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GROUP CHOICE VISION CARE INSURANCE
CERTIFICATE OF COVERAGE

POLICYHOLDER: TRICO COMPANIES LLC

POLICY NUMBER: WA 301049

POLICY EFFECTIVE DATE: DECEMBER 1, 2015

This is to certify that LifeMap Assurance Company has issued and delivered the Group Vision Care Insurance Policy to the Policyholder. The Policy insures the Employees of the Policyholder who are eligible for the insurance, become insured, and continue to be insured according to the terms of the Policy. The terms of the Policy that affect your insurance are contained in the following pages. Your coverage may be terminated or modified in whole or in part under the terms and provisions of the Policy.

The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

This Certificate of Coverage describes the benefits that an insured Employee is entitled to receive and becomes a part of the Policy. **PLEASE READ THIS CERTIFICATE CAREFULLY**.

This Certificate voids and replaces any prior Certificate issued under the Group Policy Number shown above.

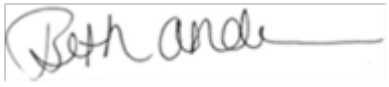
All terms of insurance under the Policy begin and end at 12:01 a.m. Standard time in the place where the Policy is delivered.

This is a vision care policy. This is not a Medicare supplement policy. It is not intended to cover all medical expenses.

Signed for LifeMap Assurance Company at its Home Office in Portland, Oregon.

Chairman, Dudley Slater

President, Beth Andersen



NON-PARTICIPATING

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VISION COVERAGE OUTLINE

Eligible Class: Class 01 - All full-time active Owners working a minimum of 30 hours per week on a regular basis.

Class 02 - All full-time active Managers working a minimum of 30 hours per week on a regular basis.

Class 03 - All full-time active Craft Employees working a minimum of 30 hours per week on a regular basis.

Eligibility Waiting Period: For Employees in an eligible class on or before 12/01/2015: date of hire*

For Employees entering an eligible class after 12/01/2015: date of hire*

*Eligibility Date is 1st of the month following the Employee's date of hire.

Initial Enrollment Period
You will be entitled to apply for coverage for yourself and your Eligible Dependents within the first 31 days of your becoming eligible for coverage according to the eligibility requirements in effect with the Policyholder. Coverage for you and your enrolling Eligible Dependents will commence on the Effective Date.

Employee Contribution: Group Vision Care Insurance is Noncontributory for Classes 01 and 02. Group Vision Care Insurance is Contributory for Class 03. Premiums are paid by you through payroll deduction.

SCHEDULE OF BENEFITS

Vision Exam Copayment	$10.00
Vision Hardware Copayment	$25.00 for lenses, frames or necessary contact lenses
Supplemental Aids Copayment	25% of the Allowed Amount

Amount paid under the Policy
We pay 100% of the Allowed Amount for Covered Services you receive less any applicable Copayment, not to exceed the billed amount. Please see the Schedule of Covered Services and Allowed Amounts for detailed information.

Providers

For the purposes of this Policy, Participating Providers include those optometrists or ophthalmologists who have contracted with Vision Service Plan Insurance Company (VSP).

Participating Providers have agreed that they will accept fees in the amount established by us as full payment for covered eye exams and lenses except for the Vision Exam, Vision Hardware and Supplemental Aid Copayments, which are the Member's responsibility.

Nonparticipating Providers have not agreed to accept fees in the amount established by us as full compensation for Covered Services, nor have they agreed to bill VSP directly on your behalf. A Nonparticipating Provider may agree to bill VSP directly on your behalf however; this agreement is between you and your Provider.

When you seek treatment from a Nonparticipating Provider or when you receive treatment from a Participating Provider without first obtaining a Benefit Authorization, you are responsible for full payment for services and/or hardware at the time of service. In order for benefits to be paid, you must then submit the claim to VSP for reimbursement.

When a Nonparticipating Provider is seen, this reimbursement will be at the Allowed Amount for Nonparticipating Providers. You or your Enrolled Dependent will be responsible for paying any difference between the Allowed Amount for Nonparticipating Providers and the billed amount in addition to any applicable Copayment.

DEFINITIONS

Wherever used in this Policy, the following definitions will apply to the terms listed below. The masculine will include the feminine and the singular will include the plural.

"You" and **"your"** mean the Insured Employee. **"We," "us"** and **"our"** mean LifeMap Assurance Company.

Actively at Work or Active Work means performing the material and substantial duties of your own occupation at the Employer's usual place of business.

Active Employment means the Employee is:

1. working for the Employer on a regular and active basis for at least the minimum number of hours stated in the Coverage Outline;
2. receiving regular earnings from the Employer; and
3. employed:
   a. at the Employer's usual place of business; or
   b. at a location to which the Employer's business requires the Employee to travel.

Allowed Amount means the lesser of:

1. the actual billed amount;
2. the full amount we will pay for Covered Services as shown in the Schedule of Covered Services and Allowed Amounts; or
3. the amount Participating Providers have agreed to accept as full payment for Covered Services.

Charges in excess of the Allowed Amount are not reimbursable by us.

Application means the document showing the eligible classes, amounts of insurance and other relevant information pertaining to the plan of insurance applied for by the Policyholder. This document is attached to and forms a part of the Policy.

Benefit Authorization means an Authorization issued by VSP to a Participating Provider identifying the individual named as a Member eligible for benefits under this Policy, and identifying those benefits to which the Member is entitled.

Certificate is the description of the benefits for this coverage. The Certificate is part of the Policy between the Employer group and us.

Contributory Insurance means you must pay all or a part the premium for this coverage.

Copayment means those amounts required to be paid by or on behalf of a Member for benefits which are not fully covered, and which are payable at the time services are rendered or materials provided.

Covered Service means a service or supply listed in the Schedule of Covered Services and Allowed Amounts. Covered Services must be performed by a Provider practicing within the scope of his or her license.

Dependent Child means your or your Spouse's child who is under age 26, unmarried, not in a domestic partnership and who meets any of the following criteria:

1. your or your Spouse's natural child, stepchild, adopted child, or child legally placed with you or your Spouse for adoption;
2. a child for whom you or your Spouse have court-appointed legal guardianship;
3. a child for whom you or your Spouse or are required to provide coverage by a legal qualified medical child support order (QMCSO).

Your or your Spouse's child who is age 26 or over and incapable of self-support because of developmental disability or physical handicap that began before his or her 26th birthday will continue to be covered if you submit written evidence of the child's incapacity within 31 days of the later of the child's 26th birthday or your or your Spouse's Effective Date.

