Fidelity Security Life Insurance Company of New York

A STOCK COMPANY
(Herein Called "the Company")

Home Office:
162 Prospect Hill Road, Suite 101A
Brewster, New York 10509-2374

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

POLICY NUMBER: VCN-1

POLICYHOLDER: Grocery Delivery e-services USA INC & SUBS, d/b/a HelloFresh

POLICY EFFECTIVE DATE: January 1, 2021

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 on 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 number and the 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

President

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 Insurance Department.

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

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

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DEFINITIONS

Benefit Frequency means the period of time in which a benefit is payable.

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

Co-payment 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 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.

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 from birth to age 26; or
3. each unmarried child at least 26 years of age: who is primarily dependent upon the Insured or the Insured's spouse for support and maintenance because the child is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental incapacity or physical handicap; who was so incapacitated and is an Insured Person under the Policy on his or her 26th birthday; and who has been continuously so incapacitated since his or her 26th birthday.

Child includes stepchild, foster child, legally adopted child, child legally placed in the Insured's home for adoption, child for whom the Insured is a party to a suit for adoption, child for whom the Insured is legally required to support due to court order or divorce decree and child under the Insured's legal guardianship.

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

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 the Insured are over the age of 18 and are mentally competent to enter into contracts;
2. the Domestic Partner and the Insured reside in the same household;
3. the Domestic Partner and the 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 the 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 the Insured are not married to or in a domestic partner relationship with any third party;
6. the Domestic Partner and the Insured are of the same sex or opposite sex; and
7. the Domestic Partner and the 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 ownership of investments, joint bank accounts, joint ownership of residence, joint ownership of a motor vehicle or shared child care expenses.

The term "spouse" wherever used, will include a Domestic Partner.

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

Formulary means a list, provided by the Company, of Vision Materials covered under the Policy.

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

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.

Medical Follow-Up Eye Examination means a vision examination for diabetic vision care.

Medically Necessary Contact Lenses means:

1. Keratoconus where the Insured Person is not correctable to 20/30 in either or both eyes using standard spectacle lenses, or the Provider attests to the specified level of visual improvement;
2. High Ametropia exceeding -10D or +10D in spherical equivalent in either eye;
3. Anisometropia of 3D in spherical equivalent or more; or
4. vision for an Insured Person can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle.

Out-of-Network Provider means a Provider, located within the PPO Service Area, who has not signed a Preferred Provider Agreement with the PPO.

Policy means the 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 an agreement between the PPO and a Provider that contains the rates and reimbursement methods for services and supplies provided by such Provider.

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

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

Retinal Imaging Examination means the recording of a portion(s) or complete retina surface and structures.

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

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

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

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

Vision Materials means those materials 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 became 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 became 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 became 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 greater, if elected, by the Policyholder. In order 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 or birth for 31 days or greater, if elected, by the Policyholder. In order 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.

Comprehensive Eye Examination. An Insured Person is eligible for one Comprehensive Eye Examination in each Benefit Frequency.

In-Network Provider Benefits. The Insured Person must pay any Co-payment 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.

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. The Company will reimburse the Insured Person for the Out-of-Network Provider benefits up to the maximum dollar amount shown in the Schedule of Benefits.

Vision Examination for Insured Persons with Type 1 or Type 2 Diabetes. If the Insured Person has Type 1 or Type 2 Diabetes, the following benefits are payable as shown in the Schedule of Benefits:

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

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

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

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

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

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

- *Lenses* provided one time in each Benefit Frequency.
- *Frames* provided one time in each Benefit Frequency.
- *Contact Lenses* provided one time in each Benefit Frequency in lieu of lenses.

LIMITATIONS

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

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

EXCLUSIONS

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

1. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
2. medical, pathological and/or surgical treatment of the eye, eyes or supporting structures;
3. any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear;
4. services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
5. plano (non-prescription) lenses;
6. non-prescription sunglasses;
7. two pair of glasses in lieu of bifocals;
8. 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
9. lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

Vision Examination for Insured Persons with Type 1 or Type 2 Diabetes Exclusions. In addition to the Exclusions, no benefits will be paid for services connected with or charges arising from services, supplies, prescription medication or treatment for Diabetes, except as specifically included in the Policy.

TERMINATION OF INSURANCE

The Policyholder or the Company may terminate or cancel the Policy as shown in the Policy. The Policyholder is responsible for notifying each Insured of the termination of the Policy.

For All Insureds. The Insureds' insurance will cease on the earliest of the following dates:

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

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

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

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

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 ask for it more than once a year after this coverage has been continued for two years. This continued coverage will end:

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

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 give 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 shall be used in defense to a claim hereunder unless it is contained in a written instrument signed by the Policyholder, the Insured, the Insured's beneficiary or personal representative, a copy of which has been furnished to the Policyholder, the Insured, the Insured's beneficiary or personal representative.

