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UNITED HEALTHCARE INSURANCE COMPANY

VISION INSURANCE

POLICY

FOR

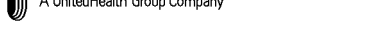
AAA IT SERVICES, LLC

GROUP NUMBER: G/GA3L3939BW VISION PLAN: SH008

EFFECTIVE DATE: March 1, 2020

OFFERED AND UNDERWRITTEN BY

UNITED HEALTHCARE INSURANCE COMPANY



Group Policy

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, CT 06103-3408

1-800-357-1371

This Policy is entered into by UnitedHealthcare Insurance Company and the "Group," as described in Exhibit 1.

When used in this document, the words "we," "us," and "our" refer to UnitedHealthcare Insurance Company .

Upon our receipt of the signed Group *Application* and payment of the first Policy Charge, this Policy is executed. The Group's *Application* is made a part of this Policy.

We agree to provide Benefits for Covered Vision Care Services stated in this Policy, including the attached *Certificate(s) of Coverage* and *Schedule(s) of Covered Vision Care Services,* subject to the terms, conditions, exclusions, and limitations of this Policy. This Policy replaces and overrules any previous agreements relating to Benefits for Covered Vision Care Services between the Group and us. The terms and conditions of this Policy will in turn be overruled by those of any future agreements relating to Benefits for Covered Vision Care Services between the Group and us.

We are not an employer or plan administrator for any purpose with respect to the administration or provision of benefits under the Group's benefit plan. We are not responsible for fulfilling any duties or obligations of an employer or plan administrator with respect to the Group's benefit plan.

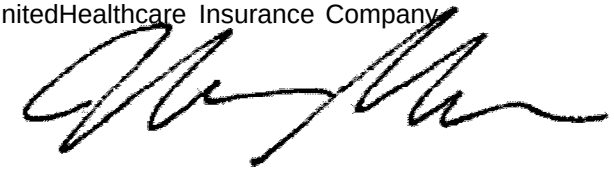
This Policy is effective on the date shown in Exhibit 1 and continues in force by the timely payment of the required Policy Charges when due, subject to the end of this Policy as provided in Article 5.

When this Policy ends, as described in Article 5, this Policy and all Benefits under this Policy will end at 12:00 midnight on the date the Policy ends.

This Policy is issued as described in Exhibit 1.

Issued By:

UnitedHealthcare Insurance Company



William J Golden, President

Article 1: Glossary of Defined Terms

The terms used in this Policy have the same meanings as those defined in *Section 9: Defined Terms* in the attached *Certificate(s) of Coverage.* In addition, the following terms apply:

Coverage Classification - one of the categories of coverage described in Exhibit 2 for rating purposes (for example: Subscriber only, Subscriber and spouse, Subscriber and children, Subscriber and family).

Material Misrepresentation - any oral or written communication or conduct, or combination of communication and conduct, that is untrue and is intended to create a misleading impression in the mind of another person. A misrepresentation is material if a reasonable person would attach importance to it in making a decision or determining a course of action, including but not limited to, the issuance of a policy or coverage under a policy, calculation of rates, or payment of a claim.

Article 2: Benefits

Subscribers and their Enrolled Dependents are entitled to Benefits for Covered Vision Care Services subject to the terms, conditions, limitations and exclusions stated in the *Certificate(s) of Coverage* and *Schedule(s) of Covered Vision Care Services* attached to this Policy. Each *Certificate of Coverage* and *Schedule of Covered Vision Care Services,* including any Riders and Amendments, describes the Covered Vision Care Services, required cost sharing, and the terms, conditions, limitations and exclusions related to coverage.

