STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-7000

CERTIFICATE AND SUMMARY PLAN DESCRIPTION
GROUP EYE CARE INSURANCE

The Policyholder **AZUL SYSTEMS, INC.**

Policy Number **160-756980** **Insured Person**

Plan Effective Date **November 1, 2018** **Certificate Effective Date**
Refer to Exceptions on 9070

Plan Change Effective Date **November 1, 2022**

Class Number 1

Standard Insurance Company certifies that you will be insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder.

Possession of this certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this certificate.

The group policy may be amended or cancelled without the consent of the insured person.

The group policy and this certificate are governed by the laws of the state in which the group policy was delivered.

STANDARD INSURANCE COMPANY

Daniel J. McMillan
President and CEO

CALIFORNIA - IMPORTANT INFORMATION

We are here to serve you . . .

Your satisfaction is very important to us. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion. In the event you need to contact someone about this insurance coverage for any reason, including your ability to access dental services in a timely manner, please contact your agent or feel free to contact us at the following:

Quality Assurance
P.O. Box 82629
Lincoln, NE 68501-2629
1-888-418-6811 (Toll-Free)

APPEAL PROCEDURE

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request. If additional information is needed we will only request what is reasonably necessary to handle the claim. A written decision based on the facts as known by us will be provided within fifteen (15) calendar days after receipt of your request.

If your appeal is about urgent care, you may call Toll Free at 888-418-6811, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of dental practice.

If you are not satisfied . . .

Should you feel you are not being treated fairly, we want you to know you may contact the California Department of Insurance with your complaint and seek assistance from the governmental agency that regulates insurance.

To contact the Department, write or call:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
1 800 927 HELP (4357) or (213) 897-8921
TDD Number: 1-800-482-4TDD (4833)
The Hotline hours are from 8:00 a.m. - 6:00 p.m.
Mon - Fri (Except Holidays)
http://www.insurance.ca.gov

CALIFORNIA
CONTINUATION BENEFITS REPLACEMENT ACT (Cal-COBRA)

NOTICE: These provisions are only applicable to certain plans as defined under the Act. Not all employers or groups are subject to this law. For further details to determine if this continuation coverage is available, please contact the person who handles the Policyholder's insurance matters.

The California Continuation Benefits Replacement Act (Cal-COBRA) signed into law effective January 1, 1998 requires that any **employer** meeting the definition under the Act allow a **qualified beneficiary** to continue group health coverage, including dental and vision care coverages after it would otherwise end, as a result of a **qualifying event**. Continuation coverage will be provided under the plan with the same terms and conditions that apply to similarly situated individuals.

A. DEFINITIONS

EMPLOYER means any employer that:

1. meets the definition of "small employer" as set forth in California;

2. employed 2-19 eligible employees on at least 50 percent of its working days during the preceding calendar year or, if the employer was not in business during any part of the preceding calendar year, employed 2 to 19 eligible employees on at least 50 percent of its working days during the preceding calendar quarter; and

3. is not subject to Section 4980B of the United States Internal Revenue Code (Federal COBRA) or Chapter 18 of the Employee Retirement Income Security Act.

QUALIFIED BENEFICIARY means any individual who, on the day before the qualifying event, is an insured under a group benefit plan. An individual will not be considered to be a qualified beneficiary if:

1. The individual is entitled or becomes entitled to Medicare benefits. Entitlement to Medicare Part A only constitutes entitlement to benefits under Medicare.

2. The individual is covered or becomes covered under another group benefit plan which does not impose any exclusion or limitation with respect to any preexisting condition.

3. The individual is covered, becomes covered or is eligible to coverage under Federal COBRA, Chapter 18 of the Employee Retirement Income Security Act, or Chapter 6A of the Public Health Service Act.

4. The qualified beneficiary fails to meet the notification requirements as stated within the Enrollment provision below.

5. The qualified beneficiary fails to submit the correct premium amount for continuation of coverage, or fails to satisfy other terms and conditions of the plan contract.

QUALIFYING EVENT means any of the following events that, but for the election of continuation of coverage under this provision, would result in a loss of coverage for the qualified beneficiary under the group benefit plan:

1. The death of the covered employee.

2. The termination of employment or reduction of hours of the covered employee's employment, except that termination for gross misconduct does not constitute a qualifying event.

3. The divorce or legal separation of the covered employee from the covered employee's spouse.

4. The loss of dependent status by a dependent enrolled in the group benefit plan.

5. With respect to a covered dependent only, the covered employee's entitlement of benefits under Medicare (Title XVIII of the United States Social Security Act).

B. ENROLLMENT

NOTICE REQUIREMENTS. The qualified beneficiary must request the continuation of coverage in writing and deliver such notice, by first-class mail, or other reliable means of delivery, to the health services plan (or to the employer if the employer has contracted with the insurer to perform the administrative services under Cal-COBRA) within the 60-day period following the later of:

1. the date that the enrollee's coverage under the group benefit plan terminated or will terminate by reason of a qualifying event;

2. the date the enrollee was sent notice of the ability to continue coverage.

PREMIUM PAYMENTS. The first premium payment must be delivered by first class mail, certified mail or other reliable means of delivery, including personal delivery, express mail, or private courier company to the health services plan (or the employer if the employer has contracted with the plan to perform the administrative services under Cal-COBRA) in accordance with the following terms and conditions:

1. the first premium must be delivered within 45 days of the date of the qualified beneficiary provided written notice to the health services plan; and

2. the first premium payment must equal an amount sufficient to pay any required premiums and all premiums due.

Failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage.

MONTHLY COST. The premium will be due monthly and will not be more than 110% of the applicable rate charged for a similarly situated individual under the group benefit plan.

C. CONTINUATION PERIOD

Continuation coverage shall terminate for those qualified beneficiaries at the first to occur of the following:

1. For those who are eligible for continuation coverage as a result of a termination of employment or reduction in work hours, the date 36 months following the date the qualified beneficiary's benefits under the contract would otherwise have terminated by reason of a qualifying event.

