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GROUP BOOKLET-CERTIFICATE FOR MEMBERS OF

PICKERING ASSOCIATES, INC.

ALL MEMBERS
Group Dental Expense Insurance

Print Date: 03/15/2007

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Your insurance has been designed to provide financial help for you when a covered loss occurs. This plan has chosen benefits provided by a Group Policy issued by Us, Principal Life Insurance Company. To the extent that benefits are provided by that Group Policy, the administration and payment of claims will be done by Us as an insurer.

Members rights and benefits are determined by the provisions of the Group Policy. This booklet briefly describes those rights and benefits. It outlines what you must do to be insured. It explains how to file claims. It is your certificate while you are insured.

The effective date of your insurance is as shown on your enrollment card. You should keep your enrollment card, any change of beneficiary or change of name forms, or other similar forms with your booklet after the form has been recorded by Us and returned to you.

THIS BOOKLET REPLACES ANY PRIOR BOOKLET THAT YOU MAY HAVE RECEIVED. Please remove your enrollment material from your prior booklet, place it with this booklet, and destroy your prior booklet. If you have any questions about this new booklet, please contact your Policyholder. In the event of future plan changes, you will be provided with a new booklet-certificate or a booklet-certificate rider.

PLEASE READ YOUR BOOKLET CAREFULLY. We suggest that you start with a review of the terms listed in the DEFINITIONS Section (at the back of the booklet). The meanings of these terms will help you understand the insurance.

The group insurance policy and your coverage under the Group Policy may be discontinued or altered by the Policyholder or Us at any time without your consent.

We reserve complete discretion to construe or interpret the provisions of this group insurance, to determine eligibility for benefits, and to determine the type and extent of benefits, if any, to be provided. Our decisions in such matters will be controlling, binding, and final as between Us and persons covered by this group insurance, subject to the Claim Procedures shown on page GH 146 D of this booklet.

The insurance provided in this booklet is subject to the laws of the state of WEST VIRGINIA.

PRINCIPAL LIFE
INSURANCE COMPANY
Des Moines, IA 50392-0001

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SUMMARY OF BENEFITS
(revised effective March 1, 2007)

This section highlights the benefits provided under this insurance. The purpose is to give you quick access to the information you will most often want to review. **Please read the other sections of this booklet for a more detailed explanation of benefits and any limitations or restrictions that might apply.**

DENTAL EXPENSE INSURANCE

If you or one of your Dependents receive dental Treatment or Service listed under the Schedule of Dental Procedures, Scheduled Benefits then in force will be payable. Scheduled Benefits are based on your class and the status of your Dependents:

Class	Scheduled Benefit
Members and their Dependent Spouses	All benefits for Covered Charges under Dental Care Units 1, 2 and 3
Dependent Children	All benefits for Covered Charges under Dental Care Units 1, 2, 3, and 4

(However, benefits for Covered Charges under Dental Care Units 2, 3, and 4 will be limited if you or if any of your Dependents become covered under the Deferred Coverage provision described on page GH 602.)

Dental Care Units

The type of Treatment or Service covered under each of the Dental Care Units is:

Preventive Procedures	Unit 1
Basic Procedures	Unit 2
Major Procedures	Unit 3
Orthodontia	Unit 4

Benefits Payable

Covered Charges under each Dental Care Unit will be the actual cost charged to you or your Dependent for the listed procedures shown in the SCHEDULE OF DENTAL PROCEDURES Section up to the maximum allowance for each procedure.

Dental benefits payable for Treatment or Service received each calendar year will be:

- Dental Care Unit 1
  100% of Covered Charges up to the Dental Maximum Payment Limit;

- Dental Care Unit 2
  80% of Covered Charges in excess of the Deductible Amount up to the Dental Maximum Payment Limit;

- Dental Care Unit 3
  50% of Covered Charges in excess of the Deductible Amount up to the Dental Maximum Payment Limit;

- Dental Care Unit 4
  50% of Covered Charges in excess of the Deductible Amount up to the Dental Maximum Payment Limit.

Deductible Amount(s)

The individual Deductible Amount for you and for each of your Dependents each calendar year will be:

- none for Covered Charges under Dental Care Unit 1; and
- $50 of Covered Charges under Dental Care Units 2 and 3 (in combination); and
- $50 of Covered Charges under Dental Care Unit 4.

Charges are applied to the Deductible Amount in the order in which they are incurred. However, if Covered Charges are incurred for Units 1, 2, and 3 on the same date, the charges will be applied to the Deductible Amount in the following order:

- first, to Unit 1 charges; and
- then, to Unit 2 charges; and
- last, to Unit 3 charges.

Covered Charges used to satisfy the Dental Care Unit 4 Deductible Amount cannot be used to satisfy the Deductible Amount for Units 1, 2, and 3, and vice versa.

In place of individual Deductibles, a family maximum Deductible may be applied. When this family maximum is satisfied for a calendar year, Dental benefits will be payable as if the individual Deductibles had been satisfied for each person in your family. The family maximum Deductible each calendar year will be:

- none for Covered Charges under Dental Care Unit 1; and
- a combined family total of $150 of Covered Charges under Dental Care Units 2 and 3 (but not counting more than $50 for any one person in your family); and
- none for Covered Charges under Dental Care Unit 4.

Maximum Payment Limit

The Dental Maximum Payment Limits for you and for each of your Dependents will be:

- Dental Care Units 1, 2, and 3 (in combination) each calendar year $1,000; and
- Dental Care Unit 4 $1,000 per lifetime.

Dental Treatment Plan

When charges for a Period of Dental Treatment (other than Emergency Treatment) are expected to exceed $300 for you or any one of your Dependents, you must file a Dental Treatment Plan with Us before treatment begins as described in the CLAIM PROCEDURES Section.

HOW TO BE INSURED - MEMBERS

DENTAL EXPENSE INSURANCE

Eligibility

To be eligible for insurance you must be a Member.

Member means any PERSON who is a Full-Time Employee of the Policyholder.

You will be eligible on the date you complete three consecutive months of continuous Active Work.

If you elect to waive insurance under the Group Policy because you are covered under group dental expense coverage or coverages provided by your Dependent's employer, the date such coverage terminates because your Dependent is no longer eligible under his/her employer's coverage will be considered the date you are eligible to request insurance as described in this section. Termination of coverage that has been continued under any state or federal continuation provisions will not be considered as a qualifying event for the purpose of these provisions.

Effective Dates - Actively at Work

If you are not Actively at Work on the date your insurance would otherwise be effective, your insurance will not be in force until the day you return to Active Work.

This Actively at Work requirement will be waived for you if:

- you are absent from Active Work because of a regularly scheduled day off, holiday, or vacation day; and
- you were Actively at Work on your last scheduled work day before the date of your absence; and
- you were capable of Active Work on the day before the scheduled effective date of your insurance or change in your insurance, whichever is applicable.

Individual Incontestability

All statements made by any person insured (you or one of your Dependents) will be representations and not warranties. In the absence of fraud, these statements may not be used to contest the insured person's insurance unless:

- the insurance has been in force for less than two years during the insured person's lifetime; and
- the statement is in written form signed by the insured person; and
- a copy of the form which contains the statement is given to the insured person or the insured person's beneficiary at the time insurance is contested.

However, the above will not preclude the assertion at any time of defenses based upon the person's not being eligible for insurance under the Group Policy or upon other provisions of the Group Policy.

In addition, if a person's age is misstated, We may, at any time, adjust premiums and benefits to reflect the correct age.

Effective Date for Initial Insurance

You must request insurance in a form provided by Us.

Your insurance will normally be in force on:

- the date you are eligible, if you make your request on or before that date; or

- the date of your request, if you make your request within 31 days after the date you are eligible; or

- the later of: (1) the date all other insurance under your plan is effective for you; or (2) the date of your request, if you make your request more than 31 days after the date you are eligible.

If you request contributory insurance more than 31 days after the date you are eligible but as a result of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN), your insurance will become effective as described below.

However, if you are not Actively at Work on the date insurance would otherwise be effective, your insurance will not be in force until the date you return to Active Work.

In addition, your Dental Expense Insurance will be subject to the Deferred Coverage Limits described on page GH 602.

Court Ordered Coverage Under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN): Deferred Coverage Limits as described on page GH 602 will not apply to you or your Dependent Child if:

- you are enrolled (or eligible to be enrolled but have failed to enroll during a previous enrollment period); and

- you failed to enroll your Dependent Child during a previous enrollment period; and

- you are required by a QMCSO or NMSN as defined by applicable federal law and state insurance laws to provide dental coverage for your Dependent Child.

The request for enrollment:

- may be made at any time after the issue date of the QMCSO or NMSN; and

- will apply only to you and/or Dependent Child(ren) listed in the QMCSO or NMSN.

The effective date for your or your Dependent Child's insurance:

- will be the date of the request for enrollment; and

- will not be subject to the Actively at Work provisions described in this section.

A request for enrollment for any Dependent not listed in the QMCSO or NMSN will be subject to the regular effective date provisions of this Group Policy.

A copy of the procedures governing qualified medical child support orders (QMCSO) can be obtained from the plan administrator without charge.

Effective Date for Benefit Changes

A change in your Scheduled Benefit amount because of a change in your status (insurance class) will normally be effective on the date of the change in status.

A change in your Scheduled Benefit amount because of a change in benefits provided under the Group Policy will normally be effective on the date of the change.

However, if you are not Actively at Work on the date the change would otherwise be effective, the change will not be in force until the day you return to Active Work.

Termination

Unless continued as provided below or on GH 117 A, GH 117 B, GH 117 C, and GH 117 D, your insurance under the Group Policy will cease on the earliest of:

- the date the Group Policy terminates; or
- the date you cease to belong to a class for which insurance is provided; or
- the date you cease to be a Member; or
- the date you cease Active Work.

Termination for Fraud

We may at any time terminate a person's eligibility under the Group Policy:

- in writing and with 31-day notice, if the individual submits any claim that contains false or fraudulent elements under state or federal law; or
- in writing and with 31-day notice, upon finding in a civil or criminal case that an individual has submitted claims that contain false or fraudulent elements under state or federal law; or
- in writing and with 31-day notice, when an individual has submitted a claim which, in good faith judgment and investigation, an individual knew or should have known, contains false or fraudulent elements under state or federal law.