Article 3: Premium Rates and Policy Charge

3.1 Premiums

Monthly Premiums payable by or on behalf of Covered Persons are shown in the *Schedule of Premium Rates* in Exhibit 2 of this Policy or in any attached *Notice of Change.*

We have the right to change the *Schedule of Premium Rates* as described in Exhibit 1 of this Policy. We also have the right to change the *Schedule of Premium Rates* at any time if the *Schedule of Premium Rates* was based upon a Material Misrepresentation that resulted in the Premium rates being lower than they would have been if the Material Misrepresentation had not been made. We have the right to change the *Schedule of Premium Rates* for this reason retroactive to the effective date of the *Schedule of Premium Rates* that was based on the Material Misrepresentation.

3.2 How Is the Policy Charge Calculated?

The Policy Charge will be calculated based on the number of Subscribers in each Coverage Classification that we show in our records at the time of calculation. The Policy Charge will be calculated using the Premium rates in effect at that time. Exhibit 1 describes the way in which the Policy Charge is calculated.

The Group is solely responsible for enrollment and Coverage Classification changes (including the end of a Covered Person's coverage) and for the timely payment of the Policy Charges.

3.3 When Is the Policy Charge Adjusted?

We may make retroactive adjustments for any additions or terminations of Subscribers or changes in Coverage Classification that are not reflected in our records at the time we calculate the Policy Charge. We will not grant retroactive credit for any change happening more than 60 days prior to the date we received notification of the change from the Group. We also will not grant retroactive credit for any calendar month in which a Subscriber has received Benefits.

The Group must notify us in writing within 60 days of the effective date of enrollments, terminations, or other changes. The Group must notify us in writing each month of any change in the Coverage Classification for any Subscriber.

If premium taxes, guarantee or uninsured fund assessments, or other governmental charges relating to or calculated in regard to Premium are either imposed or increased, those charges will be added to the Premium at that time. In addition, any change in law or regulation that affects our cost of operation may result in an increase

in Premium in an amount we determine.

3.4 How Is the Policy Charge Paid?

The Policy Charge is payable to us by the Group as described under "Payment of the Policy Charge" in Exhibit 1. The first Policy Charge is due and payable on or before the effective date of this Policy. Future Policy Charges are due and payable no later than the first day of each payment period shown in item 6 of Exhibit 1, while this Policy is in force.

All payments shall be made in United States currency, in immediately available funds, and shall be sent to us at the address on the invoice, or at another address that we may designate in writing. The Group agrees not to send us payments marked "paid in full", "without recourse", or similar language. In the event that the Group sends such a payment, we may accept it without losing any of our rights under this Policy and the Group will remain obligated to pay any and all amounts owed to us.

Late payment charges are assessed for any Policy Charge not received within 10 calendar days following the due date. We will not charge a late fee if premiums are received before the end of the grace period. There will be a service charge added to the Group's account for any check returned for non-sufficient funds. The name of all Covered Persons must be attached when payment is made.

The Group will reimburse any attorney's fees and costs related to collecting past due Policy Charges.

3.5 Does a Grace Period Apply?

A grace period of 31 days will be granted for the payment of any Policy Charge not paid when due. During the grace period, this Policy will continue in force. The grace period will not extend beyond the date this Policy ends.

The Group is responsible for payment of the Policy Charge during the grace period. If we receive written notice from the Group to end this Policy during the grace period, we will adjust the Policy Charge so that it applies only to the number of days this Policy was in force during the grace period.

This Policy ends as described in Article 5.1 if the grace period expires and the past due Policy Charge remains unpaid.

Article 4: Eligibility and Enrollment

4.1 What Are the Eligibility Rules?

Eligibility rules for each class are stated in Exhibit 2 and in the Group *Application*. The eligibility rules stated in Exhibit 2 are in addition to those shown in *Section 3: When Coverage Begins* of the *Certificate of Coverage.*

4.2 Initial Enrollment Period

Eligible Persons and their Dependents may enroll for coverage under this Policy during the Initial Enrollment Period. The Initial Enrollment Period is set by the Group.

4.3 Open Enrollment Period

An Open Enrollment Period will be provided. During an Open Enrollment Period, Eligible Persons may enroll for coverage under this Policy.

