not completed at the time of suspension.

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 31 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. Failure to give notice within such time will not invalidate or reduce any claim if it was not reasonably possible to give such notice and notice is given as soon as it is reasonably possible. Notice given by or for the Insured Person to the Company at the Company's home office, to the Company's authorized administrator or to any of the Company's authorized agents with sufficient information to identify the Insured Person will be deemed as notice to the Company.

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

Proof of Loss. Written proof of loss must be furnished to the Company at the Company's home office within 120 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.

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

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

Assignment. Benefits under the Policy may be assigned.

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

Legal Actions. No Insured Person can bring an action at law or in equity to recover on the Policy until more than 60 days after the date written proof of loss has been furnished according to the Policy. No such action may be brought after the expiration of two 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 with a minimum of 30 days prior written notice 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 or material misrepresentations. 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 to void the insurance or reduce benefits 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.

Translation Services. Translation services are available free of charge for non-English speaking Insured Persons. Please contact the Company at 1-888-249-5194 to access these services.

SCHEDULE OF BENEFITS

FanDuel Group, Inc. – Base Plan

BENEFIT FREQUENCY		
Vision Examination		
Comprehensive Eye Examination	once every 12 months	Insured Person
Vision Materials		
Frame	once every 24 months	Insured Person
Lenses and Lens Options	once every 12 months	Insured Person
Contact Lenses	once every 12 months	Insured Person

BENEFIT	*In-Network*		*Out-of-Network Provider (Reimbursement up to)*
	Plus In-Network Provider	*In-Network Provider*	
Vision Examination			
Comprehensive Eye Examination	$0 Copayment	$10 Copayment	$45
Vision Materials			
Frame	$0 Copayment up to $200 Allowance	$0 Copayment up to $150 Allowance	$105
Contact Lenses Only one of the following Contact Lenses benefits may be used for the Contact Lenses benefit. Contact Lenses are in lieu of Lenses and Lens Options.			
Conventional	$0 Copayment up to $120 Allowance	$0 Copayment up to $120 Allowance	$105
Disposable	$0 Copayment up to $120 Allowance	$0 Copayment up to $120 Allowance	$105
Medically Necessary	Paid in Full	Paid in Full	$300
Standard Plastic Lenses			
Single Vision	$25 Copayment	$25 Copayment	$45
Bifocal	$25 Copayment	$25 Copayment	$65
Trifocal	$25 Copayment	$25 Copayment	$125
Lenticular	$25 Copayment	$25 Copayment	$125
Progressive – Standard	$80 Copayment	$80 Copayment	$50
Progressive – Premium Tier 1	$110 Copayment	$110 Copayment	$50
Progressive – Premium Tier 2	$120 Copayment	$120 Copayment	$50
Progressive – Premium Tier 3	$135 Copayment	$135 Copayment	$50
Progressive – Premium Tier 4	$200 Copayment	$200 Copayment	$50
Lens Options			
Anti-Reflective Coating – Standard	$45 Copayment	$45 Copayment	$23
Anti-Reflective Coating – Premium Tier 1	$57 Copayment	$57 Copayment	$23

BENEFIT	***In-Network***		***Out-of-Network Provider*** *(Reimbursement up to)*
	Plus In-Network Provider	***In-Network Provider***	
Anti-Reflective Coating – Premium Tier 2	$68 Copayment	$68 Copayment	$23
Anti-Reflective Coating – Premium Tier 3	$85 Copayment	$85 Copayment	$23
Polycarbonate Lenses – Standard Dependent Children under 19 years of age	$0 Copayment	$0 Copayment	$20

SCHEDULE OF BENEFITS

FanDuel Group, Inc. – Buy-Up Plan

BENEFIT FREQUENCY		
Vision Examination		
Comprehensive Eye Examination	once every 12 months	Insured Person
Vision Materials		
Frame	once every 12 months	Insured Person
Lenses and Lens Options	once every 12 months	Insured Person
Contact Lenses	once every 12 months	Insured Person