Continuation

If you cease Active Work because of sickness or injury, you may be eligible for limited continuation of insurance until the earlier of the date you recover or the date insurance would otherwise terminate as described above.

If you cease Active Work because of layoff or leave of absence, insurance may be continued on a limited basis.

In addition, by paying the required contribution, if any, your insurance may be continued under the continuation provisions described on GH 117 A, GH 117 B, GH 117 C, and GH 117 D.

If you are interested in continuing your insurance beyond the date it would normally terminate, you should consult with the Policyholder before your insurance terminates.

HOW TO BE INSURED - DEPENDENTS

DENTAL EXPENSE INSURANCE

Eligibility

You will be eligible for insurance for your Dependents on the later of:

- the date you are eligible for Member insurance; or
- the date you first acquire a Dependent.

If your Dependent is employed and is covered under group coverage provided by your Dependent's employer, the date such coverage is terminated because your Dependent is no longer eligible under his/her employer's plan will be considered the date you first acquire that Dependent (and any other Dependent who was also covered under such coverage). Termination of coverage that has been continued under any state or federal continuation provisions will not be considered as a qualifying event for the purpose of these provisions.

You may elect to waive insurance for your Dependent Child until 31 days after the child's third birthday. If request for insurance is more than 31 days after your Dependent Child's third birthday, benefits will be subject to the Deferred Coverage Limits described on page GH 602.

Effective Date

Dependent insurance is available only with respect to Dependents of Members currently insured for Member insurance. If a Member is eligible for Dependent insurance, such insurance for your Dependents will be in force under the same terms (including application of Deferred Coverage Limits) as described earlier for Member insurance, except:

- Insurance will not be effective unless you are insured for Member insurance.
- A Dependent acquired after your Dependent insurance is already in force will be insured on the date acquired.
- The Actively at Work requirement does not apply to your Dependents.

In addition, your Dependent Dental Expense Insurance will be subject to the Deferred Coverage Limits described on page GH 602.

Individual Incontestability

Your Dependents will be subject to the Individual Incontestability as described earlier for Member insurance.

Termination

Unless continued as provided below or on GH 117 A, GH 117 B, GH 117 C, and GH 117 D, insurance for all of your Dependents will terminate on the earlier of:

- the date Dependent insurance is removed from the Group Policy; or
- the date your Member insurance ceases.

Insurance for any one Dependent will terminate on the date he or she ceases to be your Dependent.

However, Dental Expense Insurance will be continued beyond the maximum age for a Dependent Child who is incapable of self-support because of a Developmental Disability or Physical Handicap and is dependent on you for primary

support. You must apply for this continuation within 31 days after the child reaches the maximum age.

The custodian parent will be notified if your Dependent Child's coverage is modified or terminated.

Termination for Fraud

Your Dependents will be subject to the Termination for Fraud provisions as described earlier for Member insurance.

Continuation

In addition, under certain conditions, your Dependent's Dental Expense Insurance may be continued after the date it would normally terminate. See the continuation provisions described on page GH 117 A, GH 117 B, GH 117 C, and GH 117 D.

Dependents who Lose Eligibility Due to Your Death

If you should die while insured, your Dependent's Dental Expense Insurance will be continued without contributions until the earlier of:

- the date the Group Policy terminates; or
- the date insurance has been continued for three months.

If insurance under the Group Policy is subject to COBRA, this continuation period will be concurrent with the COBRA continuation period.

Federal Required Continuation - Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA applies to any employer (except the federal government and religious organizations) that: (a) maintains group health coverage; and (b) normally employed 20 or more employees on a typical business day during the preceding calendar year. For this purpose, "employee" means full-time employees and full-time equivalent for part-time employees.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that your group insurance allow qualified persons (described below) to continue group health coverage after it would normally end. The term "group health coverage" includes any medical, dental, vision care, and prescription drugs coverages that are part of your insurance.

A. Qualified Persons/Qualifying Events

Continuation of group health coverage must be offered to the following persons if they would otherwise lose that coverage as a result of the following events:

(1) a Member (and any covered Dependents) following the Member's:

(a) termination of employment for a reason other than gross misconduct; or

(b) a reduction in work hours.

(Note: Taking a family or medical leave under the Federal Family & Medical Leave Act (FMLA) is not a qualifying event under COBRA. A Member qualifies for COBRA when the Member does not return to work after the end of FMLA leave); and

(2) a Member's former spouse (and any Dependent Children) following a divorce or legal separation from the Member; and

(3) a Member's surviving spouse (and any Dependent Children), following the Member's death; and

(4) a Member's Dependent Child following loss of status as a Dependent under the terms of the Group Policy (e.g., attaining the maximum age, marriage, joining the armed forces, etc.); and

(5) a Member's spouse (and any Dependent Children) following the Member's entitlement to Medicare; and

(6) a Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation due to termination of employment or reduction in work hours; and

(7) if the Group Policy covers retired Members, a retired Member and his/her Dependents (or surviving Dependents) when retiree dental benefits are "substantially eliminated" or terminated within one year before or after the employer files Chapter 11 (United States Code) bankruptcy proceedings.

B. Maximum Continuation Period

Following a qualifying event, health coverage can continue up to the maximum continuation period. The maximum continuation period for a Member (and any Dependents) following a termination of employment or reduction in work hours is 18 months. The maximum continuation period for a Member's Dependent Child that is born to or placed for adoption with the Member while on COBRA continuation will extend to the end of the Member's maximum continuation period.

Following a termination of employment or reduction in work hours, a qualified person may request an 11-month

extension of COBRA continuation. The maximum COBRA continuation will be 29 months (see Disabled Extension, Section D).

When a Member becomes entitled to Medicare before employment terminates or work hours are reduced, the maximum continuation period for the Dependents will be the longer of:

(1) 36 months dating back to the Member's entitlement to Medicare; or

(2) 18 months from the date of the qualifying event (termination of employment or reduction in work hours).

The maximum continuation period for qualified Dependents following a qualifying event described in A (2) through A (5) is 36 months.

If the Group Policy covers retired Members and the qualifying event is the employer's bankruptcy filing, the following rules apply:

(1) If the retired Member is alive on the date of the qualifying event, the retired Member and his or her spouse and Dependent Children may continue coverage for the life of the retired Member. In addition, if the retired Member dies while covered under COBRA, the spouse or Dependent Children may continue coverage for an additional 36 months.

(2) If the retired Member is not alive on the date of the qualifying event, his or her spouse may continue coverage to the date of his or her death.

C. Second Qualifying Events

If during an 18-month continuation period (or, 29 months for qualified persons on the disabled extension), a second qualifying event described in A (2) through A (5) occurs, the maximum continuation period may be extended for the qualified Dependents up to 36 months. That is, following a second qualifying event, qualified Dependents may continue for up to a maximum of 36 months dating from the Member's termination of employment or reduction in work hours. The extension is only available if the second qualifying event described in A (2) through A (5), absent the first qualifying event, would result in a loss of coverage for Dependents under the Group Policy. A Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation may also be eligible for a second qualifying event that occurred prior to birth or placement for adoption.

D. Disabled Extension

Following a termination of employment or reduction in work hours, a qualified person (Member or Dependent) who has been determined disabled by the Social Security Administration either before or within 60 days after the qualifying event may request an extension of the continued coverage from 18 months to 29 months. A Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation must be determined disabled by the Social Security Administration within 60 days after the date of birth or placement for adoption. The disabled extension also applies to each qualified person (the disabled person and any family members) who is not disabled and who is on COBRA continuation as a result of termination of employment or reduction in work hours.

The 11-month extension for all qualified persons will end the earlier of (a) 30 days following the date the disabled person is no longer determined by Social Security to be disabled, or (b) the date continuation would normally end as outlined in Section E below.

E. Termination of Continued Coverage

Continued coverage ends the earliest of the following:

(1) the date the maximum continuation period ends; or

(2) the date the qualified person enrolls in Medicare; however, this does not apply to a person who is already enrolled in Medicare on the date he or she elects COBRA or to a person who is on COBRA due to the employer's bankruptcy filing as described in A (7); or

(3) the end of the last coverage period for which payment was made if payment is not made prior to the expiration of the grace period. (See Grace Period, Section I.); or

(4) the date the Group Policy is terminated (and not replaced by another group dental plan); or

(5) the date the qualified person becomes covered by and has satisfied the preexisting exclusion provision of another group dental plan; however, this does not apply to a person who is already covered by the other group dental plan on the date he or she elects COBRA.

Note: Persons who, after the date of COBRA continuation election, become entitled to Medicare or become covered under another group dental plan and have satisfied the preexisting exclusion provision, are not eligible for continued coverage. However, if the Group Policy covers retired Members, continued coverage for retired persons and their Dependents (or surviving Dependents) due to qualifying event A (7) above may not be terminated due to Medicare coverage.

F. Employer/Plan Administrator Notification Requirement

When a Member or Dependent become ineligible and loses group dental coverage due to termination of employment, reduction in work hours, death of the Member, the Member's entitlement to Medicare, or if the Group Policy covers retired Members, the commencement of the employer's Chapter 11 (United States Code) bankruptcy proceedings, the employer must notify the plan administrator of the qualifying event. The plan administrator must notify the qualified person of the right to COBRA continuation within 14 days after receiving notice of a qualifying event from the employer.

G. Qualified Person Notice and Election Requirement

Qualified persons must notify the plan administrator within 60 days after (a) the date of a qualifying event (i.e., divorce, legal separation, or a child ceases to be a Dependent Child under the terms of the Group Policy); (b) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (c) the date the qualified person is first informed of this notice obligation; otherwise the right to COBRA continuation ends. This 60-day notice period applies to initial and second qualifying events.

Qualified persons who request an extension of COBRA due to disability must submit a written request to the plan administrator before the 18-month COBRA continuation period ends and within 60 days after the latest of the following dates: (a) the date of disability determination by the Social Security Administration; (b) the date of the qualifying event; (c) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (d) the date the qualified person is first informed of this notice obligation; otherwise the right to the disabled extension ends. Qualified persons must also notify the plan administrator within 30 days after the date the Social Security Administration determines the qualified person is no longer disabled.