4.4 Effective Date of Coverage

The effective date of coverage for enrolled Eligible Persons and their Dependents is stated in Exhibit 2.

Article 5: End of Policy

5.1 When Does the Policy End?

This Policy and all Benefits for Covered Vision Care Services will automatically end on the earliest of the dates shown below:

A. On the last day of the grace period if the Policy Charge remains unpaid. The Group remains responsible for payment of the Policy Charge for the period of time this Policy remained in force during the grace period.

B. On the date specified by the Group, after at least 31 days prior written notice to us that this Policy will end.

C. On the date we specify, after at least 31 days prior written notice to the Group, that this Policy will end because the Group performed an act, practice or omission that constituted fraud or made an intentional misrepresentation of a fact that was material to the execution of this Policy or to the provision of coverage under this Policy. In this case, we have the right to rescind this Policy back to either:

- The effective date of this Policy.
- The date of the act, practice or omission, if later.

D. On the date we specify, after at least 90 days prior written notice to the Group, that this Policy will end because we will no longer issue this particular type of group vision benefit plan within the applicable market.

E. On the date we specify, after at least 180 days prior written notice to the applicable state authority and to the Group, that this Policy will end because we will no longer issue any employer vision benefit plan within the applicable market.

5.2 Payment When the Policy Ends

When the Policy ends, the Group is and will remain responsible to us for the payment of any and all Premiums which are unpaid at the time the Policy ends. This will include a pro rata portion of the Policy Charge for any period this Policy was in force during any grace period preceding the end of the Policy.

Article 6: General Provisions

6.1 What Is the Entire Policy?

This Policy, the *Certificate(s) of Coverage,* the *Schedule(s) of Covered Vision Care Services,* the Group *Application*, and any Amendments, *Notices of Change*, and Riders, make up the entire Policy.

6.2 Time Limit on Certain Defenses

No statement made by the Group, except a fraudulent misstatements made in the application for this Policy, can be used to void this Policy after it has been in force for a period of two years.

6.3 Amendments and Alterations

Amendments and Riders to this Policy are effective upon the Group's next anniversary date, except as otherwise permitted by law. Other than changes to Exhibit 2 stated in a *Notice of Change* to Exhibit 2, no change will be made to this Policy unless made by an Amendment or a Rider which is signed by one of our authorized executive officers and consistent with applicable notice requirements. No agent has authority to change this Policy or to waive any of its provisions.

6.4 Our Relationship with Providers and Groups

The relationships between us and Network providers, and relationships between us and Groups, are solely contractual relationships between independent contractors. Network providers and Groups are not our agents or employees, nor are we or any of our employees an agent or employee of Network providers or Groups.

The relationship between a Network provider and any Covered Person is that of provider and patient. The Network provider is solely responsible for the services provided. The relationship between any Group and any Covered Person is that of employer and employee, Dependent, or any other category of Covered Person described in the Coverage Classifications shown in this Policy.

The Group is solely responsible for enrollment and Coverage Classification changes (including the end of a Covered Person's coverage) and for the timely payment of the Policy Charges.

6.5 Records

We may require information related to the Policy, from the Group. Upon request, the Group must provide us with the requested information and proofs which may include:

- All documents provided to the Group by an individual in connection with coverage.
- The Group's payroll.
- Any other records pertinent to the coverage under this Policy.

By accepting Benefits under this Policy, each Covered Person authorizes and directs any person or institution that has provided services to him or her, to provide us or our designees any and all information and records or copies of records relating to the vision care services provided to the Covered Person. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form.

We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning vision care services which are needed to administer the terms of this Policy.

During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy for research and analytic purposes.

6.6 Administrative Services

The services needed to administer this Policy and the Benefits provided under it will be provided in accordance with our standard administrative procedures or those standard administrative procedures of our designee. If the Group requests that administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, the Group must pay for such services or reports at the then current charges for such services or reports.