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

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

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

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

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

SCHEDULE OF BENEFITS

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

Benefit	In-Network	Out-of-Network	Benefit Frequency
VISION EXAMINATION			
Comprehensive Eye Examination	$15 Co-payment	up to $40	12 months
Vision Examination for Insured Persons with Type 1 Or Type 2 Diabetes			
Medical Follow-Up Eye Examination	$0 Co-payment	up to $77	6 months
Retinal Imaging Examination	$0 Co-payment	up to $50	6 months
Extended Ophthalmoscopy, initial and subsequent	$0 Co-payment	up to $15	6 months
Gonioscopy	$0 Co-payment	up to $15	6 months
Scanning Laser	$0 Co-payment	up to $33	6 months
VISION MATERIALS			
Standard Plastic Lenses			12 months
Single Vision	$25 Co-payment	up to $30	
Bifocal	$25 Co-payment	up to $50	
Trifocal	$25 Co-payment	up to $70	
Lenticular	$25 Co-payment	up to $70	
Frames	$0 Co-payment, up to $130 retail allowance	up to $91	24 months
Contact Lenses ***(only one option available per Benefit Frequency)***			12 months
Conventional	$0 Co-payment, up to $125 allowance	up to $91	
Disposable	$0 Co-payment, up to $125 allowance	up to $91	
Medically Necessary	Paid in full	up to $210	
Lens Options			12 months
Standard Polycarbonate (For covered Dependent children under 19 years of age)	$0 Co-payment	up to $5	
Standard Progressive Lenses	$80 Co-payment	up to $50	
Premium Progressive Lenses			
Tier 1	$110 Co-payment	up to $50	
Tier 2	$120 Co-payment	up to $50	
Tier 3	$135 Co-payment	up to $50	
Tier 4	$200 Co-payment	up to $50	

Benefit	In-Network	Out-of-Network	Benefit Frequency
Standard Anti-Reflective Coating	$45 Co-payment	up to $5	
Premium Anti-Reflective Coating			
Tier 1	$57 Co-payment	up to $5	
Tier 2	$68 Co-payment	up to $5	
Tier 3	$85 Co-payment	up to $5	

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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

Richard B. Jones
President

Martha E. Madden
Secretary

Fidelity Security Life Insurance Company of New York

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LIMITED BENEFITS HEALTH INSURANCE REQUIRED DISCLOSURE STATEMENT

Group Vision Insurance
Policy Form Number: MN-1

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 Insurance Department.

BENEFITS

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

Comprehensive Eye Examination. An Insured Person is eligible for one Comprehensive Eye Examination in each Benefit Frequency.

In-Network Provider Benefits. The Insured Person must pay any Co-payment 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.

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. The Company will reimburse the Insured Person for the Out-of-Network Provider benefits up to the maximum dollar amount shown in the Schedule of Benefits.

Vision Examination for Insured Persons with Type 1 or Type 2 Diabetes. If the Insured Person has Type 1 or Type 2 Diabetes, the following benefits are payable as shown in the Schedule of Benefits:

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

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

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

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

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

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

- *Lenses* provided one time in each Benefit Frequency.
- *Frames* provided one time in each Benefit Frequency.
- *Contact Lenses* provided one time in each Benefit Frequency in lieu of lenses.

LIMITATIONS

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

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

EXCLUSIONS

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

1. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
2. medical, pathological and/or surgical treatment of the eye, eyes or supporting structures;
3. any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear;
4. services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
5. plano (non-prescription) lenses;
6. non-prescription sunglasses;
7. two pair of glasses in lieu of bifocals;
8. 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
9. lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

Vision Examination for Insured Persons with Type 1 or Type 2 Diabetes Exclusions. In addition to the Exclusions, no benefits will be paid for services connected with or charges arising from services, supplies, prescription medication or treatment for Diabetes, except as specifically included in the Policy.

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.

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LIMITED BENEFITS HEALTH INSURANCE
REQUIRED DISCLOSURE STATEMENT

Group Vision Insurance
Policy Form Number: MN-1

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 Insurance Department.

BENEFITS

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

Comprehensive Eye Examination. An Insured Person is eligible for one Comprehensive Eye Examination in each Benefit Frequency.

In-Network Provider Benefits. The Insured Person must pay any Co-payment 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.

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. The Company will reimburse the Insured Person for the Out-of-Network Provider benefits up to the maximum dollar amount shown in the Schedule of Benefits.

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Grocery Delivery e-services USA INC & SUBS, d/b/a HelloFresh
Insureds Age 65 and Older
Exam/Materials

Vision Examination for Insured Persons with Type 1 or Type 2 Diabetes. If the Insured Person has Type 1 or Type 2 Diabetes, the following benefits are payable as shown in the Schedule of Benefits:

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

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

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

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

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

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

- *Lenses* provided one time in each Benefit Frequency.
- *Frames* provided one time in each Benefit Frequency.
- *Contact Lenses* provided one time in each Benefit Frequency in lieu of lenses.

LIMITATIONS

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

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

EXCLUSIONS

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

1. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
2. medical, pathological and/or surgical treatment of the eye, eyes or supporting structures;
3. any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear;
4. services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
5. plano (non-prescription) lenses;
6. non-prescription sunglasses;
7. two pair of glasses in lieu of bifocals;
8. 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
9. lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

Vision Examination for Insured Persons with Type 1 or Type 2 Diabetes Exclusions. In addition to the Exclusions, no benefits will be paid for services connected with or charges arising from services, supplies, prescription medication or treatment for Diabetes, except as specifically included in the Policy.

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.