2. For those who are eligible for continuation coverage as a result of: (a) the death of an employee, (b) a loss of dependent status, (c) divorce or legal separation, or (d) the employee's eligibility for Medicare (for dependent coverage), the date 36 months following the date the qualified beneficiary's benefits under the contract would otherwise have terminated by reason of a qualifying event.

3. For those qualified beneficiaries who are eligible for continuation coverage and are determined to be disabled by the Social Security Administration at any time during the first 60 days of continuation coverage, and the spouse or dependent who has elected coverage, the date 36 months following the date the qualified beneficiary's benefits under the contract would otherwise have terminated by reason of a qualifying event. The qualified beneficiary must notify the insurer, or the employer or administrator that contracts to perform administrative services, of the social security determination within 60 days of the date of the determination letter and prior to the end of the original 36-month continuation coverage period in order to be eligible for coverage based on this criteria.

4. For those who fail to make premium payments, at the end of the period for which premium payments were made.

5. In the case of a qualified beneficiary who is initially eligible for and elects continuation coverage as a result of termination of employment or reduction of hours, as defined within paragraph (2) of "Qualifying Event", but who has another qualifying event as described in paragraphs (1), (3), (4) or (5) of "Qualifying Event", within 36 months of the date of the first qualifying event, and the qualified beneficiary has notified the plan, or the employer or administrator under contract to provide the administrative services, of the second qualifying event within 60 days of the date of the second qualifying event, the date 36 months after the date of the first qualifying event.

6. The employer, or any successor employer ceases to provide any group benefit plan to his or her employees. See Additional Provisions below.

7. The qualified beneficiary moves out of the insurer's service area or the qualified beneficiary commits fraud or deception in the use of the insurer's services.

An individual who becomes a qualified beneficiary shall continue to receive coverage until continuation coverage is terminated at the qualified beneficiary's election or the period of time provided for continuation coverage as defined in Section C. Continuation Period, whichever comes first, even if the employer that sponsored the group benefit plan subsequently becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.

D. ADDITIONAL PROVISIONS

CHANGE IN GROUP BENEFIT PLANS. If the continuation coverage would terminate prior to the end of the period the qualified beneficiary would have remained covered as a result of a termination of an agreement between the group benefit plan and the employer, and a new group benefit plan is available for active employees, then the qualified beneficiary may continue coverage based on the following terms and conditions:

1. the coverage will continue for the balance of the period that the qualified beneficiary would have remained covered under the prior plan;

2. notice must be provided to the new group benefit plan within 30 days after receiving notice of the termination of the prior plan;

3. any requirements for enrollment in, and payment to, the new group benefit plan must be met.

Coverage will terminate if the qualified beneficiary fails to comply with paragraphs (2) or (3) above.

NEWBORN OR ADOPTED CHILDREN. Any child who is born to or is placed for adoption with a former employee who is a qualified beneficiary during the period of continuation coverage, shall be considered a qualified beneficiary and entitled to receive coverage benefits as well for the remainder of

the period that the former employee is covered under the plan. Notice must be provided within 30 days of the child's birth or placement of adoption.

For purposes of this section:

"COBRA" means Section 4980B of Title 26 of the United States Code, Section 1161 et seq. of Title 29 of the United States Code, and Section 300bb of Title 42 of the United States Code, as added by the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272) and as amended.

"Cal-COBRA" means the continuation coverage that must be offered pursuant to Article 1.7 (commencing with Section 10128.50) of Chapter 1 of Part 2 of Division 2 of the Insurance Code.

Thank you for choosing Standard for your eyecare coverage. As a member, you always have complete freedom of choice in choosing your eyecare provider; however; by choosing a PPO network provider, you may reduce your out-of-pocket expenses due to the discounted fees on covered eyecare procedures.

Please read the following information so you will know from whom or what group of providers eyecare may be obtained.

For questions regarding your eyecare benefit coverage, contact our customer relations department at 1-800-877-7195 Monday-Friday, 6:00am - 7:00pm Pacific Time.

When scheduling your appointment, please verify the provider is an active network participant.

No Cost Language Services. You can get an interpreter and get documents read to you in your language. For help, call us at the number listed on your ID card or **877-233-3797**. For more help call the CA Dept. of Insurance at 1-800-927-4357 English

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 877-233-3797. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. Arabic

Անվճար թարգմանչական ծառայություններ: Դուք կարող եք օգտվել թարգմանչի ծառայություններից, և ձեր փաստաթղթերը ձեզ համար կընթերցեն ձեր լեզվով: Եթե օգնության կարիք ունեք, զանգահարեք մեզ՝ ձեր նույնականացման (ID) քարտի վրա նշված հեռախոսահամարով կամ 877-233-3797 հեռախոսահամարով: Եթե լրացուցիչ օգնության կարիք ունենաք, զանգահարեք Կալիֆորնիա նահանգի Ապահովագրության վարչություն՝ (Department of Insurance) 1-800-927-4357 հեռախոսահամարով: Armenian

免費語言服務。您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打877-233-3797與我們聯絡。欲取得其他協助，請致電1-800-927-4357與加州保險部聯絡。Chinese

निशुल्क भाषा सेवाएँ। आप एक अनुवादक की सेवाएँ लेकर दस्तावेजों को अपनी भाषा में पढ़वा सकते हैं। मदद के लिए हमें अपने आईडी कार्ड पर दिए नंबर या **877-233-3797** पर फोन करें। अधिक मदद के लिए CA Dept. of Insurance को 1-800-927-4357 Hindi

Cov Kev Pab Txais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 877-233-3797. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

無料の言語サービス　日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または877-233-3797までお問い合わせください。更なるお問い合わせは、カリフォニア州保険庁、1-800-927-4357までご連絡ください。Japanese