6.7 Employee Retirement Income Security Act (ERISA)

When this Policy is purchased by the Group to provide benefits under a vision and welfare plan governed by the federal *Employee Retirement Income Security Act* 29 U.S.C., 1001 et seq., we will not be named as, and will not be, the plan administrator or the named fiduciary of the vision and welfare plan, as those terms are used in ERISA.

6.8 Do We Require Examination of Covered Persons?

In the event of a question or dispute concerning Benefits for Covered Vision Care Services, we may require that a Network Vision Provider, of our choice examine the Covered Person at our expense.

6.9 What Happens When There Is a Clerical Error?

Clerical error will not deprive any individual of Benefits under this Policy or create a right to Benefits. Failure to report enrollments is not a clerical error. We will not provide retroactive coverage for Eligible Persons when the Group fails to report enrollments. Failure to report the end of coverage will not continue the coverage for a Covered Person beyond the date it is scheduled to end. Upon discovery of a clerical error, any needed adjustment in Premiums will be made. However, we will not grant any such adjustment in Premiums or coverage to the Group for more than 60 days of coverage prior to the date we received notification of the clerical error.

6.10 Is Workers' Compensation Affected?

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

6.11 Conformity with Law

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is deemed to be amended to follow the minimum requirements of those statutes and regulations.

6.12 Notice

When we provide written notice regarding Policy administration to the Group's authorized representative. Once delivered, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Group is responsible for giving notice to Covered Persons on a timely basis.

Any notice sent to us under this Policy and any notice sent to the Group must be addressed as described in Exhibit 1.

6.13 Continuation Coverage

We agree to provide Benefits under this Policy for those Covered Persons who are eligible to continue coverage under federal or state law, as described in *Section 4: When Coverage Ends* of the *Certificate of Coverage.*

We will not provide any administrative duties with respect to the Group's compliance with federal or state law. All duties of the plan sponsor or plan administrator remain the sole responsibility of the Group, including but not limited to notification of COBRA and/or state law continuation rights and billing and collection of Premium.

6.14 Subscriber's Individual Certificate

We will issue *Certificate(s) of Coverage, Schedule(s) of Covered Vision Care Services,* and any attachments to the Group for delivery to each Subscriber. The *Certificate(s) of Coverage, Schedule(s) of Covered Vision Care Services,* and any attachments will show the Benefits and other provisions of this Policy.

6.15 System Access

The term "systems" as used in this provision means systems that we make available to the Group to facilitate the transfer of information in connection with this Policy.

System Access

We grant the Group the nonexclusive, nontransferable right to access and use the functionalities contained within the systems, under the terms of this Policy. The Group agrees that all rights, title and interest in the systems and all rights in patents, copyrights, trademarks and trade secrets encompassed in the systems will remain ours. To access the systems, the Group will obtain, and be responsible for maintaining, at no expense to us, the hardware, software and Internet browser requirements we provide to the Group, including any amendments to those requirements. The Group is responsible for obtaining internet access.

The Group will not:

- Access systems or use, copy, reproduce, modify, or excerpt any of the systems documentation provided by us in order to access or use systems, for purposes other than as expressly permitted under this Policy.
- Share, transfer or lease its right to access and use systems, to any other person or entity which is not a party to this Policy.

The Group may designate a third party access to the systems on its behalf, provided the third party agrees to these terms and conditions. The Group remains responsible for the third party's compliance with the entire *System Access* provision.

Security Procedures

The Group will use commercially reasonable physical and software-based measures and comply with our security procedures, as may be amended from time to time, to protect the system, its functionalities, and data accessed through systems from any unauthorized access or damage (including damage caused by computer viruses). The Group will notify us immediately if any breach of the security procedures, such as unauthorized use, is suspected.

End of System Access

We have the right to end the Group's system access:

- On the date the Group does not accept the hardware, software and browser requirements provided by us, including any amendments to the requirements.
- Immediately on the date we reasonably determine that the Group has breached, or allowed a breach of, any applicable provision of this Policy. Upon the date this Policy ends, the Group agrees to cease all use of systems, and we will deactivate the Group's identification numbers and passwords and access to the system.