Domestic Partner (non state registered) means an adult of the same or opposite sex who has an emotional, physical and financial relationship with you, similar to that of a Spouse, as evidenced by the following facts:

1. you and your domestic partner share a residence and financial responsibility for a joint household and intend to continue an exclusive relationship indefinitely;
2. you and your domestic partner each are at least eighteen (18) years of age;
3. you and your domestic partner are both mentally competent to enter into a binding contract;
4. neither you nor your domestic partner are married to or legally separated from anyone else;
5. you and your domestic partner are not related to one another by blood closer than would bar marriage; and
6. neither you nor your domestic partner is a domestic partner of anyone else.

Effective Date means the date specified by us, following our acceptance of the application for coverage, as the date coverage begins for you and/or your Enrolled Dependents.

Eligibility Waiting Period means the continuous length of time you must be in Active Employment before becoming eligible for coverage under the Policy.

Emergency Condition means a condition, with sudden onset and acute symptoms, which requires the Member to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical action.

Employee means a person who:

1. is in Active Employment with the Employer;
2. is eligible for insurance according to the Coverage Outline;
3. has federal taxes deducted from his or her earnings and has had FICA deducted, matched and remitted by the Employer;
4. is not a temporary, seasonal or contract Employee; and
5. is a citizen of the United States or legally works in the United States.

Employer means the Policyholder and includes any division, subsidiary or affiliated company named in the Application for the Policy or any Policy amendments.

Enrolled Dependent means:

1. an Enrolled Employee's eligible dependent who is listed on the Enrolled Employee's application for coverage;
2. whose application is accepted by us; and
3. who is enrolled under this Policy.

Enrolled Employee means an employee of the Policyholder who is eligible under the terms of the Policy, whose application we have accepted, and who is enrolled under this coverage.

Experimental Nature means a procedure or lens that is not in general use nor accepted by the vision care profession.

Family means an Enrolled Employee and his or her Enrolled Dependents.

Immediate Family means parents, Spouse, children, siblings, half-siblings, or in-laws, or any relative by blood or marriage who shares a residence with you.

Member means the Enrolled Employee or an Enrolled Dependent.

Noncontributory Insurance means you are not required to pay any part of the premium for this coverage.

Nonparticipating Provider means an optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Members.

Participating Provider means an optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials to the Member. Participating Providers have agreed to accept discounted fees for their services and to not bill the Member for benefits payable under this Policy.

Policy, when capitalized, means the insurance policy issued and delivered to the Policyholder, including any endorsements, amendments and/or riders.

Policy Year means the 12-month period following either the Policy's original effective date or subsequent renewal date. A Policy Year may or may not be the same as a Calendar Year. This Policy is renewed, with or without changes, each Policy Year.

Policyholder means the person, individual firm, trust or other organization named in the Application for the Policy and shown on the face page of this Policy.

Provider means a licensed optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who is not the Member or part of their Immediate Family.

Spouse means your legal husband, wife, non state registered or state registered domestic partner.

Usual and Customary means the Participating Provider's usual, customary, and reasonable fee for providing services and supplies to private pay patients and those patients not covered by Medicare or Medicaid programs.

Vision Service Plan Insurance Company (VSP) means the California corporation which has signed a participating agreement with us, on behalf of itself and its affiliates, to provide vision services to the Member.

ELIGIBILITY AND ENROLLMENT

Eligibility
You become eligible to apply for coverage for yourself and your eligible Dependents on the date you have been Actively at Work for the Policyholder long enough to satisfy any required Eligibility Waiting Period.

Your eligibility date is the **later** of:

1. the Effective Date of the Policy; or
2. the date specified in the Coverage Outline which follows your completion of the Eligibility Waiting Period.

If you are a former Employee and return to active work within six months of the date your employment terminated, your previous service in an eligible class will apply toward the Eligibility Waiting Period to determine your eligibility date.

Dependents
A Dependent becomes eligible for coverage on the **later** of the following dates:

1. the date you become eligible; or
2. the date the person becomes a Dependent.

Dependents are limited to the following:

1. your Spouse; or
2. your or your Spouse's Dependent Child(ren).

Enrollment
To enroll for Group Vision Care Insurance for yourself and your eligible Dependents, you must complete and sign an enrollment form and deliver it to the Employer.

Newly Eligible Dependents

You may enroll a Dependent who becomes eligible for coverage after your Effective Date by completing and submitting an enrollment request to us.

Your request for enrollment of a new Dependent Child by birth, adoption, or placement for adoption must be made within 60 days of the date of birth, adoption, or placement for adoption. Request for enrollment of any other newly eligible Dependent must be made within 31 days of the date the Dependent attains eligibility.

Effective Date of Coverage
Subject to the Actively at Work Provision, you and your eligible Dependents will become insured the **later** of:

1. the effective date of the Policy; or
2. the coverage Effective Date assigned by us as follows:
   a. if you and/or your Dependents enroll within 31 days after first becoming eligible, coverage will take effect on your eligibility date; or
   b. if you and/or your Dependents enroll more than 31 days after first becoming eligible, coverage will take effect on the Effective Date assigned by us.

Coverage for newly eligible Dependents will begin on their Effective Dates (which, for a new Dependent Child by birth, adoption, or placement for adoption, is the date of birth, adoption, or placement for adoption, if enrolled within the specified 60 days).

Actively At Work Provision
Coverage will take effect as scheduled only if you are Actively at Work all day on the last regular working day before the scheduled Effective Date. If you are absent from work due to Illness (including pregnancy or complications of pregnancy) or Injury; coverage will not become effective until the first day after you complete one full day of Active Work.

However, coverage will take effect on your regular day off, a holiday, or a paid vacation day, if the regularly scheduled Effective Date falls on that date and you were Actively at Work on the last regular working day before that date.

Annual Enrollment Period
The Annual Enrollment Period is the period of time to be determined by the Policyholder and us during which you and/or your eligible dependents may enroll for coverage if you and and/or your eligible dependents did not enroll during your initial enrollment period. You must submit an application on behalf of all dependents you wish to enroll. Coverage for you and your enrolling eligible dependents will commence on the Effective Date.

Note: If you voluntarily terminate your coverage, you will not have the opportunity to re-enroll during the next two Annual Enrollment Periods following your termination date.

VISION BENEFITS

Benefits
The benefits described in this Policy are available to each Member subject to payment of the applicable Copayment. Copayment Amounts are applicable to services and supplies received from both Participating and Nonparticipating Providers.

Emergency Care
Benefits provided under this Policy are for routine vision care services and materials only. This Policy does not cover treatment for medical conditions, whether due to an emergency or to any other cause. If you or your Enrolled Dependent require medical treatment for any reason, you should contact a medical provider.