សេវាកម្មភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 877-233-3797 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 적혀 있는 안내 전화로 문의해 주시 길 바랍니다: 887-233-3797. 더 자세한 사항을 문의하실 분들은 캘리포니아 주 보험국으로 연락해주시 길 바랍니다: 1-800-927-4357. Korean

خدمات رایگان ترجمه. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، از با شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 877-233-3797 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تماس حاصل نمایید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਿਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹੇ ਜਾਣ ਲਈ ਕਹਿ ਸਕਦੇ ਹੋ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 877-233-3797 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

Бесплатные языковые услуги. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, пожалуйста, позвоните нам по номеру, указанному на вашей идентификационной карте, или наберите 877-233-3797. Если вам нужна дополнительная помощь, пожалуйста, обратитесь в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

Servicios de idiomas sin costo. Puede obtener un intérprete y que le lean los documentos en español. Para recibir ayuda, llámenos al número que figura en su tarjeta de identificación o al **877-233-3797**. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

Walang Gastos na mga Serbisyo sa Wika. Maaari kayong kumuha ng isang interpreter o tagapagsalin at inyong ipabasa sa Tagalog ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa inyong ID card o sa **877-233-3797**. Para sa higit pang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Tagalog

บริการทางภาษาแบบไม่มีค่าใช้จ่าย คุณสามารถได้รับบริการจากล่ามและช่วยอ่านเอกสารในภาษาของคุณได้ หากต้องการความช่วยเหลือสามารถติดต่อได้ที่หมายเลขบนบัตรประจำตัวของคุณ หรือ **877-233-3797** สำหรับความช่วยเหลือเพิ่มเติมสามารถติดต่อได้ที่กรมการประกันภัยแห่งแคลิฟอร์เนีย (CA Dept. of Insurance) หมายเลข 1-800-927-4357 Thai

Các Dịch vụ Trợ giúp Ngôn ngữ Miễn phí. Quý vị có thể nhờ một thông dịch viên đọc các tài liệu cho quý vị nghe bằng ngôn ngữ của quý vị. Để được giúp đỡ, hãy gọi cho chúng tôi theo số điện thoại được ghi trên thẻ hội viên của quý vị hoặc gọi số **877-233-3797**. Để được trợ giúp thêm, xin gọi cho Sở Bảo hiểm Tiểu bang California theo số 1-800-927-4357. Vietnamese

California

Language Assistance/Non-Discrimination/Services for the Hearing Impaired/How to File a Complaint

Language Assistance
Standard Insurance Company language assistance program is designed to help Limited English Proficient (LEP) members with their language needs. It includes, but is not limited to, accessing an interpreter. A qualified interpreter will be provided at no cost to you by calling 877-233-3797. Information on how to access an interpreter is available in the top 15 languages spoken by Limited-English-Proficient individuals in California as determined by the State Department of Health Care Services.

Services for the Hearing Impaired
If you have a disability and require use of a Telecommunications Device for the Deaf (TDD), please dial 7-1-1 to use this free service. If you require additional service, contact Standard Insurance Company between 7:00 a.m. – 12:00 a.m. (CST) Monday through Thursday, and 7:00 a.m. - 6:30 p.m. (CST) Friday by calling the number on your ID card or 800-487-5553.

Non-Discrimination Policy
Standard Insurance Company complies with applicable Federal and State civil rights laws. Standard Insurance Company does not unlawfully discriminate, exclude people or treat them differently on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation in connection with the group dental and vision care insurance benefits provided to customers.

How to file a complaint
If you believe that Standard Insurance Company has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation, you may file a grievance with Standard Insurance Company at:

Standard Insurance Company
Quality Control Unit
P.O. Box 82657
Lincoln, NE 68501-2657
1- 877-897-4328 (Toll-Free)

You may contact the California Department of Insurance with your complaint and seek assistance from the governmental agency that regulates insurance. To contact the Department, write or call:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
1-800-927-HELP (4357) or (213) 897-8921
TDD Number: 1-800-482-4TDD (4833)
The Hotline hours are from 8:00 a.m. - 6:00 p.m.
Mon - Fri (Except Holidays)
http://www.insurance.ca.gov

You may also file a discrimination complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. You can file electronically through the Office for Civil Rights Complaint Portal (https://ocrportal.hhs.gov/ocr/portal/lobby.jsf) or you can file by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019, (800) 537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

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SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

Benefit Class	Class Description
Class 1	All Eligible Employees

EYE CARE EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

When a Participating Provider is used:	
Exams - Each Benefit Period	$10
Contact Lens Fitting and Evaluation - Each Benefit Period	$60
Frames, Lenses, and Medically Necessary Contacts - Each Benefit Period	$10
When a Non-Participating Provider is used:	
Exams - Each Benefit Period	$10
Frames, Lenses, and Medically Necessary Contacts - Each Benefit Period	$10

Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.

DEFINITIONS

COMPANY refers to Standard Insurance Company. The words "we", "us" and "our" refer to Company. Our Home Office address is 900 SW Fifth Avenue, Portland, Oregon 97204-1282.

POLICYHOLDER refers to the Policyholder stated on the face page of the policy.

INSURED refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for insurance by completing the eligibility period, if any; and

c. for whom the insurance has become effective.

REGISTERED DOMESTIC PARTNER means a partner of the Insured as long as the partnership meets the requirements for such relationship as defined in Section 297 of the California Family Code or the functional equivalent registration of any other state or local jurisdiction.

Pursuant to Sections 381.5 and 10121.7 of the California Insurance Code, coverage shall be provided to Registered Domestic Partners that is equal to, and subject to the same terms and conditions as, the coverage provided to a spouse.

UN-REGISTERED DOMESTIC PARTNER: Refers to two unrelated individuals who share the necessities of life, live together, and have an emotional and financial commitment to one another. This partnership has not been registered with the California Secretary of State as prescribed under Section 297 of the California Family Code or any other state or local jurisdiction.