Exhibit 1

1. **Parties.** The parties to this Policy are UnitedHealthcare Insurance Company and AAA IT SERVICES, LLC , the Group.
2. **Effective Date.** The effective date of this Policy is 12:01 a.m. on March 1, 2020 in the time zone of the Group's location.
3. **Place of Issuance.** We are issuing this Policy in Tennessee . This Policy is governed by ERISA. To the extent that state law applies, Tennessee law governs this Policy.
4. **Premiums.** We have the right to change the *Schedule of Premium Rates* shown in Exhibit 2, after a 31-day prior written notice on the first anniversary of the effective date of this Policy shown in the Group *Application*, on any following monthly due date, or on any date the provisions of this Policy are amended. We also have the right to change the *Schedule of Premium Rates*, retroactive to the effective date, if a Material Misrepresentation has resulted in a lower schedule of rates.
5. **Computation of Policy Charge.** A full month's Premium will be charged for any Covered Person who is covered under this Policy for any portion of a calendar month.
6. **Payment of the Policy Charge.** The Policy Charge is payable to us by the Group on a monthly basis.
7. **Minimum Contribution Requirement.** The Minimum Contribution Requirement does not apply.
8. **Notice.** Any notice sent to us under this Policy must be sent to:

   UnitedHealthcare Insurance Company
   185 Asylum Street
   Hartford, CT 06103-3408

   Any notice sent to the Group under this Policy must be sent to:

   AAA IT SERVICES, LLC
   5719 Raleigh-LaGrange Rd STE 9
   Memphis, TN 381340000

Exhibit 2

1. **Class Description.**

   See Group *Application.*

2. **Eligibility.** The eligibility rules are established by the Group. The following eligibility rules are in addition to the eligibility rules shown in the Group *Application* and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage:*

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      Date of hire to 12 months of hire

   B. Other:

      Not Applicable

3. **Open Enrollment Period.** An Open Enrollment Period of at least 31 days will be provided by the Group when Eligible Persons may enroll for coverage.

4. **Effective Date for Eligible Persons.** The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is March 1, 2020 .

   For an Eligible Person who becomes eligible after the effective date of this Policy, the effective date of coverage is as determined by the Group. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates.**

   Monthly Premiums payable by or on behalf of Covered Persons are shown in the cost summary detailed through the new business premium confirmation process and renewal package.

Notice of Change to Exhibit 2

Effective March 1, 2020 , the following provision(s) included in Exhibit 2 of this Policy are replaced by the provision(s) shown below.

1. **Class Description.**

   All full-time employees.

2. **Eligibility.** The eligibility rules are established by the Group. The following eligibility rules are in addition to the eligibility rules shown in the Group Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage:*

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      Date of hire to 12 months of hire

   B. Other:

      Not Applicable

3. **Open Enrollment Period.** An Open Enrollment Period of at least 31 days, will be provided by the Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons.** For an Eligible Person who becomes eligible after the effective date of the Policy, his or her effective date of coverage is: as determined by the Group, Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates.**

   Monthly Premiums payable by or on behalf of Covered Persons are shown in the *Cost Summary* detailed through the new business premium confirmation process and renewal package.

Notice Concerning Coverage Limitations and Exclusions under the Tennessee Life and Health Insurance Guaranty Association Act

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

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

The association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contractholde r;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals), unless qualified under Section 403(b) of the Internal Revenue Code, except that, even if qualified under Section 403(b), unallocated annuities issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation are not covered.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out. The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000 no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $300,000 limit, the association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $100,000 in present value of annuities, or $300,000 in life insurance death benefits -- again, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages.

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

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

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

Tennessee Life and Health Insurance Guaranty Association

1200 One Nashville Place

150 4th Avenue North

Nashville, Tennessee 37219-2433

Tennessee Department of Commerce and Insurance

500 James Robertson Parkway

Nashville, Tennessee 37243