BENEFIT	*In-Network*		*Out-of-Network Provider (Reimbursement up to)*
	Plus In-Network Provider	*In-Network Provider*	
Vision Examination			
Comprehensive Eye Examination	$0 Copayment	$0 Copayment	$50
Vision Materials			
Frame	$0 Copayment up to $275 Allowance	$0 Copayment up to $225 Allowance	$160
Contact Lenses Only one of the following Contact Lenses benefits may be used for the Contact Lenses benefit. Contact Lenses are in lieu of Lenses and Lens Options.			
Conventional	$0 Copayment up to $120 Allowance	$0 Copayment up to $120 Allowance	$105
Disposable	$0 Copayment up to $120 Allowance	$0 Copayment up to $120 Allowance	$105
Medically Necessary	Paid in Full	Paid in Full	$300
Standard Plastic Lenses			
Single Vision	$20 Copayment	$20 Copayment	$50
Bifocal	$20 Copayment	$20 Copayment	$75
Trifocal	$20 Copayment	$20 Copayment	$150
Lenticular	$20 Copayment	$20 Copayment	$150
Progressive – Standard	$20 Copayment	$20 Copayment	$50
Progressive – Premium Tier 1	$50 Copayment	$50 Copayment	$50
Progressive – Premium Tier 2	$60 Copayment	$60 Copayment	$50
Progressive – Premium Tier 3	$75 Copayment	$75 Copayment	$50
Progressive – Premium Tier 4	$140 Copayment	$140 Copayment	$50
Lens Options			
Anti-Reflective Coating – Standard	$0 Copayment	$0 Copayment	$23
Anti-Reflective Coating – Premium Tier 1	$12 Copayment	$12 Copayment	$23

BENEFIT	***In-Network***		***Out-of-Network Provider*** *(Reimbursement up to)*
	Plus In-Network Provider	***In-Network Provider***	
Anti-Reflective Coating – Premium Tier 2	$24 Copayment	$24 Copayment	$23
Anti-Reflective Coating – Premium Tier 3	$40 Copayment	$40 Copayment	$23
Polycarbonate Lenses – Standard Dependent Children under 19 years of age	$0 Copayment	$0 Copayment	$20

Fidelity Security Life Insurance Company® of New York

A STOCK COMPANY
(Herein Called "the Company")

Home Office:
162 Prospect Hill Road, Suite 101B
Brewster, New York 10509-2374
Phone: 845-363-1635

Administrative Office:
2600 Grand Blvd., Suite 900
Kansas City, Missouri 64108-4626
Phone: 888-968-0054

REPLACEMENT COVERAGE AMENDMENT RIDER

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

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 such person is not actively at work or is confined in a Hospital.

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; and
2. 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 definitions, limitations, exclusions and conditions of the Policy/Certificate except as stated.

FIDELITY SECURITY LIFE INSURANCE COMPANY OF NEW YORK

Bradford R. James — President

Martha E. Madden — Secretary

Fidelity Security Life Insurance Company®
of New York

A STOCK COMPANY
(Herein Called "the Company")

Home Office:
162 Prospect Hill Road, Suite 101B
Brewster, New York 10509-2374
Phone: 845-363-1635

Administrative Office:
2600 Grand Blvd., Suite 900
Kansas City, Missouri 64108-4626
Phone: 888-968-0054

LIMITED BENEFITS HEALTH INSURANCE
REQUIRED DISCLOSURE STATEMENT

Group Vision Insurance
Policy Form Number: MN-28

The Policy provides limited benefits health insurance ONLY. The Policy does NOT provide basic hospital, basic medical or major medical insurance, as defined by the New York State Department of Financial Services.

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 services provided as a result of any state or Federal workers' compensation, employers' liability or occupational disease law.

SERVICES AND MATERIALS NOT COVERED

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. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
4. any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment;
5. safety eyewear;
6. solutions, cleaning products or frame cases;
7. non-prescription sunglasses;
8. plano (non-prescription) lenses;
9. plano (non-prescription) contact lenses;
10. two pair of glasses in lieu of bifocals;
11. electronic vision devices;
12. services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or
13. lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.

This disclosure statement is a very brief summary of the Insured Person's coverage under the group Policy.

The Certificate of Insurance sets forth the rights and obligations of both the Insured Person and the Company. It is therefore important that you READ YOUR CERTIFICATE carefully.

The expected benefit ratio for this coverage is 65%. This ratio is the portion of future premiums that the Company expects to return as benefits, when averaged over all people with this coverage.