CHILD. Child refers to the child of the Insured, a child of the Insured's spouse, a child of the Insured's Registered Domestic Partner, or a child of the Insured's Un-Registered Domestic Partner, if they otherwise meet the definition of Dependent.

DEPENDENT refers to:

a. an Insured's spouse or an Insured's Registered Domestic Partner or an Un-Registered Domestic Partner.

b. each unmarried and married child less than 26 years of age, for whom the Insured, the Insured's spouse or the Insured's Registered Domestic Partner or the Insured's Un-Registered Domestic Partner is legally responsible, including natural born children, adopted children from the date of placement for adoption, and children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws. Grandchildren, spouses of Dependents and other Dependent family members under the age of 26 are not eligible for coverage under this plan.

c. each unmarried child age 26 or older who is Totally Disabled and becomes Totally Disabled as defined below while insured as a dependent under b. above. Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

Injury or Sickness for Certain Dependents
Coverage will continue for a covered Dependent student if the student is unable to remain enrolled in school and must take a medically necessary leave of absence. Coverage will continue for a period not to exceed 24 months or

the date on which coverage would otherwise terminate in accordance with the terms and provisions of the group policy, whichever comes first. We may require documentation and certification by the student's treating physician of the medical necessity of a leave of absence.

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and

2. Chiefly dependent upon the Insured for support and maintenance.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider is a Provider who has a contract with Us to provide services to Insureds at a discount. A Participating Provider is also referred to as a "Network Provider". The terms and conditions of the agreement with our network providers are available upon request. Members are required to pay the difference between the plan payment and the Participating Provider's contracted fees for covered services. A Non-Participating Provider is any other provider and may also be referred to as an "Out-of-Network Provider." Members are required to pay the difference between the plan payment and the provider's actual fee for covered services, and may also be subject to higher deductibles and out-of-pocket maximums. Therefore, the out-of-pocket expenses may be lower if services are provided by a Participating Provider.

PLAN EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

PLAN CHANGE EFFECTIVE DATE refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder's records or on the cover of the certificate.

TELEHEALTH SERVICE refers to a health care service delivered by a dentist, or a health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or health professional's license or certification to a patient at a different physical location than the dentist or health professional using telecommunications or information technology.

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

If employment is the basis for membership, a member of the Eligible Class for Insurance is any full time active employee working at least 30 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

If both spouses are Members, and if either of them insures their dependent children, then the spouse, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 3rd birthday. The child may be added at birth or within 31 days of the 3rd birthday.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any full time active employee working at least 30 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Any spouse who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

SECTION 125. This plan is provided as part of the Employer's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this plan.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this plan at that time will have their coverage become effective on November 1.

Members may change their election option only during an Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the date of employment. The Eligibility Period will be reduced by any continuous period during which you were an employee of the Employer immediately preceding the date you became a Member.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the date of employment. The Eligibility Period will be reduced by any continuous period during which you were an employee of the Employer immediately preceding the date you became a Member.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the first of the month falling on or first following:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

But any person who is not in active service or is totally disabled will be insured on the Effective Date if:

a. the person was insured under a policy of group insurance providing like benefits which ended on the day immediately before the Effective Date of the policy providing this coverage; and

b. the person is considered a Member or an eligible Dependent under the policy providing this coverage, and had the prior policy contained the same definition of eligibility, would have been a Member or Dependent under the prior policy.

TERMINATION DATES

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. in the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums, subject to the Grace Period; or
3. the date of the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

CONTINUATION OF COVERAGE. If coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. Contact your plan administrator for details.

In addition to the provision below, please review the provisions of the California Continuation Benefits Replacement Act (Cal-COBRA) included within this document.

<u>Labor Dispute</u>
For Employees Only

If membership is because of employment and the Insured's active service stops because of a labor dispute, the insurance may be continued subject to the following rules:

1. This provision only applies when the Policyholder is required by a collective bargaining agreement to pay all or part of the Insured's premiums.

2. The premium due for each Insured subject to this provision and the Insured's dependents, if applicable, will be that shown in the policy.

3. Payment of the premium by the Insured must be to the Policyholder, union, or other collection entity and forwarded to us on a monthly basis.

The insurance continued during such labor dispute will stop on the earliest of the following dates:

1. the date six months from the date cessation of work due to the labor dispute started.
2. the date that 75% of the Insureds subject to the labor dispute are continuing the coverage.
3. for any individual Insured:

    i. the date he or she takes full-time employment with another employer.
    ii. the last day of the period for which the Insured has made a premium payment.

Neither the Policyholder or us may cancel or alter the terms of the policy during the labor dispute, except that we can adjust premiums the same as we could if there were no labor dispute.

Any continuation of an Insured's benefits under this provision is applicable to the Insured's dependents, provided they were insured under the policy when the labor dispute started.

EYE CARE EXPENSE BENEFITS

If an Insured has Covered Expenses under this section, we pay benefits as described. The Insured can choose any provider at any time. We delegate vision network and claims processing of the vision benefits provided under this plan to Vision Service Plan (VSP).

COVERED EXPENSES
Covered Expenses include the lesser of:

a. the charge for the covered procedure furnished; or
b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Eye Care Services.

Covered Expenses are the eye care expenses incurred by an Insured for services or supplies. We pay up to the Maximum Covered Expense shown in the Schedule of Eye Care Services.

DEDUCTIBLE AMOUNT
The Deductible Amount is on the Schedule of Benefits. It is an amount of Covered Expenses for which no benefits are payable. It applies separately to each Insured. Benefits are paid only for those Covered Expenses that are over the Deductible Amount.

PARTICIPATING PROVIDERS
A Participating Provider is a provider who has agreed to participate in the VSP network and agrees to provide services and supplies to the Insured at a discounted fee. For questions related to providers or benefit payments, please contact VSP's Customer Care Division at (800) 877-7195.