For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Member should contact VSP's Customer Service Department for assistance.

Emergency vision care is subject to the same benefit frequencies, plan allowances, Copayments and exclusions stated in this Policy. Reimbursement to Participating Providers will be made in accordance with their agreement with VSP.

Benefit Authorizations
A Benefit Authorization confirms your eligibility for benefits under this Policy. If a Member receives vision services or supplies without a Benefit Authorization, that Member is responsible for paying the full amount of the services and/or supplies to the Provider at the time of service.

When a Member makes an appointment with a Participating Provider they must advise the Provider that they have vision coverage with VSP through LifeMap Assurance Company. The Participating Provider will then contact VSP directly and obtain the Benefit Authorization.

When services or supplies are received from a Participating Provider and a Benefit Authorization has been obtained, the Member is responsible for payment of the applicable Copayment, any amounts which exceed the Allowed Amount, and any amounts for non-covered services or supplies at the time of service. VSP will then pay the Participating Provider for any benefits payable under this Policy and according to the agreement with the doctor.

When you seek treatment from a Nonparticipating Provider or when you receive treatment from a Participating Provider without first obtaining a Benefit Authorization, you are responsible for full payment for services and/or hardware at the time of service. In order for benefits to be paid, you must then submit the claim to VSP for reimbursement.

When a Nonparticipating Provider is seen, this reimbursement will be at the Allowed Amount for Nonparticipating Providers, as shown in the Schedule of Covered Services and Allowed Amounts. You or your Enrolled Dependent will be responsible for paying any difference between the Allowed Amount for Nonparticipating Providers and the billed amount in addition to any applicable Copayment.

Covered Services and Supplies

Covered Services are those services and supplies listed in the Schedule of Covered Services and Allowed Amounts section of this Policy. In order for a service to be considered a Covered Service it must be performed by a Provider practicing within the scope of his or her license.

We cover the following vision services and hardware:

1. Eye examinations, limited to one every twelve months beginning with the first date of service, including:
   a. appropriate examination of visual functions; and
   b. prescription of corrective eyewear where indicated.

   There is a Vision Exam Copayment of $10.00 payable by the Member to the Provider at the time services are rendered. **Note:** Contact lens evaluation and fitting services are not included in the eye exam benefit.
2. Prescription lenses, limited to one set every 12 months beginning with the first date of service.

   There is an additional $25.00 Vision Hardware Copayment payable at the time the lenses are ordered. If both frames and lenses are purchased separately during the 12 months, the Copayment will apply to only the first item purchased. If both frames and lenses are purchased together, only one $25.00 Copayment will be required for the combined purchase.
3. Frames, limited to one set every 24 months beginning with the first date of service. Benefits for lenses and frames include the following professional services when necessary:
   a. prescribing and ordering proper lenses;
   b. assisting in frame selection;
   c. verifying accuracy of finished lenses;
   d. proper fitting and adjustments of frames;
   e. subsequent adjustments to frames to maintain comfort and efficiency; and
   d. progress or follow-up work as necessary.

   Polycarbonate lenses will be covered only when prescribed for a child or a disabled person.

   There is an additional $25.00 Vision Hardware Copayment payable at the time the frames are ordered. Please see the Copay information under lenses for more information.
4. Contacts lenses, available once every 12 months beginning with the first contact lens purchase in lieu of all other lens and frame benefits.

   Contact lenses will be considered necessary if the patient has at least one of the following conditions:
   a. allergies to frame materials that prevent the patient from wearing any type of frame material;
   b. physical condition of ears or nose prohibiting the use of glasses - necessary contact lenses may be provided for patients experiencing discomfort from glasses on the nose, bridge or sinuses after surgery or when other conditions of these areas that inhibit the use of glasses;
   c. Irregular Astigmatism;
   d. Aphakia;
   e. Nystagmus;
   f. a difference in the prescription for each eye of 2.00 diopters;
   g. a prescription of at least 10.00 diopters;
   h. Keratoconus;
   i. previous corneal transplant surgery;or
   j. Corneal Dystrophies.

   Review and approval by VSP is not required for a Member to be considered eligible for the necessary contact lenses benefit.

   There is an additional $25.00 Vision Hardware Copayment payable at the time necessary contact lenses are ordered. The Copayment does not apply to elective contact lenses.

5. Low vision services, professional services for severe visual problems not correctable with regular lenses, including:
   a. supplemental testing including complete low vision analysis/diagnosis, a comprehensive examination of visual functions, and the prescription of corrective eyewear or vision aids where indicated; and
   b. supplemental aids.

   The maximum benefit for all low vision services and materials is $1,000 every 2 years.

   There is an additional Supplemental Aids Copayment payable at the time aid is ordered. The Supplemental Aids Copayment is 25% of the Allowed Amount for that aid.

   Low Vision benefits secured from Nonparticipating Providers are subject to the same time and Copayment provisions as for Participating Providers. The Member should pay the Nonparticipating Provider's full fee at the time of service. When the Member submits the claim, they will be reimbursed an amount not to exceed what VSP would pay a Participating Provider for the same services and/or materials.

Additional Discounts*

In addition to the benefits stated under Covered Services, each Member will receive additional discounts.

Members will receive a discount of 20% toward the purchase of additional complete pairs of prescription glasses and sunglasses (frames, lenses and lens options) from Participating Providers. Additional pairs are those purchased beyond the benefit frequency allowed under this Policy.

Members will receive a discount of 15% off of contact lens examination services from any Participating Provider.

Discounts are also available for laser vision correction. The average is 15% off the regular price or 5% off of the promotional price. Discounts are only available from contracted facilities.

Discounts are applied to the Participating Provider's usual and customary fees for such services and/or supplies and will apply to each purchase made by the Member on the date of the Member's eye exam and for the 12 months immediately following the eye exam.

Limitations:

- Discounts do not apply to vision care benefits obtained from Nonparticipating Providers.
- 20% discount applies to complete pairs of glasses only.
- Discounts do not apply if prohibited by the manufacturer.
- Discounts do not apply to sundry items, e.g., contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.

* Professional judgment will be applied when evaluating prescriptions written by another Provider. Participating Providers may request a discounted additional exam.

Schedule of Covered Services and Allowed Amounts

When services or supplies are received from a Participating Provider and a Benefit Authorization was obtained prior to the date of service, benefits appearing in the Participating Provider column below are applicable. These amounts are subject to any Copayments and other conditions, limitations and/or exclusions of the Policy.