Fidelity Security Life Insurance Company® of New York

A STOCK COMPANY
(Herein Called "the Company")

Home Office:
162 Prospect Hill Road, Suite 101B
Brewster, New York 10509-2374
Phone: 845-363-1635

Administrative Office:
2600 Grand Blvd., Suite 900
Kansas City, Missouri 64108-4626
Phone: 888-968-0054

LIMITED BENEFITS HEALTH INSURANCE
REQUIRED DISCLOSURE STATEMENT

Group Vision Insurance
Policy Form Number: MN-28

The Policy provides limited benefits health insurance ONLY. The Policy does NOT provide Medicare supplement insurance, long term care insurance, nursing home insurance only, home care insurance only, or nursing home and home care insurance as defined by the New York State Department of Financial Services.

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 services provided as a result of any state or Federal workers' compensation, employers' liability or occupational disease law.

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.

Insureds Age 65 and Older
Exam/Materials
VCN-19

SERVICES AND MATERIALS NOT COVERED

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. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
4. any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment;
5. safety eyewear;
6. solutions, cleaning products or frame cases;
7. non-prescription sunglasses;
8. plano (non-prescription) lenses;
9. plano (non-prescription) contact lenses;
10. two pair of glasses in lieu of bifocals;
11. electronic vision devices;
12. services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or
13. lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.

This disclosure statement is a very brief summary of the Insured Person's coverage under the group Policy.

The Certificate of Insurance sets forth the rights and obligations of both the Insured Person and the Company. It is therefore important that you READ YOUR CERTIFICATE carefully.

The expected benefit ratio for this coverage is 65%. This ratio is the portion of future premiums that the Company expects to return as benefits, when averaged over all people with this coverage.

Fidelity Security Life Insurance Company® of New York

A STOCK COMPANY
(Herein Called "the Company")

Home Office:
162 Prospect Hill Road, Suite 101B
Brewster, New York 10509-2374
Phone 845-363-1635

Administrative Office:
2600 Grand Blvd., Suite 900
Kansas City, Missouri 64108-4626
Phone 888-968-0054

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 the Company, (herein referred to as "we", "our" or "us"), protects 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; health 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 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 January 1, 2026, 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. The new terms of our notice will be 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 you 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 "Contact Information" provided at the end of this Notice.

Uses and Disclosures of Your PHI
In conducting our business we may create, receive and maintain PHI 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:

For 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.

For 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 with other insurance carriers, to examine medical necessity, to obtain payments including obtaining payment under a contract for re-insurance, and related health care data processing, 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.

For Health Care Operations: We may use and disclose your PHI as necessary, and as permitted by law, for our health care operations. 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. You should understand that we will not be able to take back any disclosures we have already made with authorization. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this notice. We also need to obtain your prior written authorization if your PHI relates to psychotherapy notes or where the PHI is 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.

To 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 may 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.

For 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, LLC., 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 or disclosing your genetic information for underwriting.

For the 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.

To Avert a Serious Threat to Health or Safety: We may disclose PHI to avert a serious threat to someone's health or safety. We may also disclose PHI to federal, state or local agencies engaged in disaster relief, as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.

To 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 abide by specific HIPAA rules to appropriately safeguard the privacy of your information.

For Disclosures of PHI Deemed Highly Sensitive or Confidential: For certain kinds of PHI, federal and state law may require enhanced privacy protection. These may include PHI that is (1) About alcohol and drug abuse prevention, treatment and referral; (2) About HIV/AIDS testing, diagnosis or treatment; (3) About genetic testing*; or (4) About psychotherapy notes. If the PHI is subject to enhanced protection, we can only disclose it with your prior written authorization unless specifically permitted or required by law.

* FSLNY does not currently collect, use or disclose genetic or neurotechnology data.

Your Rights Regarding PHI That We Maintain About You
The following are your various rights as a consumer under HIPAA concerning your PHI. Should you have questions about or wish to exercise a specific right, please contact us in writing using the "Contact Information" provided at the end of this Notice.

Right to Inspect and Copy Your PHI: 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.

Right to List of Disclosures: 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, purposes of national security, to law enforcement, to corrections personnel, directly to you 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. Your request should indicate in what form you want the list (for example, paper or electronic). 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.

Right to Request Restrictions. 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.

Right to Request Confidential Communications: You have the right to request that we communicate with you about PHI in a certain way or at a certain location. 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.

Right to Amend Your PHI: 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 Notification Following a Breach of Unsecured Protected Health Information: We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with us using the "Contact Information" provided at the end of this Notice. All complaints must be submitted in writing. You may file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling (877) 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. 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 of New York, HIPAA Customer Service
Telephone: 888-968-0054 Fax: 816-968-0660
Address: 2600 Grand Blvd., Suite 900, Kansas City, MO 64108-4626