NON-PARTICIPATING PROVIDER
A Non-Participating Provider is any other provider. Non-Participating providers may be referred to as Affiliate or Open Access Providers. Non-Participating Providers are not subject to our Quality Management Programs. Your out-of-pocket expenses may be greater when you visit a Non-Participating Provider. However, more cost savings or convenience may be available through VSP arrangements with Affiliate Providers. Please contact VSP's Customer Care Division for details at (800) 877-7195).

TIMELY ACCESS TO CARE
You have the right to receive care and services in a timely manner.

Appointment Type	**Timeframe**
Routine Eye Exam	Within 30 calendar days
Non-Urgent Medical	Within seven days
Urgent Care	If call is received during office hours, and the doctor determines the need of the member to be urgent, member should be seen within 24 hours
Telephone Screening	Evaluated to determine the severity of the condition and disposition of the patient
Specialty Referral	Within 14 calendar days from the time the primary care provider requests the referral

EYE CARE SUPPLIES
Eye care supplies are all services listed on the Schedule of Eye Care Services. They exclude services related to Eye Care Exams.

REQUEST FOR SERVICES
When requesting services, the Insured must advise the Participating Provider's office that he or she has coverage under this network plan. If the Insured receives services from a Participating Provider without this notification, the benefits may be limited to those for a Non-Participating Provider.

ASSIGNMENT OF BENEFITS
We pay benefits to the Participating Provider for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, we pay benefits to the Insured unless arranged differently through an Affiliate or Open Access provider, or otherwise required by state regulation.

EXTENSION OF BENEFITS
If your policy terminates, we will pay claims for eye care services and supplies that you received or ordered prior to your policy's termination. You will have six months following the date of service to submit your claim.

EXPENSES INCURRED
An expense is incurred at the time a service is rendered or a supply item furnished.

PROOF OF LOSS
Written proof of loss must be given to us within 90 days after the incurred date of the services provided by a Participating Provider and within 180 days after the incurred date of the services provided by a Non-Participating Provider. If it is impossible to give written proof within the required time period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible.

LANGUAGE INTERPRETER SERVICES
You have the right to receive language interpreter services at the time of your appointment. Call 800-877-7195. Request an interpreter when scheduling your appointment.

LIMITATIONS
This plan has the following limitation:

Some brands of spectacle frames may be unavailable at all locations for purchase as Covered Expenses, or may be subject to additional out-of-pocket expenses. Insureds may obtain details regarding frame brand availability from their treating provider or by calling VSP's Customer Care Division at (800) 877-7195.

This product does not offer any Affordable Care Act essential pediatric health benefits.

EXCLUSIONS
This plan does not cover:

Services and/or materials not specifically included in this Schedule as covered Plan Benefits,

Plano lenses (lenses with refractive correction of less than plus or minus .50 diopter) except as specifically allowed in the frames benefit section below,

Services or materials that are cosmetic, including Plano contact lenses to change eye color and artistically painted Contact Lenses,

Two pairs of glasses in lieu of Bifocals,

Replacement of Spectacle Lenses, Frames, and/or contact lenses furnished under this plan that are lost or damaged, except at the normal intervals when services are otherwise available,

Orthoptics or vision training and any associated supplemental testing,

Medical or surgical treatment of the eyes,

Contact lens modification, polishing or cleaning,

The refitting of Contact Lenses after the initial 90-day fitting period,

Contact Lens insurance policies or service contracts,

Additional office visits associated with contact lens pathology,

Local, state and/or federal taxes, except where law requires us to pay,

Membership fees for any retail center in which an Affiliate or Open Access provider office may be located. Covered persons may be required to purchase a membership in such entities as a condition of accessing network benefits under the plan. Members have the option however to obtain services from any vision provider. If a member chooses to visit an Affiliate or Open Access provider office at a retail center, and the retail center of the provider requires the purchase of a membership in order to access their providers, the membership is not provided under this contract and may be an additional cost to the member.

SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for which benefits are payable under this section, You must first pay a Deductible for certain services as indicated on the Schedule of Benefits in the - Eye Care Expense Benefits section.

SERVICE	WHEN COVERED	PLAN MAXIMUM COVERED EXPENSE *Participating Provider*	*Non-Participating Provider**
Vision Examination(s)			
Eye Exam	Once every 12 months	Covered in Full	Up to $ 45.00
Contact Lens Fitting & Evaluation	Once every 12 months	Covered in Full	See Elective Contact Lenses benefit below
Complete Pair of Spectacles			
Lenses (per pair, only one pair of lens type below allowed per covered period)			
Single Vision	Once every 12 months	Covered in Full	Up to $ 30.00
Lined Bifocal	Once every 12 months	Covered in Full	Up to $ 50.00
Lined Trifocal	Once every 12 months	Covered in Full	Up to $ 65.00
Lenticular	Once every 12 months	Covered in Full	Up to $100.00
Frames			
Single Frame	Once every 12 months	Up to $200.00	Up to $ 70.00
Contact Lenses (in lieu of Complete Pair of Spectacles)			
Elective	Once every 12 months	Up to $200.00	Up to $145.00
Medically Necessary**	Once every 12 months	Covered in Full	Up to $210.00

Low Vision (for severe visual problems not correctable with regular lenses, as determined by the treating provider) Insureds can receive professional services for treatment of severe visual problems that are not correctable with regular lenses. The treating provider determines if an Insured's condition meets the criteria for coverage of this benefit. Insureds may contact VSP's Customer Care Division for details at (800-877-7195) for additional information.

*Insureds may receive additional savings and some services may be covered in full by choosing to visit an Affiliate Non-Participating Provider.

**The benefit for Medically Necessary contact lenses is in lieu of the Elective contact lenses benefit listed. The treating provider determines if an Insured meets the coverage criteria for this benefit.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies if an Insured person has eye care coverage under more than one **Plan**. **Plan** is defined below. All benefits provided under this policy are subject to this section.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total **Allowable expense**.

DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or eye care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in automobile "no fault" and traditional "fault" type contracts; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

B. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as eye care benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

C. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense.**

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and co-payments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

(1) If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

(2) If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

(3) If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

(4) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other **Plan**.

B. (1) Except as provided in Paragraph B(2) below, a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.

D. Each **Plan** determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or

If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

The **Plan** covering the **Custodial parent**;

The **Plan** covering the spouse of the **Custodial parent**;

The **Plan** covering the **non-custodial parent**; and then

The **Plan** covering the spouse of the **non-custodial parent**.

(c) For a dependent child covered under more than one **Plan** of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

(6) If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more **Closed panel** plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give the Company any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A Payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by the Company is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 90 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided by a Participating Provider and within 180 days after the incurred date of the services provided by a Non-Participating Provider. If it is impossible to give written proof within the required time period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible. For Eye Care benefits that use either the EyeMed or VSP network, please refer to the limitations section on the Eye Care Expense Benefits page.

TIME OF PAYMENT. We will pay all benefits immediately when we receive due proof. Any balance remaining unpaid at the end of any period for which we are liable will be paid at that time.

PAYMENT OF BENEFITS. Participating Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Participating Provider directly.

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed $5,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than five years after proof of loss is required.

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and

2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.

NOTICE REQUIREMENTS. If an Insured's coverage under this policy is terminated, premiums are increased, benefits are reduced or eliminated or eligibility for such coverage is restricted in any way, then such action will not be effective unless written notice of the action is delivered by mail to the last known address of the appropriate insurance producer and the administrator, if any, at least 45 days prior to the effective date of the action and to the last known address of the Employer Unit and the certificate holder at least 30 days prior to the effective date of the action.

WORKER'S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.

TELEHEALTH SERVICES
All services under this plan are covered when appropriately delivered through telehealth services and are subject to the same deductible and annual or lifetime dollar maximum (if applicable) as for equivalent services that are not provided through telehealth.

ERISA INFORMATION AND NOTICE OF YOUR RIGHTS

A. General Plan Information

Name of Plan:	Eye Care Insurance
Name, Address of Plan Sponsor:	AZUL SYSTEMS, INC. 385 MOFFETT PARK DR STE 115 SUNNYVALE, CA 94089
Plan Sponsor Tax Id Number:	37-1423943
Plan Number:	501
Type of Plan:	Group Insurance Plan
Name, Address, Phone Number of Plan Administrator:	JENNIFER WANG AZUL SYSTEMS, INC. 385 MOFFETT PARK DR STE 115 SUNNYVALE, CA 94089 650-230-6581
Name, Address of Registered Agent for Service of Legal Process:	Plan Sponsor
If Legal Process Involves Claims For Benefits Under The Group Policy, Additional Notification of Legal Process Must Be Sent To:	Standard Insurance Company 1100 SW 6th Ave Portland, OR 97204-1093
Sources of Contributions:	Employer/Member
Funding Method:	Standard Insurance Company--Fully Insured
Plan Fiscal Year End:	October 31
Type of Administration:	
General Administration	Plan Sponsor
Contract & Claim Administration	Standard Insurance Company

B. Notice of Legal Process

Service of legal process may be made upon the plan administrator at the address listed above.

C. Eligibility and Benefits Provided Under the Group Policy

Please refer to the **Conditions for Insurance** within the Group Policy and Certificate of Coverage for a detailed description of the eligibility for participation under the plan as well as the benefits provided. If this plan includes a participating provider (PPO) option, provider lists are furnished without charge, as a separate document.

D. Qualified Medical Child Support Order ("QMCSO")

QMCSO Determinations. A Plan participant or beneficiary can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determinations from the Plan Administrator.

E. Termination Of The Group Policy

The Group Policy which provides benefits for this plan may be terminated by the Policyholder at any time with prior written notice to Standard Insurance Company It will terminate automatically if the Policyholder fails to pay the required premium. Standard Insurance Company may terminate the Group Policy on any Premium Due Date if the number of persons insured is less than the required minimum, or if Standard Insurance Company believes the Policyholder has failed to perform its obligations relating to the Group Policy.

After the first policy year, Standard Insurance Company may also terminate the Group Policy on any Premium Due Date for any reason by providing a 60-day advance written notice to the Policyholder.

The Group Policy may be changed in whole or in part. No change or amendment will be valid unless it is approved in writing by a Standard Insurance Company executive officer.

F. Claims For Benefits

Claims procedures are furnished automatically, without charge, as a separate document.

G. Continuation of Coverage Provisions (COBRA)

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) gives Qualified Beneficiaries the right to elect COBRA continuation after insurance ends because of a Qualifying Event. The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. The law does not, however, apply to plans sponsored by the Federal government and certain church-related organizations.

i. Definitions For This Section

Qualified Beneficiary means an Insured Person who is covered by the plan on the day before a qualifying event. Any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary.

A Qualifying Event occurs when:

1. The Member dies (hereinafter referred to as Qualifying Event 1);

2. The Member's employment terminates for reasons other than gross misconduct as determined by the Employer (hereinafter referred to as Qualifying Event 2);

3. The Member's work hours fall below the minimum number required to be a Member (hereinafter referred to as Qualifying Event 3);

4. The Member becomes divorced or legally separated from a Spouse (hereinafter referred to as Qualifying Event 4);

5. The Member becomes entitled to receive Medicare benefits under Title XVII of the Social Security Act (hereinafter referred to as Qualifying Event 5);

6. The Child of a Member ceases to be a Dependent (hereinafter referred to as Qualifying Event 6);

7. The Employer files a petition for reorganization under Title 11 of the U.S. Bankruptcy Code, provided the Member is retired from the Employer and is insured on the date the petition is filed (hereinafter referred to as Qualifying Event 7).

ii. Electing COBRA Continuation

A. Each Qualified Beneficiary has the right to elect to continue coverage that was in effect on the day before the Qualifying Event. The Qualified Beneficiary must apply in writing within 60 days of the later of:

1. The date on which Insurance would otherwise end; and

2. The date on which the Employer or Plan Administrator gave the Qualified Beneficiary notice of the right to COBRA continuation.