When services or supplies are received from a Nonparticipating Provider or without first obtaining a Benefit Authorization, the Member is reimbursed for such services or supplies according to the schedule in the Nonparticipating Provider Benefit column below, after any applicable Copayment. These amounts are subject to any conditions, limitations and/or exclusions of the Policy. When services or supplies are received from a Nonparticipating Provider or without first obtaining a Benefit Authorization, the Member pays the Provider the full fee at the time of service and submits an itemized bill to VSP for reimbursement.

Allowed Amount
(This is the amount we will pay)

Covered Service or Hardware	Performed by a Participating Provider	Performed by a Nonparticipating Provider	Frequency of Benefit
Eye Examination	Covered In Full*	Up to $45*	Once Every 12 Months**
Lenses			Once Every 12 Months**
Single Vision	Covered In Full*	Up to $30*	
Lined Bifocal	Covered In Full*	Up to $50*	
Lined Trifocal	Covered In Full*	Up to $65*	
Lenticular	Covered In Full*	Up to $100*	
Frames	Up to $130*	Up to $70*	Once Every 24 Months**
Contact Lenses			Once Every 12 Months**
Necessary – professional fees and materials	Covered In Full*	Up to $210*	
Elective – professional fees and materials***	Up to $130	Up to $105	
Low Vision Services			Once Every 2 Years**
Supplemental Testing	Covered In Full	Up to $125	
Supplemental Aides	75% of the billed amount up to $1,000****	75% of the billed amount up to $1,000****	

* After any applicable Copayment due from the Member.

** Beginning with the first date of service.

*** A 15% discount applies to a Participating Provider's usual and customary fees for contact lens evaluation and fitting. Contact lens evaluation and fitting are not included in the Eye Examination benefit. (See Additional Discounts on page C-11.)

**** The Maximum benefit for all low vision services and materials is $1,000 every 2 years. There is no guarantee that the amount reimbursed will cover 75% of the provider's full fee.

EXCLUSIONS

The following are the general exclusions from coverage under the Policy. Other exclusions may apply and, if so, will be described elsewhere in the Policy.

This Policy is designed to cover visual needs rather than cosmetic materials. When the Member selects a non-covered service or supply at the same time as a Covered Service or supply, only the portion of charges relating to the Covered Service will be considered eligible for payment. This Policy will only cover the basic cost of the allowed lenses, and the Member will be responsible for the additional costs of the options including:

a. Optional cosmetic processes;
b. Anti-reflective coating;
c. Color coating;
d. Mirror coating;
e Scratch coating;
f. Blended lenses;
g. Cosmetic lenses;
h. Laminated lenses;
i. Oversize lenses;
j. Polycarbonate lenses;
k. Photochromic lenses; tinted lenses except Pink #1 and Pink #2;
l. Progressive multifocal lenses; and
m. UV (ultraviolet) protected lenses.

No benefits will be provided for any of the following conditions, treatments, services, supplies, or accommodations, including any direct complications or consequences that arise from them, as follows:

Benefits Not Stated means services and supplies that are not identified as benefits under the Policy. When a non-Covered Service or supply is performed or received at the same time as a Covered Service, only the portion of charges relating to the Covered Service will be considered eligible for payment.

Corrective vision treatment of an Experimental Nature.

Costs for services and/or materials above the Allowed Amount.

Expenses incurred prior to the Member's Effective Date under this Policy or after coverage under this Policy terminates.

Medical or surgical treatment of the eyes.

Orthoptics or vision training and any associated supplemental testing.

Plano lenses (less than a ± .50 diopter power).

Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available.

Two pair of glasses in lieu of bifocals.

WHEN COVERAGE ENDS

This section describes the situations when coverage will end for you and/or your Enrolled Dependents. If one of your Enrolled Dependents is no longer eligible for this coverage, you must notify us within 30 days.

No person will have a right to receive benefits under this Policy after the date it is terminated. Termination of your or your Enrolled Dependent's coverage under this Policy for any reason will completely end all our obligations to provide you or your Enrolled Dependent benefits for Covered Services received after the date of termination. This applies whether or not you or your Enrolled Dependent is then receiving treatment or is in need of treatment for any illness or injury incurred or treated before or while this Policy was in effect.

Policy Termination or Non Renewal by the Policyholder or by us means coverage ends for you and your Enrolled Dependents on the date the Policy is terminated or not renewed

In the event this Policy is terminated and coverage is not replaced by the Policyholder, we will mail to the Policyholder a notice of termination. It is then the duty of the Policyholder to send each Enrolled Employee a notice of the termination, explaining rights to continuation or portability of coverage under federal and/or state law.

If You Are No Longer Eligible as explained in the following paragraphs, you and your Enrolled Dependents' coverage ends on the last day of the monthly period in which your eligibility ends. However, it may be possible for you and/or your Enrolled Dependents to continue coverage under the Policy according to the COBRA continuation of coverage provisions of this Certificate.

Termination of Your Employment or You Are Otherwise No Longer Eligible
If you are no longer eligible due to termination of employment or you are otherwise no longer eligible according to the terms of the Policy, your coverage will end for you and all Enrolled Dependents on the last day of the monthly period following the date on which eligibility ends.

Nonpayment of Premium
If you fail to make required timely contributions to premium, your coverage will end for you and all Enrolled Dependents on the last day of the period for which you have made any required contribution.

Termination by You
Pre-tax contribution and Noncontributory: You have the right to terminate this coverage with respect to yourself and our Enrolled Dependents by giving notice to us during your Annual Enrollment Period or after a Qualifying Life Event. Coverage will end on the last day of the monthly period following the date we receive such notice.

Qualifying Life Event for the purposes of terminating or changing coverage elections includes each of the events described under Section 125 of the Internal Revenue Service code. Please contact your Employer for more information.

Post tax contribution: You have the right to terminate this coverage with respect to yourself and our Enrolled Dependents by giving notice to us. Coverage will end on the last day of the monthly period following the date we receive such notice.

Note: If you voluntarily terminate your coverage, you will not have the opportunity to re-enroll during the next two Annual Enrollment Periods following your termination date.

Fraudulent Use of Benefits
If you or your Enrolled Dependent engages in an act or practice that constitutes fraud in connection with coverage or makes an intentional misrepresentation of fact in connection with coverage, coverage under this Policy will terminate for that Member. If this coverage terminates for an Enrolled Employee, it will also terminate for the Employee's Enrolled Dependents.