Notification of a qualifying event to the plan administrator must be in writing and must include the following information: (a) name and identification number of the Member and each qualified beneficiary; (b) type and date of initial or second qualifying event; (c) if the notice is for an extension due to disability, a copy of any letters from the Social Security Administration and the Notice of Determination; and (d) the name, address and daytime phone number of the qualified person (or legal representative) that the plan administrator may contact if additional information is needed to determine COBRA rights.

Within 14 days after receiving notice of a qualified event from the qualified person, the plan administrator must provide the qualified person with an election notice.

Qualified persons must make written election within 60 days after the later of: (a) the date group health coverage would normally end; or (b) the date of the plan administrator's election notice. The election notice must be returned to the plan administrator within this 60-day period; otherwise the right to elect COBRA continuation

ends.

Each qualified person has an independent right to elect COBRA. A covered Member may elect COBRA continuation on behalf of his/her covered spouse. A covered Member, parent, or legal guardian may elect COBRA continuation on behalf of his/her covered Dependent Children.

To protect COBRA rights, the plan administrator must be informed of any address changes for covered Members and Dependents. Retain copies of any notices sent to the plan administrator.

H. Monthly Cost

Persons electing continued coverage can be required to pay 102% of the cost for the applicable coverage (COBRA permits the inclusion of a 2% billing fee). Persons who qualify for the disabled extension and are not part of the family unit that includes the disabled person can be required to continue to pay 102% of the cost for the applicable coverage during the disability extension. Persons who qualify for the disabled extension and are part of the family unit that includes the disabled person can be required to pay 148% of the cost for the applicable coverage (plus a 2% billing fee) for the 19th through the 29th month of coverage (or through the 36th month if a second qualifying event occurs during the disabled extension).

I. Grace Period

Qualified persons have 45 days after the initial election to remit the first payment. The first payment must include all payments due when sent. All other payments (except for the first payment) will be timely if made within the Grace Period. "Grace Period" means the first 31-day period following a premium due date. Except for the first payment, a Grace Period of 31 days will be allowed for payment of premium. Continued coverage will remain in effect during the Grace Period provided payment is made prior to the expiration of the Grace Period. If payment is not made prior to the expiration of the Grace Period, continued coverage will terminate at the end of the last coverage for which payment was made.

J. Policy Changes

Continued coverage will be subject to the same benefits and rate changes as the Group Policy.

K. Newly Acquired Dependents

A qualified person may elect coverage for a Dependent acquired during COBRA continuation. All enrollment and notification requirements that apply to Dependents of active Members apply to Dependents acquired by qualified persons during COBRA continuation.

Coverage for a newly acquired Dependent will end on the same dates as described for qualified persons in Section B above. Exception: Coverage for newly acquired Dependents, other than the Member’s Dependent Child who is born to or placed for adoption with the Member, will not be extended as a result of a second qualifying event.

L. Contact Information

To notify the plan administrator of an initial or second qualifying event, request a disabled extension, request termination of COBRA, change of address, or request additional information concerning the Group Policy or COBRA, contact the following:

PICKERING ASSOCIATES INC Insurance Plan
PICKERING ASSOCIATES INC Benefits Department
7845 EMERSON AVE
PARKERSBURG WV 26104
304-464-5305

FEDERAL FAMILY AND MEDICAL LEAVE ACT (FMLA)

Continuation

Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

This is a general summary of the FMLA and how it affects the Group Policy. See your employer for details on this continuation provision.

FMLA and Other Continuation Provisions

If your employer is an Eligible Employer and if the continuation portion of the FMLA applies to your coverage, these FMLA continuation provisions:

- are in addition to any other continuation provisions of the Group Policy, if any; and
- will run concurrently with any other continuation provisions of the Group Policy for sickness, injury, layoff, or approved leave of absence, if any.

Eligible Employer

Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year.

Eligible Employee

Eligible Employee means an employee who has worked for the Eligible Employer:

- for at least 12 months; and
- for at least 1,250 hours (approximately 24 hours per week) during the year preceding the start of the leave; and
- at a worksite where the Eligible Employer employs at least 50 employees within a 75-mile radius.

For this purpose, "employs" has the meaning provided by the Federal Family and Medical Leave Act (FMLA).

Mandated Unpaid Leave

Eligible Employers are required to allow 12 workweeks of unpaid leave during any 12-month period to Eligible Employees for one or more of the following reasons:

- The birth of a child of an Eligible Employee and in order to care for the child.
- The placement of a child with the Eligible Employee for adoption or foster care.
- To care (physical or psychological care) for the spouse, child, or parent of the Eligible Employee, if they have a "serious health condition."
- A "serious health condition" that makes the Eligible Employee unable to perform the functions of his or her job.

Reinstatement

An Eligible Employee's terminated coverage may be reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA), subject to the Actively at Work requirements of the Group Policy.

See your employer for details on this reinstatement provision.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

Federal law requires that if your insurance would otherwise end because you enter into active military duty or inactive military duty for training, you may elect to continue insurance (including Dependents insurance) in accordance with the provisions of Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Continuation

If Active Work ends because you enter active military duty, insurance may be continued until the earliest of:

- for you and your Dependents:
    - the date the Group Policy is terminated; or
    - the end of the premium period for which premium is paid if you fail to make timely payment of a required premium; or
    - the date 24 months after the date you enter active military duty; or
    - the date after the day in which you fail to return to Active Work or apply for reemployment with the Policyholder.
- for your Dependents:
    - the date Dependent Dental Expense Insurance would otherwise cease as provided on GH 126; or
    - any date desired, if requested by you before that date.

The continuation provision will be in addition to any other continuation provisions described in the Group Policy for sickness, injury, layoff, or approved leave of absence, if any.

Reinstatement

For Dental Expense Insurance, the reinstatement time period may be extended for an approved leave of absence taken in accordance with the provisions of the federal law regarding USERRA. The Actively at Work provision, described in the Group Policy, will not apply to the reinstated insurance.

This is a general summary of the USERRA and how it affects your Group Policy. See your employer for details on this continuation provision.

DESCRIPTION OF BENEFITS

DENTAL EXPENSE INSURANCE
(PAYMENT PROVISIONS)

Benefit Qualification

To qualify for payment of the benefits provided by your plan for an insured class, you and your Dependents must:

- be insured in that class on the date dental Treatment or Service is received; and
- file a Dental Treatment Plan with Us before treatment begins when charges for a Period of Dental Treatment (other than Emergency Treatment) are expected to exceed $300; and
- satisfy the requirements listed in the CLAIM PROCEDURES Section.

Benefits Payable

Benefits payable will be as described in this section, subject to:

- all listed limitations; and
- the terms and conditions of COORDINATION WITH OTHER BENEFITS.

Payment Conditions

If you or one of your Dependents receive any Treatment or Service that is listed in the Schedule of Dental Procedures, We will pay Dental benefits for Covered Charges:

- in excess of the Deductible Amount(s); and
- at the payment percentage(s) indicated; and
- to the maximum allowances (indicated in the Schedule of Dental Procedures) and Maximum Payment Limits;

as described in the SUMMARY OF BENEFITS Section.

Deferred Coverage Limits (for request more than 31 days after (1) the date eligible; or (2) the date you elect to terminate insurance)

Other than coverage as required under a QMCSO or NMSN as described on page GH 116, if you request insurance for you or your Dependent more than 31 days after the date the person is eligible, or you elect to terminate insurance and more than 31 days later request to be insured again, during the first 24 months in which insurance is in force, benefits will be limited as follows:

- During the first 12 months, benefits will be payable only for Dental Care Unit 1 (Preventive Procedures) Covered Charges.
- During the second 12 months, benefits will be payable only for Dental Care Unit 1 (Preventive Procedures) Covered Charges and Dental Care Unit 2 (Basic Procedures) Covered Charges.

After insurance has been in force for 24 consecutive months, benefits will be payable for charges incurred for Covered Charges under Dental Care Units 1, 2, 3, and 4.

These Deferred Coverage provisions will not apply to Covered Charges incurred for an Accidental Injury that results from an accident that occurred on or after your insurance or your Dependent's insurance became effective.

Covered Charges

Covered Charges will be the actual cost charged to you or your Dependent for Treatment or Service for the listed procedures shown in the SCHEDULE OF DENTAL PROCEDURES Section up to the maximum allowance for each procedure. Also:

- If We determine that more than one procedure could be performed to correct a dental condition, Covered Charges will be limited to the maximum allowance for the least expensive of the procedures that would provide professionally acceptable results.
- Covered Charges will include only those charges for Treatment or Service that begins (see below) while you and your Dependents are insured under the Group Policy.
- Covered Charges will include only those charges for Treatment or Service that is completed while you and your Dependents are insured under the Group Policy (except when the Treatment or Service is covered under the Extended Benefits provision).

Beginning Date for Treatment or Service

Treatment or Service will be considered to begin:

- for root canal therapy, on the date the pulp chamber is opened, and the pulp canal explored to the apex; and
- for crowns, fixed bridgework, inlays or onlay restoration, on the date the tooth or teeth are fully prepared; and
- for complete or partial dentures, on the date the master impression is made; and
- for orthodontia, on the date the appliance or bands are first set; and
- for all other, on the date the Treatment or Service is performed.

Completion Date for Treatment or Service

Treatment or Service will be considered to be completed:

- for crowns, on the date the crown is seated; and
- for fixed bridgework, on the date the bridge is seated; and
- for inlay or onlay restorations, on the date the inlay or onlay is seated; and
- for complete or partial dentures, on the date the complete or partial denture is seated.