B. A Qualified Beneficiary who does not elect COBRA Continuation coverage during their original election period may be entitled to a second election period if the following requirements are satisfied:

1. The Member's Insurance ended because of a trade related termination of their employment, which resulted in being certified eligible for trade adjustment assistance;

2. The Member is certified eligible for trade adjustment assistance (as determined by the appropriate governmental agency) within 6 months of the date Insurance ended due to the trade related termination of their employment; and

3. The Qualified Beneficiary must apply in writing within 60 days after the first day of the month in which they are certified eligible for trade adjustment assistance.

iii. Notice Requirements

1. When the Member becomes insured, the Plan Administrator must inform the Member and Spouse in writing of the right to COBRA continuation.

2. The Qualified Beneficiary must notify the Plan Administrator in writing of Qualifying Event 4 or 6 above within 60 days of the later of:

a. The date of the Qualifying Event; or

b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.

3. A Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, must notify the Plan Administrator of the disability in writing within 60 days of the later of:

a. The date of the disability determination;

b. The date of the Qualifying Event; or

c. The date on which the Qualified Beneficiary loses coverage due to the Qualifying Event.

4. Each Qualified Beneficiary who has become entitled to COBRA continuation with a maximum duration of 18 or 29 months must notify the Plan Administrator of the occurrence of a second Qualifying Event within 60 days of the later of:

   a. The date of the Qualifying Event; or

   b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.

5. The Employer must give the Plan Administrator written notice within 30 days of the occurrence of Qualifying Event 1, 2, 3, 5, or 7.

6. Within 14 days of receipt of the Employer's notice, the Plan Administrator must notify each Qualified Beneficiary in writing of the right to elect COBRA continuation.

In order to protect your rights, Members and Qualified Beneficiaries should inform the Plan Administrator in writing of any change of address.

iv. COBRA Continuation Period

1. 18-month COBRA Continuation

   Each Qualified Beneficiary may continue Insurance for up to 18 months after the date of Qualifying Event 2 or 3.

2. 29-month COBRA Continuation

   Each Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, may continue coverage for up to 29 months after the date of the Qualifying Event. All Insured Persons in the Qualified Beneficiary's family may also continue coverage for up to 29 months.

3. 36-Month COBRA Continuation

   If you are a Dependent, you may continue Coverage for up to 36 months after the date of Qualifying Event 1, 4, 5, or 6. Each Qualified Beneficiary who is entitled to continue Insurance for 18 or 29 months may be eligible to continue coverage for up to 36 months after the date of their original Qualifying Event if a second Qualifying Event occurs while they are on continuation coverage.

Note: The total period of COBRA continuation available in 1 through 3 will not exceed 36 months.

4. COBRA Continuation For Certain Bankruptcy Proceedings

   If the Qualifying Event is 7, the COBRA continuation period for a retiree or retiree's Spouse is the lifetime of the retiree. Upon the retiree's death, the COBRA continuation period for the surviving Dependents is 36 months from the date of the retiree's death.

v. Premium Requirements

Insurance continued under this provision will be retroactive to the date insurance would have ended because of a Qualifying Event. The Qualified Beneficiary must pay the initial required premium not later than 45 days after electing COBRA continuation, and monthly premium on or before the Premium Due Date thereafter. The monthly premium is a percentage of the total premium (both the portion paid by the employee and any portion paid by the employer) currently in effect on each Premium Due Date. The premium rate may change after you cease to be Actively at Work. The percentage is as follows:

18 month continuation - 102%

29 month continuation - 102% during the first 18 months, 150% during the next 11 months

36 month continuation - 102%

vi. When COBRA Continuation Ends

COBRA continuation ends on the earliest of:

1. The date the Group Policy terminates;

2. 31 days after the date the last period ends for which a required premium payment was made;

3. The last day of the COBRA continuation period.

4. The date the Qualified Beneficiary first becomes entitled to Medicare coverage under Title XVII of the Social Security Act;

5. The first date on which the Qualified Beneficiary is: (a) covered under another group Eye Care policy and (b) not subject to any preexisting condition limitation in that policy.

H. Your Rights under ERISA

As a participant in this Plan, you are entitled to certain rights and protections under the Employment Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to operate and administer this plan prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Rights

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling those publications hotline of the Employee Benefits Security Administration

CLAIMS REVIEW PROCEDURES
AS REQUIRED UNDER
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The following provides information regarding the claims review process and your rights to request a review of any part of a claim that is denied. Please note that certain state laws may also require specified claims payment procedures as well as internal appeal procedures and/or independent external review processes. Therefore, in addition to the review procedures defined below, you may also have additional rights provided to you under state law. If your state has specific grievance procedures, an additional notice specific to your state will also be included within the group policy and your certificate.

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed claim form along with any requested information to:

Vision Service Plan
Attn: Claims Services
P.O. Box 385018
Birmingham, AL 35238-5018

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it.

We will provide you written notice regarding the payment under the claim within 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Eye Care practice.
e. A description of any additional information needed to support your claim and why such information is necessary.
f. Information concerning your right to a review of our decision.
g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

APPEAL PROCEDURE

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Eye Care practice.
f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please review your certificate for such information, call us, or contact your state insurance regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for appeal should be directed to:

Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.

HIPAA Notice of Privacy Practices

To: All Insureds covered under a Eye Care Insurance policy ("Health Plan") with Standard Insurance Company

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

Standard Insurance Company ("The Standard") is committed to protecting the health information that we maintain about you. As required by rules effective April 14, 2003, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), this notice provides you with information about your rights and our legal duties and practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures that The Standard will make of your protected health information.