Fraud or Misrepresentation in Application
We have issued this coverage in reliance upon all information furnished to us by you or on behalf of you and your Enrolled Dependents. In the event of any intentional material misrepresentation of fact or fraud regarding a Member (including, but not limited to a person who is listed as a dependent, but does not meet the eligibility requirements listed in this Certificate), coverage under this Policy will terminate for such Member.

Family and Medical Leave is applicable if your Employer grants you a leave of absence under the Family and Medical Leave Act of 1993 (Public Law 103-3, "FMLA").
The Act is generally applicable to private employers of 50 or more employees and public employers of any size. You will be entitled to continued coverage under this provision only to the extent you are eligible for leave under the terms of the FMLA. The following rules apply:

1. you and your Enrolled Dependents will remain eligible to be enrolled under the Policy during the FMLA leave for a period of up to 12 weeks during a 12-month period for one of the following:
   a) in order to care for your newly born child;
   b) in order to care for your spouse, child, or parent, if such spouse, child, or parent has a serious health condition;
   c) the placement of a child with you for adoption or foster care; or
   d) you suffer a serious physical or mental health condition.

During the FMLA leave, timely payment of the monthly premium must continue to be made through the Employer. The provisions described here will not be available if this Policy terminates.

If you and/or your Enrolled Dependents elect not to remain enrolled during the FMLA leave, you (and/or your Enrolled Dependents) will be eligible to be reenrolled under the Policy on the date you return from the FMLA leave. In order to reenroll after you return from a FMLA leave, you must sign a new application just as if you were a newly eligible employee. In this situation, if you reenroll within the required time, all of the terms and conditions of the Policy will resume at the time of reenrollment as if there had been no lapse in coverage. You (and/or your Enrolled Dependents) will receive credit for any waiting period served prior to the FMLA leave and you will not have to re-serve any probationary period under this Policy, although you and/or your Enrolled Dependents will receive no waiting period credits for the period of non-coverage.

Persons entitled to coverage under this provision will not be entitled to any other extension of benefits described in this section for the same situation that entitles them to coverage under this provision. Entitlement to FMLA leave does not constitute a qualifying event for the purposes of COBRA continuation. However, a person who does not return to active employment following FMLA leave may be entitled to COBRA continuation coverage. The duration of that COBRA continuation will be calculated from the date the person fails to return from the FMLA leave.

The provisions and administration described here are based on the requirements of the Family and Medical Leave Act of 1993, as amended, and will be governed by the FMLA law and any subsequent amendments and regulations. If any conflicts arise between the provisions described here and FMLA, the minimum requirements of FMLA will govern. This leave provision is available only to employers that are required by law to comply. The Employer must keep us advised regarding the eligibility for coverage of any employee who may be entitled to the benefits extended by FMLA.

Leave of Absence
If you are granted a non-FMLA temporary leave of absence by your Employer, you can continue coverage for up to three months. Premiums must be paid through the Employer in order to maintain coverage during a leave of absence.

A leave of absence is a period off work granted by your Employer at your request during which you are still considered to be employed and are carried on the employment records of the Employer. A leave can be granted for any reason acceptable to the Employer. If you are on leave for an FMLA-qualifying reason, you remain eligible under the Policy only for a period equivalent to FMLA leave and may not also continue coverage under a non-FMLA leave.

Reenrolling after Layoff
If you are rehired and return to active work within six months of being laid off, you and any previously Enrolled Dependents may reenroll under this Policy on the date you are rehired, regardless of any lapse in coverage. Your Employer must notify us that you are being rehired following a layoff and the necessary premiums for your coverage must be paid. At the time you are rehired, you do not have to re-satisfy any Eligibility Waiting Period required by this Policy. All Policy provisions will resume at the time you reenroll whether or not there was a lapse in your coverage.

When Your Enrolled Dependents Are No Longer Eligible
If your dependent is no longer eligible as explained in the following paragraphs (unless specified to the contrary below), his or her coverage will end on the last day of the monthly period in which his or her eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Policy according to the COBRA continuation of coverage provisions of this Certificate.

Divorce, Annulment or Termination of Domestic Partnership
Eligibility ends for your enrolled Spouse and the Spouse's children (unless such children remain eligible by virtue of their continuing relationship to you) on the last day of the monthly period following the date a divorce, annulment or termination of domestic partnership is final.

This provision does not apply to any termination of a domestic partnership that occurs as a matter of law should you and your domestic partner enter into a marriage.

If You Die
If you die, coverage for your Enrolled Dependents ends on the last day of the monthly period in which your death occurs.

Loss of Dependent Status
1. for an enrolled child who is no longer an eligible dependent due to exceeding the dependent age limit, eligibility ends on the last day of the monthly period in which the child exceeds the dependent age limit; or
2. for an enrolled child who is no longer eligible due to disruption of placement prior to legal adoption and who is removed from placement, eligibility ends on the date the child is removed from placement; or
3. for an enrolled child who is no longer an eligible dependent for any other cause (not described above), eligibility ends on the last day of the monthly period in which the child is no longer a dependent.

Certificates of Creditable Coverage
Requests for and inquiries about required certificates relating to period(s) of creditable coverage under the Policy should be directed to the Employer, or to us at PO Box 1271, M/S E8L, Portland, OR 97207-1271.

COBRA CONTINUATION OF COVERAGE

COBRA is a continuation of this coverage for a limited time after certain events cause a loss of eligibility. COBRA continuation does not apply to all groups. Complete details are available from your Employer.

If your Employer is subject to COBRA, COBRA continuation is available to your Enrolled Dependents if they lose eligibility because:

1. your employment is terminated (unless the termination is for gross misconduct); or
2. your hours of work are reduced; or
3. you die; or
4. you and your Spouse divorce, the marriage is annulled or your domestic partnership is terminated; or
5. you become entitled to Medicare benefits; or
6. your Enrolled Dependent loses eligibility as a dependent child under this coverage.

COBRA also is available to you if you lose eligibility because your employment terminates (other than for gross misconduct) or your hours of work are reduced. (A special COBRA continuation also applies to you and your Enrolled Dependents under certain conditions if you are retired and your Employer files for bankruptcy. Complete details are available from your Employer.)

There are some circumstances involving disability or the occurrence of a second one of these events that can result in extension of the limited period of continuation following a termination of employment or reduction in working hours. COBRA also can terminate earlier than the maximum periods. See our Employer for details.

General Rules
Generally, you or your Enrolled Dependents are responsible for payment of the full premium for COBRA continuation, plus an administration fee, even if the Employer contributes toward the premiums of those not on COBRA continuation. The administration fee is 2% or, during any period of extension for disability, 50%.