Limitations

Dental Covered Charges will not include and no benefits will be paid for:

- Treatment or Service that is not for Necessary Dental Care; or
- any part of a charge for Treatment or Service that exceeds Prevailing Charges; or
- the services of any person who is not a Dentist or Dental Hygienist; or
- the services of any person in your Immediate Family or any person in your Dependent's Immediate Family; or
- personalization of dentures or crowns (or any other treatment that is primarily cosmetic); or
- Treatment or Service that does not meet professionally recognized standards of quality; or
- implants; or
- drugs or medicines, other than antibiotic injections; or
- instructions for plaque control, oral hygiene, or diet; or
- bite registration or occlusal analysis; or
- Treatment or Service to alter or maintain vertical dimension or restore or maintain occlusion; or
- Treatment or Service to duplicate or replace a lost or stolen prosthetic device or to duplicate or replace a lost or stolen appliance; or
- Treatment or Service for provisional or permanent splinting; or

- Orthodontic Treatment or Service received within 24 months after your Dependent Child's Dental Expense Insurance is effective, unless the appliance or bands were first inserted on or after the effective date; or

- Treatment or Service that results:

    - from an injury arising out of or in the course of any employment for wage or profit if the Member or Dependent is eligible to be covered under a Workers' Compensation Act or other similar law; except that this limitation will not apply to partners, proprietors, or corporate officers who are not covered by a Workers' Compensation Act or other similar law; or

    - from a sickness covered by a Workers' Compensation Act or other similar law; or

- Treatment or Service that is temporary; or

- Treatment or Service replacing tooth structure lost from abrasion or attrition; or

- Treatment or Service which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years; or

- Treatment or Service provided outside the United States, unless you or your Dependent are outside the United States for one of the following reasons:

    - travel, provided the travel is for a reason other than securing dental care diagnosis or treatment, and travel is for a period of six months or less; or

    - a business assignment, provided you or your Dependent are temporarily outside the United States for a period of six months or less; or

    - Full-Time Student status, provided the student is either:

        - enrolled and attending an accredited school in a foreign country; or

        - is participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit; or

- Treatment or Service for which you or your Dependent have no financial liability or that would be provided at no charge in the absence of insurance; or

- Treatment or Service that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or

- Treatment or Service that results from war or act of war; or

- Treatment or Service for which benefits are payable under the Medical Expense Coverage of your plan; or

- Treatment or Service that results from participation in criminal activities.

SCHEDULE OF DENTAL PROCEDURES

Unless We agree otherwise, Covered Charges will include only charges for procedures listed in the Schedule of Dental Procedures. If a nonlisted procedure is accepted, We will determine its maximum allowance based on the maximum allowance for a listed procedure of comparable nature.

Dental Care Unit 1 - Preventive Procedures

Subject to the terms and conditions described under Payment Conditions in this section, the maximum allowance for each procedure described below will be the actual cost charged to you or your Dependent for Necessary Dental Care, but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Dental Procedure

Examinations

Oral examination (evaluation)
Periodic examination (evaluation)

Only one of the listed examinations will be covered in any six consecutive months.

Radiographs

Full mouth survey

Complete series (including bitewings)
Panoramic

Only one of the listed full mouth surveys will be covered in any 60 consecutive months.

Bitewing

For Dependent Children under age 18, only one set will be covered in any six consecutive months.

For adults 18 years of age or older, only one set will be covered in any 12 consecutive months.

Occlusal
Periapical
Extraoral X-Rays

Sialography
TMJ
Cephalometric film
Posterior-anterior or lateral skull and facial bone survey
Other extraoral

Only one of the listed extraoral procedures will be covered in any six consecutive months.

Diagnostic x-rays performed in conjunction with root canal therapy or orthodontic treatment will not be considered Unit 1 Covered Charges.

Preventive Services

Prophylaxis (cleaning of teeth)

Covered once in any six consecutive months.

Topical application of fluoride

Applicable only to Dependent Children under age 16. Only one application will be covered in any 12 consecutive months.

Space maintainers

Applicable only to Dependent Children under age 16. Repairs to space maintainers are not covered.

Topical application of sealants

Applicable only to first and second permanent molars for Dependent Children under age 16. Covered once each tooth in any 36 consecutive months.

Other Services

Harmful habit appliance

Limited to one time per person under the age of 16.

Subject to the terms and conditions described under Payment Conditions in this section, the maximum allowance for each procedure described below will be the actual cost charged to you or your Dependent for Necessary Dental Care, but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Dental Procedure

Restorations

Fillings (amalgam, silicate, plastic, or composite).

> Multiple restorations on one surface will be paid as a single filling. Replacement of existing fillings are covered only if at least 24 consecutive months have passed since placement of prior filling, unless required by new decay in an additional tooth surface. Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations.

Stainless steel crown

Oral Surgery

Extraction of teeth
Alveoloplasty
Removal of dental cysts and tumors
Surgical incision and drainage of dental abscess

Other Surgical Procedures

Surgical exposure to aid eruption
Excision of hyperplastic tissue

Periodontic Services

Scaling and root planing (each quadrant)

> Covered once each quadrant in any 24 consecutive months.

Periodontal appliance

> One appliance is covered in any 36 consecutive months.

Periodontal prophylaxis (including probing, charting, exam, polishing, scaling, root planing and similar maintenance procedures).

> Covered only if at least three months have elapsed after completion of active therapeutic scaling and root planing or active surgical periodontal treatment and then not more than once in 12 consecutive months.

Endodontic Services

Vital pulpotomy

> Covered for deciduous teeth only

Root canal therapy including treatment plan, diagnostic x-rays, clinical procedures, and follow-up care.

Apexification
Apicoectomy
Retrograde filling
Root resection
Hemisection

Anesthesia

General anesthesia
IV sedation

General anesthesia or IV sedation is covered as a separate procedure only when required for complex oral surgical procedures covered under the Group Policy (and only when performed in a dental office).

Other Services

Emergency exam

Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

Consultation with specialist

Covered once in any 12 consecutive months.

Antibiotic drug injection
Biopsy of oral tissue
Palliative treatment

Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

Bacteriologic culture
Histopathologic examination

Subject to the terms and conditions described under Payment Conditions in this section, the maximum allowance for each procedure described below will be the actual cost charged to you or your Dependent, but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Dental Procedure

Periodontal Surgical Procedures

Gingival flap procedure
Gingivectomy
Gingival curettage
Osseous surgery
Pedicle soft tissue graft
Free soft tissue graft

Only one of the listed periodontic surgical procedures is covered for each quadrant in any 24 consecutive months.

Other Services

Recementing

Inlay
Onlay
Crown
Bridgework

Covered only if done more than 12 months after initial insertion of inlay, onlay, crown, or bridge, and then not more than one time in any 24 consecutive months.

Repairs to complete or partial denture, bridge, or crown

Covered only if repair is done more than 12 months after initial insertion of denture, bridge, or crown, and then not more than one time in any 24 consecutive months.

Relining or rebasing complete or partial dentures

Covered only if relining or rebasing is done more than 12 months after initial insertion of the denture and then not more than one time in any 24 consecutive months.

Tissue conditioning

Covered only if at least 12 months have elapsed since the insertion of a complete or partial denture and not more than once in any 24 consecutive months.

Denture adjustment

Covered once in any 12 consecutive months and only if at least 12 months have elapsed since the insertion of the denture.

Restorations

Inlays and onlays

Inlay or onlay restorations are covered only if the tooth cannot be restored by a filling and (for replacements) at least seven years (84 consecutive months) have elapsed since the last placement.

Labial veneer

Veneer restorations are covered only if the tooth cannot be restored by a filling and (for replacements) at least seven years (84 consecutive months) have elapsed since the last placement.

Crowns (single restorations only)

Resin (laboratory)
Resin, prefabricated
Resin with nonprecious metal
Resin with semiprecious metal
Resin with gold
Porcelain
Porcelain with nonprecious metal
Porcelain with semiprecious metal
Porcelain with gold
Gold (3/4 cast)
Gold (full cast)
Nonprecious metal (full cast)
Semiprecious metal (full cast)

Crowns are covered only if the tooth cannot be restored by a filling and (for replacements) at least seven years (84 consecutive months) have elapsed since the last placement. Crowns for the primary purpose of splinting, altering, or maintaining vertical dimension, or restoring occlusion are not covered. Crowns for the replacement of veneer, inlay or onlay are covered only if at least seven years (84 consecutive months) have elapsed since the last placement of the restoration. Crowning of implant replacing a tooth missing prior to the effective date is not covered. For persons under 16 years of age, the benefit for crown on vital teeth are limited to resin or stainless steel crowns.

Cast post and core

Covered only for teeth that have had root canal therapy.

Steel post and composite or amalgam

Covered only for teeth that have had root canal therapy.

Prosthodontics, Fixed

Fixed bridges - initial placement or replacement

Initial placement of fixed bridges to replace teeth which were missing prior to the effective date of the insured person's insurance will not be covered unless it includes the replacement of a Functioning Natural Tooth extracted while the person is insured under the Group Policy (provided that tooth was not an abutment to an existing partial denture that is less than five years old). In that event, benefits are payable only for the replacement of those teeth which were extracted while insured under the Group Policy.

Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge is more than seven years old (84 consecutive months) and is not serviceable and cannot be repaired.

Prosthodontics, Removable

Complete or partial dentures - initial placement or replacement

Initial placement of complete or partial dentures to replace teeth which were missing prior to the effective date of the insured person's insurance will not be covered unless it includes the replacement of a Functioning Natural Tooth extracted while person is covered under the Group Policy. In that event, benefits are payable only for the replacement of those teeth which were extracted while insured under the Group Policy.

Benefits for the replacement of an existing complete or partial denture are payable only if the existing denture is more than five years old (60 consecutive months) and is not serviceable and cannot be repaired.

Covered Charges for complete or partial dentures do not include any additional charges for overdentures or for precision or semiprecision attachments.

Dental Care Unit 4 - Orthodontia (For Dependent Children Only)

Subject to the terms and conditions described under Payment Conditions in this section, the maximum allowance for the orthodontic services described below will be the actual cost charged to you or your Dependent for Necessary Dental Care, but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Orthodontic Services

Formal, full-banded retention and treatment, including x-rays and other diagnostic procedures.

Removable or fixed appliances for tooth or bony structure guidance or retention.

DENTAL EXPENSE INSURANCE

EXTENDED BENEFITS (after termination of insurance)

If Dental Expense Insurance under the Group Policy ceases and if you or your Dependents qualify, We will pay for:

- root canal therapy, but only if the pulp chamber was opened and the pulp canal explored to the apex while you or a Dependent were insured under the Group Policy; and

- crowns, bridges, inlays, or onlay restorations, but only if the tooth or teeth were fully prepared while you or a Dependent were insured under the Group Policy; and

- complete or partial dentures, but only if the master impression was made while you or a Dependent were insured under the Group Policy; and

- orthodontia, but only if the appliance or bands were first set while the Dependent Child was insured under the Group Policy. The amount payable will be the part of the quarterly payment that would have been payable had insurance remained in force during the period extended benefits are payable;

provided the Treatment or Service is received within 30 days after your insurance or a Dependent's insurance terminates.