"Protected health information" includes any identifiable information that we obtain from you or others that relates to your past, present or future health care and treatment or the payment for your health care and treatment. Your health care professional may have different policies or notices regarding his or her use and disclosure of your health information created in the health care professional's office or clinic.

The Standard reserves the right to change the terms of this notice and to make the revised notice effective for all protected health information we maintain. You may request a paper copy of the most current privacy notice from our office or access it on our Web site at **www.standard.com/hipaa.**

Permitted Uses and Disclosures of Your Health Information

We will disclose health information about you when required to do so by federal, state or local law. For example, we may disclose health information when required by a court order, subpoena, warrant, summons or similar process. The following describes the purposes for which The Standard is permitted or required by law to use or disclose your Health Plan coverage information without your authorization:

Treatment. This means the provision, coordination or management of your health care and related services, including any referrals for health care from one health professional to another. For example, we may use or disclose health information about you to facilitate treatment or services by health care providers. We may disclose health information about you to other health care professionals who are involved in taking care of you.

Payment. This means activities to facilitate payment for the treatment and services you receive from health care professionals, including to obtain premium, to determine eligibility, coverage or benefit responsibilities under your insurance coverage, or to coordinate your insurance coverage. For example, the information on claim forms sent to us may include information that identifies you, as well as your diagnosis, and the procedures and supplies used. We may share this information with outside health care consultants performing a business service for The Standard. Likewise, we may share health information with other insurance carriers to coordinate benefit payments. We mail Explanation of Benefits forms and other information to the address we have on record for the primary member. In addition, claim information may be accessible through our website requiring an access code and our toll-free number.

Health Care Operations. This means the support functions related to treatment and payment, such as quality assurance activities, case management, underwriting, premium rating, business management and other general administrative activities. For example, we may use health information in connection with conducting quality assessment and improvement activities, underwriting, premium rating and other activities relating to your coverage, including auditing functions and fraud detection and reporting. We may also disclose health information to business associates if they need to receive health information to provide a service to us and by contract agree to abide by the same high standards of safeguarding your health information. We are prohibited from using or disclosing your genetic health information for underwriting purposes.

Public Health Activities. We may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury (including abuse) or disability, or to a governmental agency or regulator with health care oversight responsibilities.

Military and Veterans. If you are a member of the armed forces, we may disclose health information about you as required by military command authorities.

Workers' Compensation. We may disclose health information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Coroners and Medical Examiners. We may disclose health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Organ and Tissue Donation. We may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Research Purposes. We may disclose health information for research purposes.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

Law Enforcement and National Security and Intelligence Activities. We may disclose health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

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

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care, (2) to protect your health and safety or the health and safety of others or (3) for the safety and security of the correctional institution.

Disclosure to your Plan Sponsor. Information may be disclosed to your plan sponsor for purposes of plan administration if the plan sponsor has certified that plan documents have been amended as required by HIPAA. De-identified summary health information may be disclosed to your plan sponsor for the purposes of obtaining health insurance bids or modifying, amending, or terminating the health plan.

In the following situations generally we must obtain your authorization before disclosing your health information:

Sale of Protected Health Information. We must obtain your authorization prior to selling your health information. If we will obtain financial remuneration for such sale, we must disclose that to you in the authorization.

Psychotherapy Notes. Most uses and disclosures of your psychotherapy notes require your authorization.

Marketing. We must obtain your authorization prior to using or disclosing your health information for marketing purposes in most situations. If we will obtain financial remuneration for such marketing, we must disclose that to you in the authorization.

Other Uses and Disclosures of Your Health Information. Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization, except to the extent that we have already taken action in reliance on your authorization.

Your Rights Regarding Your Health Information

The following describes your rights regarding the health information we maintain about you. To exercise your rights, you must submit your request in writing to Standard Insurance Company, Attn: Quality Assurance Specialist, PO Box 82629, Lincoln, NE 68501-2629.

Right to Inspect and Copy. You have the right to inspect and copy health information that we maintain about you. To inspect or copy your health information, you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Please contact our Privacy Contact at the address or telephone number listed on the last page of this document if you have questions about access to your health information.

Right to Amend. If you feel that the health information we have about you is incorrect or incomplete, you may ask us in writing to amend the information. You have the right to request an amendment for as long as we maintain the information.

In addition, you must provide a reason that supports your request. Any agreed-upon correction to your health information will be included as an addition to, and not a replacement of, already existing records.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) is not part of the health information kept by us, (2) was not created by us, unless the person or entity that created the information is no longer available to make the amendment, (3) is not part of the information which you would be permitted to inspect and copy or (4) is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures of your health information made by us in the six years prior to the date that the accounting is requested (or shorter period as requested). This does not include disclosures (1) to carry out treatment, payment, or health care operations; (2) made to you or pursuant to your authorization; (3) for national security or intelligence purposes; (4) to corrections institutions or law enforcement officials or (5) made prior to April 14, 2003.

Your first request for an accounting in any 12-month period shall be provided without charge. A reasonable fee shall be imposed for each subsequent request for an accounting within the same 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation of the health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to

your request unless your request is to restrict disclosure to a health plan for purposes of payment or health care operations when you or someone on your behalf (but not the health plan) has already made full payment.

To request restrictions, you must make your request in writing to our Privacy Contact indicated below. 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.

Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will accommodate reasonable requests. We will not ask you the reason for your request. Please make this request in writing to our Privacy Contact indicated below.

Right to Breach Notification. We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your health information. We are also required by law to notify affected individuals following a breach of unsecured health information.

Your Right to File a Complaint. If you believe your privacy rights have been violated, please submit your complaint in writing to:

Standard Insurance Company
Attn: Quality Assurance Specialist
PO Box 82629
Lincoln, NE 68501-2629

You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Privacy Contact

If you have any questions or would like further information about this notice or your rights regarding your health information, please contact the Quality Assurance Specialist at 800.547.9515 or the above address.

This notice is revised effective September 23, 2016.