In order to preserve your and your Enrolled Dependent's rights under COBRA, you or your Enrolled Dependents must inform the Employer in writing within 60 days:

1. of your divorce, annulment, termination of domestic partnership, or loss of dependent child status; or
2. if your initial loss of eligibility was due to your termination of employment or reduction in working hours and you experience another one of the events listed above; or
3. a Social Security disability determination that you or your Enrolled Dependent was disabled for Social Security purposes at the time of a termination of employment or reduction in working hours or within the first 60 days of COBRA continuation following that event. (If a final determination is later made that you or your Enrolled Dependent is no longer disabled for Social Security purposes, you or your Enrolled Dependent must provide the Employer notice of that determination within 30 days of the date it is made.)

The Employer also must meet certain notification, election and payment deadline requirements. It is therefore very important that you keep the Employer informed of the current address of all Members who are or may become qualified beneficiaries.

If you or your Enrolled Dependents do not elect COBRA continuation coverage, coverage under the Policy will end according to the terms of the Policy and we will not pay claims for services provided on and after the date coverage ends. Further, this may jeopardize your or your Enrolled Dependents' future eligibility for an individual plan.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one **Plan. Plan** is defined below.

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 according to 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 dental 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. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

1. **Plan** includes: Group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

2. **Plan** does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; 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; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; 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 dental 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 must make payment in an 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 equal 100% of the **Total Allowable expense** for that claim. This means that when this **Plan** is **Secondary,** it must pay the amount which, when combined with what the **Primary plan** paid, totals 100% of the highest **Allowable expense.** In addition, if this **Plan** is **Secondary,** it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the **Primary plan**) and record these savings as a benefit reserve for the covered person. This reserve must be used to pay any expenses during that calendar year, whether or not they are an **Allowable expense** under this **Plan.** If this **Plan** is **Secondary** , it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, 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.**

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

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense,** unless one of the **Plans** provides coverage for private hospital room expenses.

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

3. If a person is covered by two 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.**

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 in the form of services through a panel of providers who are primarily 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 under any other **Plan.**

B. 1. Except as provided in subsection (2), a **Plan** that does not contain a coordination of benefits provision that is consistent with this chapter 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 is excess to any other parts of the **Plan** provided by the contract holder. Examples include major medical coverages that are superimposed over 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 claim determination periods commencing after the **Plan** is given notice of the court decree;

      (ii) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;

      (iii) 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 determine the order of benefits;

      (iv) 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 subsection (a) above determine the order of benefits; or

      (v) 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,** first;

         • The **Plan** covering the spouse of the **Custodial parent,** second;

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

         • The **Plan** covering the spouse of the **non-custodial parent,** last

   c. For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of subsection (a) or (b) above 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 under section D(1) can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided under 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 under section 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** must 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

When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a claim determination period are not more than the total **Allowable expenses.** In determining the amount to be paid for any claim, the **Secondary plan** must make payment in an 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 equal one hundred percent of the total **Allowable expense** for that claim **Total Allowable expense** is the highest **Allowable expense** of the **Primary plan** or the **Secondary plan.** In addition, the **Secondary plan** must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

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.** Organization responsibility for **COB** administration 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. Organization responsibility for **COB** administration need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give Organization responsibility for **COB** administration any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

If payments that should have been made under **This plan** are made by another **Plan,** the issuer has the right, at its discretion, to remit to the other **Plan** the amount it determines appropriate to satisfy the intent of this provision. The amounts paid to the other **Plan** are considered benefits paid under **This plan.** To the extent of such payments, the issuer is fully discharged from liability under **This plan.**

RIGHT OF RECOVERY

The issuer has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The issuer may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

Questions about Coordination of Benefits?

Contact Your State Insurance Department

GENERAL PROVISIONS

Entire Contract-Policy Changes
This Certificate is furnished in accordance with and subject to the terms of the Policy. The entire contract consists of the Policy, which includes the Application, and any attached papers; this Certificate; and any riders or endorsements. No change in the Policy will be effective until approved by one of our officers. This approval can only be made in writing and must be noted on or attached to the Policy. No agent has authority to change the Policy or Certificate or to waive any of their provisions.

Certificates
The Employer is responsible for giving to the Employee a complete copy of the Certificate for the Employee's applicable class within 31 days after receipt of the Certificates from us.

Agency
For all purposes under this Policy the Policyholder acts on its own behalf or as agent of the Employee. Under no circumstances will the Policyholder be deemed our agent without a written authorization.

Misstatement of Age
If a person's age has been misstated, an equitable adjustment will be made in the premium. A refund will not be made for a period more than 12 months before the date we are advised of the error.

Incontestability
In the absence of fraud, all statements you make in an application will be deemed representations and not warranties. No statement made for the purpose of obtaining coverage will void such coverage or reduce benefits unless contained in a written document signed by you, a copy of which is furnished to you.

After coverage has been in effect for two years during the lifetime of the Insured Person, no misrepresentation will be used to reduce or deny a claim or to deny the validity of coverage. The validity of the Policy will not be contested after it has been in force for two years, except for nonpayment of premiums.

No Waiver
The failure or refusal of either party to demand strict performance of this Policy or to enforce any provision will not act as or be construed as a waiver of that party's right to later demand its performance or to enforce that provision. No provision of the Policy will be deemed waived by us unless such waiver is reduced to writing and signed by one of our authorized officers.

Legal Action
No legal action may be brought to recover on this Policy until 60 days after proof of loss has been furnished. No action may be brought after 3 years from the time written proof of loss is required to be furnished.

Limitations on Liability
In all cases, you have the exclusive right to choose a vision care provider. Participating Provider facilities and professionals are neither employees nor agents of LifeMap Assurance Company. Providers are responsible for the quality of care they render. Since we do not provide any vision care services, we cannot be held liable for any claim or damages connected with injuries you suffer while receiving vision services or supplies provided by professionals who are neither our employees nor agents.

Worker's Compensation
This insurance is not in lieu of Workers' Compensation; it does not affect any requirement for Workers' Compensation coverage.

Notices to Members or to the Employer required in the Policy will be deemed to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to an Enrolled Employee or to the Employer will be addressed to the Enrolled Employee or to the Employer at the last known address appearing in our records. If we receive a United States Postal Service change of address form (COA) for an Enrolled Employee, we will update our records accordingly. Additionally, we may forward notice for an Enrolled Employee to the plan administrator if we become aware that we don't have a valid mailing address for the Enrolled Employee.

Any notice to us required in the Policy may be given by mail addressed to: LifeMap Assurance Company, PO Box 1271, M/S E8L, Portland, OR 97207-1271; provided, however that any notice to us will not be deemed to have been given to and received by us until physically received by us.