You or a Dependent will qualify if:

- you or a Dependent would have qualified for benefit payment under the Group Policy had insurance remained in force; and

- the Treatment or Service began while you or a Dependent were insured under the Group Policy; and

- the Group Policy is in force at the time Treatment or Service is received.

However, no extended benefits will be paid for Treatment or Service received on or after the date you or your Dependents become eligible for other group dental expense coverage.

COORDINATION WITH OTHER BENEFITS

DENTAL EXPENSE INSURANCE

Applicability

These Coordination of Other Benefits (COB) provisions apply to This Plan when you or one of your Dependents have dental care insurance under more than one Plan. "Plan" and "This Plan" are defined below.

If the COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

- will not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but
- may be reduced when, under the order of benefits determination rules, another plan determines its benefits first.

Definitions

"Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment provided under:

- any insured or noninsured group, service, prepayment, or other program arranged through an employer, trustee, union, or association; and
- any program required or established by state or Federal law (including Medicare Parts A and B); and
- any program sponsored by or arranged through a school or other educational agency; and
- the first-party medical expense provisions of any automobile policy issued under a no-fault insurance statute and traditional fault-type contracts, including the self-insured equivalent of any minimum benefits required by law.

The term Plan will not include benefits provided under:

- individual or family insurance contracts;
- individual or family subscriber contracts;
- individual or family coverage through Health Maintenance Organizations (HMOs);
- individual or family coverage under other prepayment, group practice, and individual practice plans;
- group or group-type hospital indemnity benefits of $100 per day or less;
- student accident policy. These contracts cover grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour basis or on a "to and from school" basis; and
- a state plan under Medicaid, and will not include a law or plan when, by law, its benefits are in excess of those of any private insurance plan or other nongovernmental plan.

"This Plan" is the dental expense benefits described in this booklet.

"Primary Plan/Secondary Plan." The order of benefit determination rules state whether This Plan is a Primary or a Secondary Plan as to another plan covering the person.

- When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

- When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

- When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

"Allowable Expense" means a necessary, reasonable, and customary item of expense for dental care; when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

"Claim Determination Period" means the part of a calendar year during which you or a Dependent would receive benefit payments under This Plan if this section were not in force.

Effect on Benefits

Benefits otherwise payable under This Plan for Allowable Expenses during a Claim Determination Period may be reduced if:

- benefits are payable under any other Plan for the same Allowable Expenses; and

- the rules listed below provide that benefits payable under the other Plan are to be determined before the benefits payable under This Plan.

The reduction will be the amount needed to provide that the sum of payments under This Plan plus benefits payable under the other Plan(s) is not more than the total of Allowable Expenses.

For this purpose:

- benefits payable under other Plans will include the benefits that would have been paid had claim been made for them.

- for any person covered by Medicare Part A, benefits payable will include benefits provided by Medicare Part B, whether or not the person is covered under that Part B.

Order of Benefit Determination

General. Except as described below under Medicare Exception and Exception for Plans Issued Under the West Virginia Public Employees Insurance Act, the benefits payable of a Plan that does not have a coordination of benefits provision similar to the provision described in this section will be determined before the benefits payable of a Plan that does have such a provision. In all other instances, the order of determination will be:

Rules. This Plan determines its order of benefits using the first of the following rules which applies:

- Nondependent/Dependent. The Plan which covers the person as an employee, Member, or subscriber (that is, other than a Dependent) are determined before those of the Plan which covers the person as a Dependent. Exception: If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, 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 benefits of the Plan covering the person as a Dependent are determined before those of the Plan covering that person as other than a Dependent.

- Dependent Child--Parents Not Separated or Divorced. If a Dependent Child is covered by both parents' Plans, the Plan of the parent whose birthday falls earlier in the calendar year will be determined before those of the Plan of the parent whose birthday falls later in that year. But, if both parents have the same birthday or if the other Plan does not have a birthday rule, and as a result the Plans do not agree on the order of benefits, the benefits of the Plan which covered a parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

  However, if the other Plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- Dependent Child--Separated or Divorced Parents. If a Dependent Child of legally separated or divorced parents is covered under two or more Plans, benefits for the Dependent Child are determined in this order:

  - first, the Plan of the parent with custody of the child;

  - then, the Plan of the spouse of the parent with custody of the child; and

  - finally, the Plan of the parent not having custody of the child.

  However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the Dependent Child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply for any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the Dependent Child, the Plans covering the Dependent Child shall follow the order of benefit determination rules for Dependent Children of parents who are not separated or divorced.

- Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid-off nor retired are determined before those of a Plan which covers that person as a laid-off or retired employee. The same would hold true if a person is a Dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

- Continuation of Coverage. If coverage is provided for a person under a right of continuation according to Federal or state law and the person is also covered under another Plan, the following will be the order of benefit determination:

  - first, the benefits of a Plan covering the person as an employee, Member, or subscriber (or as that person's Dependent);

  - second, the benefits under the continuation coverage.

  If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

- Longer/Shorter Length of Coverage. If none of the above rules determine the order of benefits, the benefits of the Plan which covered an employee, Member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

Medicare Exception

Unless otherwise required by Federal law, benefits payable under Medicare will be determined before the benefits payable under the Group Policy.

Federal law will usually apply in such instances if:

- the benefits are applicable to an active (rather than a retired) Member or to that Member's spouse; and
- the Member's employer has 20 or more employees.

Exception for Plans Issued Under the West Virginia Public Employees Insurance Act

Benefits payable under the Group Policy will be determined before the benefits payable under a plan issued pursuant to the West Virginia Public Employees Insurance Act.

How COB Works

Example 1: The natural father is insured as a Member under This Plan. Company A covers the natural mother. Company B covers the stepfather. The natural mother has custody of the child and the divorce decree does not establish financial responsibility for dental care expenses.

The following order of benefits would apply to the child:

1. Company A would be Primary (mother's carrier).
2. Company B would be Secondary (stepfather's carrier).
3. We would then determine the benefits payable, if any, under This Plan.

Example 2: Mrs. Smith has filed a claim for $1,300 with both Company A and Company B. Company A insures Mrs. Smith as an employee under a plan which pays 80% of Covered Charges after a $50 calendar year deductible is satisfied. Company B insures her as a dependent spouse under a plan.

Both plans have a COB provision, therefore, Company A would pay first since it insures Mrs. Smith as an employee. Since Company A pays first, it calculates benefits in full as though duplicate coverage did not exist.

Company A

Allowable Expenses	$	1,300
Less Deductible	-	50
		1,250
x 80% coinsurance	x	80%
Benefit Payable	$	1,000

Once Company A has determined and paid its benefits, Mrs. Smith's claim is then considered by Company B. In calculating its benefit, Company B must include any expenses that would be allowable expenses under the Company A plan.

Company B

Allowable Expenses	$	1,300
Less Company A's benefit	-	1,000
Benefit Payable	$	300

CLAIM PROCEDURES

Notice of Claim

Written notice of claim must be given to Us within 20 days after the date of loss. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

Claim Forms

Claim forms and other information needed to prove loss must be filed with Us in order to obtain payment of benefits. The Policyholder will provide forms to assist you in filing claims. If the forms are not provided within 15 days after We receive such notice, you will be considered to have complied with the requirements of the Group Policy upon submitting, within the time specified below for filing proof of loss, written proof covering the occurrence, character, and extent of the loss.

Proof of Loss

Completed claim forms and other information needed to prove loss should be filed promptly. Written proof of loss should be sent to Us within 90 days after the date of loss. Proof required includes the date, nature, and extent of the loss. We may request additional information to substantiate your loss or require a signed unaltered authorization to obtain that information from the provider. Your failure to comply with such request could result in declination of the claim. We may also require x-rays, dental charts, and other evidence needed to determine the dental condition treated and the services provided.

Payment, Denial, and Review

The Employee Retirement Income Security Act (ERISA) permits up to 90 days for processing claims and up to 60 days for the review of denied claims.

In actual practice, benefits under this Group Policy may be payable sooner, provided We receive complete and proper proof of loss. Furthermore, if a claim is not payable or cannot be processed, We will submit a detailed explanation of the basis for its denial.

A claimant may request a review of a claim denial by written request to Us within 120 days of receipt of the notice of denial. The claimant must provide all additional information to Us within one year of the receipt of the notice of denial. We will notify the claimant of the final decision and reasons in support of its decision.

For purposes of this section, "claimant" means you or your Dependent.

Dental Treatment Plan

When charges for a Period of Dental Treatment (other than Emergency Treatment) are expected to exceed $300, a Dental Treatment Plan must be filed with Us before treatment begins. A form is available for this purpose. Upon receipt of the Dental Treatment Plan, We will indicate the benefits payable for the proposed treatment and return the form to the attending Dentist.

The filing of a Dental Treatment Plan is intended to help avoid any misunderstanding between you, the Dentist and Us as to how much will be paid for dental work. A Dental Treatment Plan is not a guarantee of what We will pay. It informs you and the Dentist, in advance, what We will pay for a covered dental service named in the Dental Treatment Plan. Payment is subject to the Benefit Qualifications as shown on the GH 600 page of this booklet. If We do not agree with a Dental Treatment Plan, or if one is not sent in, We have the right to base payments on treatment suited to your condition by accepted standards of dental practice.

Facility of Payment

We will normally pay all benefits (for other than orthodontia) to you. However, if the claimed benefits result from a Dependent's dental care, We may make payment to the Dependent. Orthodontia benefits will be payable as described below. Also, in the special instances listed below, payment will be as indicated. All payments so made will discharge Us to the full extent of those payments.

- If payment amounts remain due upon your death, those amounts may, at Our option, be paid to your estate, spouse, child, or parent, or a provider of dental services.

- If We believe a person is not legally able to give a valid receipt for a benefit payment, and no guardian has been appointed, We may pay whoever has assumed the care and support of the person.

Payment of Orthodontia Benefits

We will pay orthodontia benefits:

- immediately upon receipt of proof that the initial treatment (including setting of the appliance or bands) has been completed; and

- at the end of each following calendar quarter upon receipt of proof that the Period of Dental Treatment has continued.

The benefit amount payable for the initial treatment will be actual charges, but not more than 1/3 of the total estimated Covered Charges for the entire Period of Dental Treatment.

The quarterly benefit amounts payable will be determined by averaging the remaining estimated Covered Charges over the estimated time required to complete the Period of Dental Treatment. Adjustments may be made when changes occur in the estimated Covered Charges or estimated Period of Dental Treatment time.

Unbundling

When certain complicated dental procedures are performed, other less extensive procedures are performed at the same time, as component parts of the primary procedure. For benefit purposes under this Group Policy, these less extensive procedures are considered to be integral components of the primary procedure. Even if the Dentist bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

Dental Examinations

We may have the person whose loss is the basis for dental claim examined by a Dentist. We will pay for these examinations and will choose the Dentist to perform them.

Legal Action

Legal action for a claim may not be started earlier than 90 days after proof of loss is filed. Further, no legal action may be started later than three years after proof is required to be filed.

Time Limits

All time limits listed in this section will be adjusted as required by law.

NOTE: For additional Claim Procedures information, see GH 198 ERISA Claims (Health).

STATEMENT OF RIGHTS

Federal law requires that this section be included in your booklet:

As a participant in this plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. See GH 451, if applicable, for further information concerning preexisting condition exclusions.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

DEFINITIONS

Several words and phrases used to describe your plan are capitalized whenever they are used in this booklet. These words and phrases have special meanings as explained in this section.

Accidental Injury means an injury to the natural teeth that results solely from accidental means. Not included is any injury that results from chewing.

Active Work; Actively at Work means the active performance of all of a Member's normal job duties at the Policyholder's usual place or places of business.

Deductible; Deductible Amount means a specified dollar amount of Covered Charges that must be incurred by the insured person before benefits will be payable under the Group Policy for all or part of the remaining Covered Charges during the calendar year.

Dental Hygienist means a person who works under the supervision of a Dentist and is licensed to practice dental hygiene.

Dental Treatment Plan means the Dentist's report of proposed treatment which:

- is written on a form provided by Us; and
- lists the procedures required for the Period of Dental Treatment; and
- shows the charges for each procedure; and
- is accompanied by any diagnostic materials that We might require.

Dentist means:

- a person licensed to practice dentistry; and
- a licensed Physician who provides dental Treatment or Service.

Dependent means:

- your spouse, if your spouse:
  - is not in the Armed Forces of any country; and
  - is not insured under the Group Policy as a Member; and
- your Dependent Child (or Children) as defined below.

Dependent Child; Dependent Children means:

- Your natural or legally adopted child, if your child:
  - is not married; and
  - is not in the Armed Forces of any country; and
  - is not insured under the Group Policy as a Member; and

    - is less than 19 years of age.

- Your stepchild, if that child:
    - meets the requirements above; and
    - receives principal support from you.
- Your foster child, if that child:
    - meets the requirements above; and
    - lives with you; and
    - receives principal support from you; and
    - is approved in writing by Us as a Dependent Child.
- Your child 19 years but less than 25 years of age who otherwise qualifies above, if your child receives principal support from you and is a Full-Time Student, as defined.

Dependent Child will include any child covered under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) as defined by applicable federal law and state insurance laws that are applicable to the Group Policy, provided the child meets the Group Policy's definition of a Dependent Child.

Developmental Disability means a Dependent Child's substantial handicap, as determined by Us, which:

- results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder; and
- is diagnosed by a Physician as a permanent or long term continuing condition.

Emergency Treatment means any Necessary Dental Care which is rendered as the direct result of an unforeseen occurrence or combination of circumstances which requires immediate, urgent action or remedy.

Full-Time Employee means any person who is regularly scheduled to work for the Policyholder for at least 25 hours a week. Work must be at the Policyholder's usual place or places of business or at another place to which an employee must travel to perform his or her regular duties.

An owner, proprietor, or partner of the Policyholder's business will be deemed to be an eligible employee for purposes of the Group Policy, provided he or she is regularly scheduled to work for the Policyholder for at least 25 hours a week and otherwise meets the definition of Full-Time Employee.

Full-Time Student means your Dependent Child attending a school that has a regular teaching staff, curriculum and student body and who:

- attends school on a full-time basis, as determined by the school's criteria and
- is dependent on you for principal support.

Functioning Natural Tooth means a Natural Tooth which is performing its normal role in the chewing process in the insured person's upper or lower arch and which is opposed in the person's other arch by another Natural Tooth or prosthetic (i.e., artificial) replacement.

Group Policy means the policy of group insurance issued to the Policyholder by Us which describes benefits and provisions for insured Members and Dependents.

Immediate Family means an insured person's mother, father, sister, brother, spouse, or child(ren).

Member means any PERSON who is a Full-Time Employee of the Policyholder.

Natural Tooth means any tooth or part of a tooth that is organic and formed by the natural development of the body (i.e., not manufactured).

Necessary Dental Care means any Treatment or Service prescribed by a Dentist and considered by Us to be necessary and appropriate.

Orthodontic Treatment or Service means any Treatment or Service for:

- straightening of teeth, formal, full-banded retention and treatment, including x-rays and other diagnostic procedures; and

- removable or fixed appliances for tooth or bony structure guidance or retention.

Period of Dental Treatment means all sessions of dental care that result from the same initial diagnosis and any related complications.

Physical Handicap means a Dependent Child's substantial physical or mental impairment, as determined by Us, which:

- results from injury, accident, congenital defect, or sickness; and

- is diagnosed by a Physician as a permanent or long-term dysfunction or malformation of the body.

Physician means a licensed Doctor of Medicine (M.D.) or Osteopathy (D.O.).

Policyholder means PICKERING ASSOCIATES, INC..

Prevailing Charges means:

- As determined by Us, the amount that most dental care providers charge within a geographic cost area for a Treatment or Service.

- For purposes of insurance provided under the Group Policy, an actual charge for a Treatment or Service will be in excess of Prevailing Charges if, as determined by Us, 80% or more of all other charges reported to Us for the same (or a similar) Treatment or Service provided within the same (or a comparable) cost area are lower in amount than the actual charge.

Treatment or Service, when used in this booklet, will be considered to mean "treatment, service, substance, material, or device".

We, Us, and Our mean Principal Life Insurance Company, Des Moines, Iowa.

BOOKLET-CERTIFICATE RIDER

Subject: Employee Retirement Income Security Act (ERISA) Claims Procedures for Medical, Prescription Drugs, Dental, and Vision Care Expense Insurance (Effective July 1, 2002)

The provisions of your booklet-certificate are revised as described below.

The Department of Labor has promulgated regulations regarding claims procedure requirements for group health plans. If your plan of benefits includes Medical, Prescription Drugs, Dental, or Vision Insurance, certain sections of your group booklet-certificate have been changed to comply with the above-referenced regulation.

Note: Changes have been made only to reflect the requirements of ERISA. Any special state requirements relating to payment of claims and/or utilization review remain unchanged unless they prevent the application of the ERISA requirements.

The Utilization Management Program section of your Comprehensive Medical Expense Insurance* booklet-certificate has been changed as follows:

- The following Definitions have been added:
  - **Notification of Utilization Review Services**

    Receipt of necessary information to initiate review of a request for Utilization Review services to include the patient's name and your name (if different from patient's name), attending Physician's name, treating facility's name, diagnosis and date of service.

  - **Urgent Review**

    Utilization Review that must be completed sooner than a Prospective Review in order to prevent serious jeopardy to your or the patient's life or health or the ability to regain maximum function, or in the opinion of a Physician with knowledge of your or the patient's medical condition, would subject you or the patient to severe pain that cannot be adequately managed without treatment. Whether or not there is a need for an Urgent Review is based upon Our determination using the judgement of a prudent layperson who possess an average knowledge of health and medicine.

- The following provisions have been added and/or revised:
  - **Notice of Utilization Review**

    For purposes of satisfying the claims processing requirements, receipt of claim will be considered to be met when We receive Notification of Utilization Review Services. We may request additional information to substantiate the loss or require a Signed unaltered authorization to obtain that information from the provider. Failure to comply with Our request could result in declination of Utilization Review Services.

    If you, your Dependent, or designated patient representative fails to follow Our procedures for filing a claim for a Hospital Admission Review, a Prospective Review or an Urgent Review, We will notify you, your Dependent, or designated patient representative of the failure and the proper procedures to be followed.

  - **Utilization Review Program**
    - **Prospective Review**

For an initial Prospective Review, a decision will be made within two (2) business days of the date We receive all the necessary information needed to complete the review or within fifteen (15) calendar days of the date We receive Notification of Utilization Review Services, whichever time period is earlier. If a determination cannot be made due to insufficient information, We will provide an explanation of the information needed to complete the review. You, the patient, the attending Physician or other Ordering Provider or the facility rendering the service is permitted up to forty-five (45) calendar days to provide the necessary information. We will render a decision within two (2) business days of either receiving the necessary information or upon the expiration of forty-five (45) calendar days, We will render a decision within fifteen (15) calendar days, if no additional information is received. If We certify a health care service, notification will be provided promptly by telephone, facsimile, or in Writing to the attending Physician or other Ordering Provider, the facility rendering service, and you or the patient. Written notification will be sent within two (2) business days of the determination. For Noncertifications, notification will be made to the attending Physician or other Ordering Provider or facility rendering service by telephone within one (1) business day and Written notification will be sent within one (1) business day, with notice also sent to you or the patient.

- **Urgent Review**

  For an Urgent Review, a review decision will be made within seventy-two (72) hours of the date We receive Notification of Utilization Review Services. If a determination cannot be made due to insufficient information, We will provide an explanation of the information needed to complete the review. You, the patient, the attending Physician or other Ordering Provider or the facility rendering the service is permitted up to forty-eight (48) hours to provide the necessary information. We will render a decision within forty-eight (48) hours of either receiving the necessary information or if no additional information is received, the expiration of the forty-eight (48) hours to provide the specified additional information.

- **Concurrent Review**

  For a Concurrent Review, a review decision will be made within one (1) business day of the date We receive all of the necessary information needed to complete the review or prior to the end of the current certified period. If We certify a health care service, notification will be provided promptly either by telephone, facsimile, or in Writing to the attending Physician or other Ordering Provider, the facility rendering service, and you or the patient within one (1) business day of receipt of all information necessary to complete the review. For Noncertifications, notification will be made to the attending Physician or other Ordering Provider or facility rendering service by telephone within one (1) business day and Written notification sent within one (1) business day, with notice also sent to you or the patient.