CONTRACT AND CLAIM PROVISIONS

Assignment
No assignment by any Member of any coverage under the Policy shall be valid, except that this provision will not prohibit payment to providers of services and supplies covered by the provisions of the Policy.

When Benefits Are Available
In order for vision expenses to be covered under the Policy, they must be incurred while coverage is in effect. Coverage is in effect when all of the following conditions are met:

1. the person is eligible to be covered according to the eligibility provisions of the Policy;
2. the person has applied for coverage and has been accepted by us; and
3. premium for the person for the current month has been paid by the Policyholder on a timely basis.

The expense of a service is incurred on the day the service is rendered and the expense of a supply is incurred on the day the supply is ordered.

Participating Provider Claims when a Benefit Authorization has been Obtained Prior to Treatment
When a Member makes an appointment with a Participating Provider they must advise the Provider that they have vision coverage with VSP through LifeMap Assurance Company. The Participating Provider will then contact VSP directly and obtain the Benefit Authorization.

When treatment is received from a Participating Provider and a Benefit Authorization has been obtained, the Participating Provider will furnish VSP with the forms and information needed to process your claim. VSP will then pay the Participating Provider directly for Covered Services.

Claims for Reimbursement for Services or Supplies Provided by a Nonparticipating Provider or when a Benefit Authorization has not been Obtained Prior to Treatment
In order for us to reimburse you for Covered Services rendered by a Nonparticipating Provider or by a Participating Provider when a Benefit Authorization was not obtained prior to treatment, you must first send VSP a claim. Be sure the claim is complete and includes the information listed under Claims for Reimbursement. Reimbursement will be at the Allowed Amount for Nonparticipating Providers.

Notice of Claim
If the Member receives treatment or supplies from a Nonparticipating Provider or a Participating Provider when a Benefit Authorization was not obtained prior to treatment, claims for benefits under this Policy must be presented to VSP in writing within 180 days of the date of service, or as soon as reasonably possible. The written request must include the following information:

1. an itemized description of the services given and the charges for them;
2. the date treatment was given;
3. the patient's name, date of birth, and the group, LifeMap Assurance Company; and
4. the treating Providers' name, address, TIN and license number.

Additional information may be requested by the VSP to process the request.

All claims should be sent to the address below.

Vision Service Plan
PO Box 997105
Sacramento, CA 95899-7105

Time Payment of Claims
Losses covered by this Policy will be paid by as soon as we receive:

1. the bills which substantiate proof of loss; and
2. any medical/vision information we request.

Payment of Claim

1. We may pay you, the Provider, or you and the Provider jointly.
2. We may make benefit payments for a child covered by a legal qualified medical child support order (QMCSO) directly to the custodial parent or legal guardian of such child.
3. If a person entitled to receive payment under the Policy has died, is a minor, or is incompetent, we may pay the benefits (up to $1,000) to a relative by blood or marriage of that person who we believe is equitably entitled to the payment.
4. A payment made in good faith under this provision will fully discharge us to the extent of the payment.

Claims Determinations

Within 30 days of our receipt of a complete claim, we will notify you of the action we have taken on it, adverse or not. However, this 30-day period may be extended by an additional 15 days in the following situations:

1. when we cannot take action on the claim due to circumstances beyond our control, we will notify you within the initial 30-day period that an extension is necessary. This notification includes an explanation of why the extension is necessary and when we expect to act on the claim; or
2. when we cannot take action on the claim due to lack of information, we will notify you within the initial 30-day period that the extension is necessary. This notification includes a specific description of the additional information needed and an explanation of why it is needed.

We must allow you at least 45 days to provide us with the additional information if we are seeking it from you. If we do not receive the requested information to process the claim within the time we have allowed, we will deny the claim.

We will notify you of the actions taken on your claim. We may pay claims or deny them. If we deny all or part of a claim, the reason for our action will be reported to you in writing. We will also include instructions for filing an Appeal or Grievance if you disagree with the action.

Claims Recovery

If we pay a benefit to which you or your Enrolled Dependent was not entitled, or if we pay a person who is not eligible for benefits at all, we have the right, to recover the payment from the person we paid or anyone else who benefited from it, including a provider of services. Our right to recovery includes the right to deduct the mistakenly paid amount from future benefits we would provide the Enrolled Employee or any of his or her Enrolled Dependents, even if the mistaken payment was not made on that person's behalf.

This claims recovery provision in no way reduces our right to reimbursement or subrogation.

Right to Receive and Release Necessary Information and Vision Records

It is important to understand that your health information may be requested or disclosed by us. This information will be used for the purpose of facilitating health care treatment, payment of claims, or business operations necessary to administer health care benefits; or as required by law.

GREIVANCES AND APPEALS

Grievance Procedures

Grievances include concerns or disagreements regarding access to care, or the quality of care, treatment or service.

If a Member has a question or a problem, the Member should first call VSP's Customer Service Department at (800) 877-7195. The Customer Service Department will make every effort to answer the Member's question and/or resolve the matter informally.

If a matter is not initially resolved to the satisfaction of the Member, the Member may communicate a grievance to VSP in writing by using the complaint form that may be obtained upon request from the Customer Service Department.

Members have the right to submit written comments, documents, and other relevant information regarding the grievance to assist in VSP's review.

VSP will review the grievance and all information submitted. You will be provided a written reply within 30 days of receipt of the grievance, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than 120 days after VSP's receipt of the grievance. If additional time is needed, VSP will provide written notification of the reason for the delay and the extension of time allowed, per applicable state and federal laws.

Upon final resolution, the Member will be notified of the outcome in writing. If the grievance is denied, the written reply will include information about the basis for the decision and other disclosures as required under state and federal laws.

If a Member disagrees with VSP's determination, they may request a second level appeal within 60 calendar days from the date of the determination. VSP shall resolve any second level appeal within 30 calendar days.

All written Grievances should be sent to the address below:

Vision Service Plan
Attn: Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670

Appeal Procedures

Appeals include concerns or complaints regarding billing or eligibility.

If you or your Enrolled Dependent have a concern regarding billing of premium or eligibility, an appeal or request for review may be submitted (along with any additional information which would affect the situation) to us for consideration.

We will review the information submitted and you will be provided a written reply within 30 days after the appeal was received by us. If additional time is needed, we will provide written notification of the reason for the delay and the extension of time allowed, per applicable state and federal laws.

All written Appeals should be sent to the address below.