- **Retrospective Review**

  For a Retrospective Review, a determination will be made within thirty (30) calendar days after We receive Notification of Utilization Review Services. If a determination cannot be made due to insufficient information, We will provide an explanation of the information needed to complete the review. You, the patient, the attending Physician or other Ordering Provider or the facility rendering the service is permitted up to forty-five (45) calendar days to provide the necessary information. We will render a decision within fifteen (15) calendar days of either receiving the necessary information or the expiration of forty-five (45) calendar days, if no additional information is received. Written notification will be sent to the attending Physician or other Ordering Provider, the facility rendering service, and you or the patient within two (2) business days of the determination (but not later than thirty (30) calendar days from receipt of Notification of Utilization Review Services). For Noncertifications, notification will be made to you, the patient, attending Physician or other Ordering Provider or facility rendering service in Writing within one (1) business day (but not later than thirty (30) calendar days from receipt of Notification of Utilization Review Services).

- **Request for Reconsideration**

  When an initial determination is made not to certify an admission or other service and no peer-to-peer conversation has occurred, the Peer Clinical Reviewer that made the initial decision will be made available within one (1) business day to discuss the Noncertification decision with the attending Physician or other Ordering Provider upon their request. If the original Peer Clinical Reviewer is not available, another Peer Clinical Reviewer will be made available to discuss the review.

  At the time of the conversation, if the reconsideration process is unable to resolve the difference of opinion regarding a decision not to certify, the attending Physician or other Ordering Provider will be informed of their right to initiate an appeal and the procedure to do so.

- **Appeal of Noncertifications**

  You, your Dependent, a designated patient representative, Physician or other health care provider has the right to request two appeal reviews of any utilization management determination, by telephone, fax, or in Writing. We will make a full and fair review of the Noncertification. The first level of appeal review must be completed before filing a civil action or pursuing any other legal remedies.

- **Expedited Appeal Review and Voluntary Appeal Review**

  An Expedited Appeal Review is a request, usually by telephone but can be Written, for an additional review of a determination not to certify imminent or ongoing services and an appeal of an Urgent Review. An Expedited Appeal Review must be requested within 180 calendar days of the receipt of a Noncertification. To resolve the expedited appeal, maximum information will be shared by telephone, fax, or in Writing. A Peer Clinical Reviewer who did not make the original determination, is not a subordinate of the Peer Clinical Reviewer who made the original determination, and who is in the same or similar specialty as the attending Physician or other Ordering Provider will conduct the review.

  A determination on the expedited appeal of an imminent or ongoing service will be made within one (1) business day of receiving the necessary information needed to complete the appeal review or within thirty (30) calendar days from request of an expedited appeal review. Notification of the appeal review outcome will be made by telephone to the attending Physician or other Ordering Provider with Written notification sent to you or the patient, the attending Physician or other Ordering Provider within two (2) business days of an expedited appeal of an initial review and within one (1) business day of an expedited appeal of a Concurrent Review or declination.

  A determination on the expedited appeal of an Urgent Review decision will be made within seventy-two (72) hours from request of an expedited appeal review.

  If the Noncertification is affirmed on the appeal review, you, the patient, attending Physician or other Ordering Provider can request a voluntary appeal. The appeal may be requested by telephone, fax, or in Writing. You, the patient, attending Physician or other Ordering Provider may submit Written comments, documents, records, and other information relating to the request for appeal. We will make a determination within thirty (30) calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, We will send a Written explanation of the additional information that is required or an authorization for you or the patient’s Signature so information can be obtained from the attending Physician or other Ordering Provider. This information must be sent to Us within forty-five (45) calendar days of the date of the Written request for the information or as required by state law. Failure to comply with the request for additional information could result in declination of the appeal. A determination will be made and notification of the

outcome will be provided within thirty (30) calendar days of the receipt of all necessary information to properly review the appeal request or as required by state law.

Election of a second appeal is voluntary and does not negate your right or the patient's right to bring civil action following notification of the decision rendered during the expedited appeal, nor does it have any effect on your rights or the patient's rights to any other benefit under the Group Policy. We offer the voluntary appeal process in an effort that the claim may be resolved in good faith without legal intervention. At anytime during the second appeal process, you or the patient may file a civil action or pursue any other legal remedies.

Note: The expedited appeal process does not apply to Retrospective Reviews.

- **Standard Appeal Review and Voluntary Appeal Review**

A standard appeal may be requested either in Writing or verbally. It must be requested within 180 calendar days of the receipt of a Noncertification. To complete the standard appeal process, it may be necessary for Us to request a statement from the attending Physician or other Ordering Provider and request all or part of the medical records. A Peer Clinical Reviewer who was not involved in the prior review, is not a subordinate of the Peer Clinical Reviewer who made the original determination, and who is in the same or similar specialty as the attending Physician or other Ordering Provider will conduct the review. A determination will be made within thirty (30) calendar days of receiving the request for an appeal review.

Notification will be made in Writing to you or the patient, the attending Physician or other Ordering Provider within two (2) business days (but not later than thirty (30) calendar days from receiving the request for an appeal review).

If the Noncertification is affirmed on the appeal review, you, the patient, attending Physician or other Ordering Provider can request a voluntary appeal. The appeal may be requested by telephone, fax, or in Writing. You, the patient, attending Physician or other Ordering Provider may submit Written comments, documents, records, and other information relating to the request for appeal. We will make a determination within thirty (30) calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, We will send a Written explanation of the additional information that is required or an authorization for your or the patient's Signature so information can be obtained from the attending Physician or other Ordering Provider. This information must be sent to Us within forty-five (45) calendar days of the date of the Written request for the information or as required by state law. Failure to comply with the request for additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within thirty (30) calendar days of the receipt of all necessary information to properly review the appeal request or as required by state law.

Election of a second appeal is voluntary and does not negate your right or the patient's right to bring civil action following notification of the decision rendered during the standard appeal, nor does it have any effect on your rights or the patient's rights to any other benefit under the Group Policy. We offer the voluntary appeal process in an effort that the claim may be resolved in good faith without legal intervention. At anytime during the second appeal process, you or the patient may file a civil action or pursue any other legal remedies.

*For insureds in Massachusetts: This provision also applies to Dental Expense Insurance.

The Claim Procedures section of your Medical, Dental, and/or Vision Care Expense Insurance booklet-certificate have been changed as follows:

- **Notice of Claim**

Written notice of claim must be given to Us within 20 calendar days after the date of loss. Failure to give

notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

- **Claim Forms**

  Claim forms and other information needed to prove loss must be filed with Us in order to obtain payment of benefits. The Policyholder will provide forms to assist you in filing claims. If the forms are not provided within 15 calendar days after We receive such notice of claim, you will be considered to have complied with the requirements of the Group Policy regarding proof of loss upon submitting, within the time specified below for filing proof of loss, written proof covering the occurrence, character, and extent of the loss.

- **Proof of Loss**

  Completed claim forms and other information needed to prove loss should be filed promptly. Written proof of loss should be sent to Us within 90 calendar days after the date of loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when We receive proof of loss. Proof of loss includes the patient's name, your name (if different from patient's name), provider of services, dates of service, diagnosis, description of Treatment or Service provided and extent of the loss. We may request additional information to substantiate your loss or require a signed unaltered authorization to obtain that information from the provider. Your failure to comply with such request could result in declination of the claim. For Dental Expense Insurance, We may also require x-rays, dental charts, and other evidence needed to determine the dental condition treated and the services provided.

- **Payment, Denial, and Review**

  The Employee Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. If a claim cannot be processed due to incomplete information, We will send a written explanation prior to the expiration of the 30 calendar days. The claimant is then allowed up to 45 calendar days to provide all additional information requested. We will render a decision within 15 calendar days of either receiving the necessary information or upon the expiration of 45 calendar days if no additional information is received.

  In actual practice, benefits under the Group Policy may be payable sooner, provided We receive complete and proper proof of loss. If a claim is not payable or cannot be processed, We will submit a detailed explanation of the basis for its denial.

  A claimant may request an appeal of a claim denial by written request to Us within 180 calendar days of receipt of the notice of denial. We will make a full and fair review of the claim. We may require additional information to make the review. We will notify the claimant in writing of the appeal decision within 60 calendar days of receiving the appeal request. The first level of appeal review must be completed before filing a civil action or pursuing any other legal remedies.

  After exhaustion of the formal appeal process, a claimant may request a voluntary appeal. The appeal must be requested in writing. The claimant may submit written comments, documents, records, and other information relating to the claim for benefits. We will make a determination within 60 calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, We will send a written explanation of the additional information that is required or an authorization for the claimant's signature so information can be obtained from the provider. This information must be sent to Us within 45 calendar days of the date of the written request for the information or as required by state law. Failure to comply with the request for additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 60 calendar days of the receipt of all necessary information to properly review the appeal request or as required by state law.

  Election of a second appeal is voluntary and does not negate the claimant's right to bring civil action following the first appeal, nor does it have any effect on the claimant's right to any other benefit under the Group Policy. We offer the voluntary appeal process in an effort that the claim may be resolved in good

faith without legal intervention. At anytime during the voluntary appeal process, the claimant may file a civil action or pursue any other legal remedies.

For purposes of this section, "claimant" means you or your Dependent.

- **Legal Action**

  Legal action with respect to a claim may not be started earlier than 90 calendar days after proof of loss is filed and before the appeal procedures have been exhausted. Further, no legal action may be started later than three years after proof is required to be filed.

If your insurance includes Prescription Drugs Expense Insurance and/or Mail Order Maintenance Prescription Drugs Expense Insurance, the following changes have been made:

- The following Definition has been added:

  "Pharmacy Benefit Manager" means AdvancePCS.

- If your booklet-certificate includes a provision for preauthorization of certain drugs, to request a preauthorization, contact the Pharmacy Benefit Manager at the telephone number listed on your or your Dependent's identification card.

- The following provision for **Payment, Denial, and Review** of claims has been added:

  For Prescription Drugs Expense Insurance: Any transaction at a pharmacy for prescription drug benefits is not a claim for benefits under the Employee Retirement Income Security Act (ERISA). To file a claim for benefits when utilizing a Member Pharmacy, contact the Pharmacy Benefit Manager at the telephone number listed on your or your Dependent's identification card or contact Us. To file a claim for benefits when utilizing a Nonmember Pharmacy or when an identification card is not utilized at a Member Pharmacy, submit a prescription drug claim form to the Pharmacy Benefit Manager.

  For Mail Order Maintenance Prescription Drugs Expense Insurance: Any transaction at a pharmacy for prescription drug benefits is not a claim for benefits under the Employee Retirement Income Security Act (ERISA). To file a claim for benefits, when utilizing a pharmacy We have designated to provide mail service, contact the Pharmacy Benefit Manager at the telephone number listed on your or your Dependent's identification card or contact Us.

  Written proof of loss must be sent to the Pharmacy Benefit Manager or Us within 90 calendar days after the date of loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when the Pharmacy Benefit Manager or We receive proof of loss. Proof of loss includes the patient's name, your name (if different from the patient's name), prescription drug name and date prescription drug dispensed. The Pharmacy Benefit Manager or We may request additional information to substantiate the loss or require a Signed unaltered authorization to obtain that information from the provider. Failure to comply with the Pharmacy Benefit Manager or Our request could result in declination of the claim.

  The Employee Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. If a claim cannot be processed due to incomplete information, the Pharmacy Benefit Manager or We will send a Written explanation prior to the expiration of the 30 calendar days. The claimant is then allowed up to 45 calendar days to provide all additional information requested. The Pharmacy Benefit Manager or We will render a decision within 15 calendar days of either receiving the necessary information or upon the expiration of 45 calendar days if no additional information is received.

  In actual practice, benefits under the Group Policy may be payable sooner, provided the Pharmacy Benefit Manager or We receive complete and proper proof of loss. If a claim is not payable or cannot be processed, the Pharmacy Benefit Manager or We will submit a detailed explanation of the basis for the denial.

A claimant may request an appeal of a claim denial by Written request to Us within 180 calendar days of receipt of notice of the denial. We will make a full and fair review of the claim. We may require additional information to make the review. We will notify the claimant in Writing of the appeal decision within 60 calendar days of receiving the appeal request. The first level of appeal review must be completed before filing a civil action or pursuing any other legal remedies.

After exhaustion of the formal appeal process, a claimant may request a voluntary appeal. The appeal must be requested in Writing. The claimant may submit Written comments, documents, records, and other information relating to the claim for benefits. We will make a determination within 60 calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, We will send a Written explanation of the additional information that is required or an authorization for the claimant's Signature so information can be obtained from the provider. This information must be sent to Us within 45 calendar days of the date of the Written request for the information or as required by state law. Failure to comply with the request for additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 60 calendar days of the receipt of all necessary information to properly review the appeal request or as required by state law.

Election of a second appeal is voluntary and does not negate the claimant's right to bring civil action following the first appeal, nor does it have any effect on the claimant's right to any other benefit under the Group Policy. We offer the voluntary appeal process in an effort that the claim may be resolved in good faith without legal intervention. At anytime during the voluntary appeal process, the claimant may file a civil action or pursue any other legal remedies.

If a prescription drug is not covered under Prescription Drugs Expense Insurance and/or Mail Order Maintenance Prescription Drugs Expense Insurance, it may be submitted for consideration under Medical Expense Insurance.

For purposes of this section, "claimant" means you or your Dependent.

Please keep this rider with your booklet-certificate(s). Your booklet-certificate(s) will be updated sometime in the future to incorporate these provisions.

Nothing in this rider will vary, alter, or extend any provision or condition of the Group Policy(ies) other than as stated in this rider.

PRINCIPAL LIFE INSURANCE COMPANY
DES MOINES, IOWA 50392-0302

Notice of Privacy Practices for Personal Health Information

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

This Notice of Privacy Practices describes the practices of Principal Life Insurance Company for safeguarding individually identifiable personal health information. The terms of this Notice apply to members and dependents for their group medical expense, group dental expense and/or group vision care expense insurance. This Notice was effective April 14, 2003 and revisions to this Notice are effective June 1, 2005.

We are required by law to maintain the privacy of our members' and dependents' personal health information and to provide notice of our legal duties and privacy practices with respect to personal health information. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all personal health information maintained by us. Copies of revised Notices will be mailed to plan sponsors for distribution to the members then covered by the plan. You have the right to request a paper copy of the Notice, although you may have originally requested a copy of the Notice electronically by e-mail.

Uses and Disclosures of Your Personal Health Information

Authorization. Except as explained below, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing a use or disclosure. Unless we have taken any action in reliance on the authorization, you have the right to revoke an authorization if the request for revocation is in writing and sent to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, Des Moines, IA 50392-0302. A form to revoke an authorization can be obtained from the Health Information Protection Analyst.

Disclosures for Treatment. We may disclose your personal health information as necessary for your treatment. For instance, a doctor or healthcare facility involved in your care may request your personal health information in our possession to assist in your care.

Uses and Disclosures for Payment. We will use and disclose your personal health information as necessary for payment purposes. For instance, we may use your personal health information to process or pay claims, for subrogation, to perform a hospital admission review to determine whether services are for medically necessary care or to perform prospective reviews. We may also forward information to another insurer in order for it to process or pay claims on your behalf.

Uses and Disclosures for Health Care Operations. We will use and disclose your personal health information as necessary for health care operations. For instance, we may use or disclose your personal health information for quality assessment and quality improvement, credentialing health care providers, premium rating, conducting or arranging for medical review or compliance. We may also disclose your personal health information to another insurer, health care facility or health care provider for activities such as quality assurance or case management. We participate in an organized health care arrangement with your health plan. Your health plan may have its own privacy practices that are not reflected in this Notice. We may disclose your personal health information to your health plan for its health care operations. We may contact your health care providers concerning prescription drug or treatment alternatives.

Other Health-Related Uses and Disclosures. We may contact you to provide reminders for appointments; information about treatment alternatives; or other health-related programs, products or services that may be available to you.

Information Received Pre-enrollment. We may request and receive from you and your health care providers personal health information prior to your enrollment under the group policy. We will use this information to determine whether you are eligible to enroll under the policy and to determine the rates. If you do not enroll, we will not use or disclose the information we obtained about you for any other purpose. Information provided on enrollment forms or applications will be utilized for all coverages being applied for, some of which may be protected by the state, not federal, privacy

laws.

Business Associate. Certain aspects and components of our services are performed by outside people or organizations pursuant to agreements or contracts. It may be necessary for us to disclose your personal health information to these outside people or organizations that perform services on our behalf. We require them to appropriately safeguard the privacy of your personal health information.

Plan Sponsor. We may disclose your personal health information to the plan sponsor, provided that the plan sponsor certifies that the information will be maintained in a confidential manner and will not be utilized or disclosed for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.

Family, Friends and Personal Representatives. With your approval, we may disclose to family members, close personal friends, or another person you identify, your personal health information relevant to their involvement with your care or paying for your care. If you are unavailable, incapacitated or involved in an emergency situation, and we determine that a limited disclosure is in your best interests, we may disclose your personal health information without your approval. We may also disclose your personal health information to public or private entities to assist in disaster relief efforts.

Other Uses and Disclosures. We are permitted or required by law to use or disclose your personal health information, without your authorization, in the following circumstances:

- For any purpose required by law;
- For public health activities (for example, reporting of disease, injury, birth, death or suspicion of child abuse or neglect);
- To a governmental authority if we believe an individual is a victim of abuse, neglect or domestic violence;
- For health oversight activities (for example, audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions);
- For judicial or administrative proceedings (for example, pursuant to a court order, subpoena or discovery request);
- For law enforcement purposes (for example, reporting wounds or injuries or for identifying or locating suspects, witnesses or missing people);
- To coroners and funeral directors;
- For procurement, banking or transplantation of organ, eye or tissue donations;
- For certain research purposes;
- To avert a serious threat to health or safety under certain circumstances;
- For military activities if you are a member of the armed forces; for intelligence or national security issues; or about an inmate or an individual to a correctional institution or law enforcement official having custody; and
- For compliance with workers' compensation programs.

We will adhere to all state and federal laws or regulations that provide additional privacy protections. We will only use or disclose AIDS/HIV-related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by state and federal law or regulation.

Your Rights

Restrictions on Use and Disclosure of Your Personal Health Information. You have the right to request restrictions on how we use or disclose your personal health information for treatment, payment or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your care or the paying of your care. To request a restriction, you must send a written request to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0302. A form to request a restriction can be obtained from the Health Information Protection Analyst. We are not required to agree to your request for a restriction. If your request for a restriction is granted, you will receive a written acknowledgement from us.

Receiving Confidential Communications of Your Personal Health Information. You have the right to request communications regarding your personal health information from us by alternative means (for example by fax) or at alternative locations. We will accommodate reasonable requests. To request a confidential communication, you must send a written request to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0302. A form to request a confidential communication can be obtained from the Health Information Protection Analyst.

Access to Your Personal Health Information. You have the right to inspect and/or obtain a copy of your personal health information we maintain in your designated record set, with a couple of exceptions. To request access to your information, you must send a written request to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0302. A form to request access to your personal health information can be obtained from the Health Information Protection Analyst. A fee will be charged for copying and postage.

Amendment of Your Personal Health Information. You have the right to request an amendment to your personal health information to correct inaccuracies. To request an amendment, you must send a written request to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0302. A form to request an amendment to your personal health information can be obtained from the Health Information Protection Analyst. We are not required to grant the request in certain circumstances.

Accounting of Disclosures of Your Personal Health Information. You have the right to receive an accounting of certain disclosures made by us after April 14, 2003, of your personal health information. To request an accounting, you must send a written request to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0302. A form to request an accounting of your personal health information can be obtained from the Health Information Protection Analyst. The first accounting in any 12-month period will be free; however, a fee will be charged for any subsequent request for an accounting during that same time period.

Complaints. If you believe your privacy rights have been violated, you can send a written complaint to us at Grievance Coordinator, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0302 or to the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

If you have any questions or need any assistance regarding this Notice or your privacy rights, you may contact the Group Call Center at Principal Life Insurance Company at (800) 986-3343, extension 76398.

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Plan Arranged By

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45750

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Des Moines, Iowa 50392-0002