LifeMap Assurance Company
Attn: Billing Supervisor
P.O. Box 1271 M/S E8L
Portland, OR 97207-1271

LifeMap Assurance Company®
200 SW Market Street
P.O. Box 1271, M/S E8L
Portland, OR 97207-1271
(503) 721-7161 • (800) 794-5390

TERMINATION OF DOMESTIC PARTNERSHIP ENDORSEMENT

This Endorsement is effective on the effective date of the Policy or Certificate to which it is attached or January 1, 2013, whichever is later.

Any reference to **Termination of Domestic Partnership** within the provisions of this Policy shall be revised to include the following:

This provision does not apply to any termination of a domestic partnership that occurs as a matter of law should you and your domestic partner enter into a marriage.

ALL OTHER TERMS AND CONDITIONS OF THIS POLICY REMAIN UNCHANGED.

LIFEMAP ASSURANCE COMPANY

Chairman, Dudley Slater

President, Beth Andersen

ERISA INFORMATION

The following information is provided in accordance with the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). This Trico Companies LLC document, together with the Certificate of Coverage issued by LifeMap Assurance Company, is the Summary Plan Description (SPD) required by the Employee Retirement Income Security Act of 1974 ("ERISA"). This Trico Companies LLC document is not intended to give you any substantive rights to benefits that are not already provided by the attached Certificate of Coverage. The following information is furnished by the Plan Administrator and is not a part of the Group Policy or this Certificate of Coverage. LifeMap Assurance Company assumes no responsibility for the accuracy or sufficiency of the information in this section. For complete information required by ERISA, contact the Plan Administrator.

Plan Name:

Trico Companies LLC Group Choice Vision Care Insurance Policy

Plan Sponsor:

Trico Companies LLC
15066 Josh Wilson Road
Burlington, WA 98233
Phone: (360) 757-2373

Plan Numbers:

The Plan is identified by the following numbers under the Internal Revenue Service rules:

Employer Identification Number (EIN): 46-1346762

Plan Number (PN): 502

Type of Welfare Plan:

This is a Group Vision Insurance Benefit Plan

Plan Year:

The Plan year begins December 1 and ends November 30

Type of Plan Administration:

The Plan is fully insured. Benefits are provided under a group insurance contract entered into between Trico Companies LLC and LifeMap Assurance Company.

Claims for benefits are sent to the Insurance Company. The Insurance Company is responsible for determining eligibility for and the amount of any benefits payable under the Plan and for providing the claims procedures to be followed and the claims forms to be used by employees pursuant to the Plan. The Insurance Company also has the authority to require employees to furnish it with such information as it determines is necessary for the proper administration of the Plan.

Plan Administrator and Named Fiduciary:

Trico Companies LLC
Attn: Human Resources
15066 Josh Wilson Road
Burlington, WA 98233
Phone: (360) 757-2373

Agent For Service of Legal Process:

Trico Companies LLC
15066 Josh Wilson Road
Burlington, WA 98233
Phone: (360) 757-2373
Service of legal process may also be made on the Plan Administrator.

Insurance Company

LifeMap Assurance Company
P.O. Box 1271 MS E3A
Portland, Oregon 97207-1271
Tel: (503)412-7965
Toll-free: (800) 286-1129

Sources and Methods of Contributions to the Plan:

Insurance premiums for employees and their families are paid in part by the Plan Sponsor out of its general assets, and in part by employee payroll deductions.

Contact the Plan Sponsor for a schedule of the applicable premiums.

Any employee payroll deductions shall be used in their entirety prior to using Plan Sponsor contributions to pay for premiums under this plan. Any refund, rebate, dividend, experience adjustment, or other similar payment under the group insurance contracts entered into between Trico Companies LLC and the Insurance Company shall be allocated, consistent with the fiduciary obligations imposed by ERISA, to reimburse Trico Companies LLC for premiums that it has paid.

Plan Amendment or Termination Provisions:

The Plan Sponsor has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument signed by the Plan Sponsor President or Human Resources Manager, both of whom are authorized to amend or terminate the Plan and to sign insurance contracts with the Insurance Company or other carriers, including amendments to those contracts. In addition, termination of the group insurance contract entered into between the Plan Sponsor and Insurance Company will constitute termination of the Plan, unless the Plan Sponsor exercises its sole discretion to obtain a substitute contract of insurance.

If the Plan is terminated, Members will not have any further rights, other than the payment of benefits for covered expenses incurred before the Plan was terminated. The amount and form of any final benefit will depend on any provisions affecting the Plan, and the Plan Sponsor's decisions.

Important Disclaimer:

Benefits hereunder are provided solely pursuant to an insurance contract between the Plan Sponsor and the Insurance Company. If the terms of this summary document conflict with the terms of the insurance contract, the terms of the insurance contract will control, unless superseded by applicable law.

STATEMENT OF ERISA RIGHTS

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

- Examine, without charge, at the Plan Administrator's principal office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, 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 copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

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 do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

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 that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, 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 per 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, and if you have exhausted the claims procedures available to you under the Plan, 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.

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 contact 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 the publications hotline of the Employee Benefits Security Administration.

CLAIM REVIEW PROCEDURES

The Insurance Company is responsible for evaluating all benefit claims under the Plan. The Insurance Company will decide your claim in accordance with its reasonable claims procedures, as required by ERISA.

See the attached Certificate of Coverage issued by LifeMap Assurance Company for information about how to file a claim and for details regarding the Insurance Company's claims procedures.

The Plan will make every effort to make a determination on vision claims within 30 days of receipt of the claim.

If the Plan is not able to make a decision on the claim within 30 days of receipt of the claim for reasons beyond the control of the Plan, the decision may be extended for as many as 15 additional days. If this is the case, written notice will be provided to the claimant prior to the end of the first 30 days that details the specific reason(s) for the delay. The notice will identify the additional information or documents needed to resolve the claim.

The maximum time the Plan will take to make a decision on the claim will be 90 days.

CLAIM APPEAL PROCEDURES

If a vision claim or request for services or supplies is denied in whole or in part, the Plan will provide the claimant with a letter stating the specific reason(s) for the adverse determination. The claimant will also be provided with a description of any additional information or material necessary to perfect the claim and an explanation as to why such material is necessary.

The claimant will have 180 days following receipt of an adverse benefit determination to file an appeal. Another person may be authorized to act for the claimant under this appeal procedure.

The appeal will be decided within 30 days after receipt of the appeal. The 30 day time period will start when the appeal is filed without regard to whether all of the information necessary to decide the appeal accompanies the filing.

If, for reasons beyond the control of the Plan, the appeal cannot be decided within 30 days, the appeal decision may be extended for as many as 90 additional days. The maximum time to decide the appeal will be 120 days.