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03/01/2007

GROUP BOOKLET-CERTIFICATE FOR MEMBERS OF

PICKERING ASSOCIATES, INC.

ALL MEMBERS
Group Vision Care Expense Insurance

Print Date: 03/15/2007

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Your benefit plan 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 coverage 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 the 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 A 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
(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.**

VISION CARE EXPENSE INSURANCE

If you or one of your Dependents are sick or injured, Scheduled Benefits then in force will be payable for Medically Necessary Care. Scheduled Benefits are based on your class:

Class	Scheduled Benefits
All Members and their Dependents	See Maximum Payment Limits below

Benefits Payable

Benefits Payable for Treatment or Service received will not be more than the Maximum Payment Limit shown below for each examination or vision aid.

	Maximum Payment Limit
Complete Visual Analysis (one per 12-month period)	$50
Frames (one set per 24-month period)	$100
*Single Vision Lenses (pair)	$50
*Bifocal Lenses (pair)	$75
*Trifocal Lenses (pair)	$100
*Lenticular Lenses (pair)	$150
*Contact Lenses (in lieu of lens and frame benefit):	

If Contact Lenses are prescribed: after cataract surgery; or if vision in the better eye can be corrected to 20/70 or better only by use of contact lenses; or for Medically Necessary reasons, the maximum payment for a pair of contact lenses will be equal to the maximum payment for Single Vision Lenses plus Frames, not to exceed the following:

- Single Vision Lenses ($50): Two lenses payable once in any period of 12 consecutive months; plus

- Frames ($100): One set of frames payable once in any period of 24 consecutive months.

The Contact Lenses benefit will be in lieu of the lens and frame benefit. If Contract Lenses are chosen, there will be no Benefits Payable for the lens benefit for a period of 12 consecutive months from the date of service and there will be no Benefits Payable for the frame benefit for a period of 24 consecutive months from the date of service.

*Not more than two lenses (one pair) per 12-month period.

The Vision Care Maximum Payment Limit for you or your Dependents during any period of 12 consecutive months (24 consecutive months for frames) will not exceed the Maximum Payment Limits shown above.

See Page GH 431 for a complete description of Member Vision Care Expense Insurance.

See Page GH 434 for a complete description of Dependent Vision Care Expense Insurance.

HOW TO BE INSURED - MEMBERS

VISION CARE 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.

If you are a Member on March 1, 2007, you will be eligible on that date.

If you are not a Member until later, 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 vision care 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 and Eligibility

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.

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.

Effective Date for Non-Contributory Insurance

Insurance for which you contribute no part of the premium will become effective on the date you are eligible. You must request insurance in a form approved by Us.

Effective Date for Contributory Insurance

If you are required to contribute towards the cost of your insurance, you must request insurance in a form approved by Us. The requested insurance will become effective on:

- the date you are eligible, if the request is made on or before that date; or

- the date you are eligible, 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 request for insurance is made more than 31 days after the date an individual is eligible but as a result of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN), insurance for such individual will become effective as described under Court Ordered Coverage below.

If request for contributory insurance is made more than 31 days after the date an individual is eligible and other than during the Annual Enrollment Period or Special Enrollment Period described below, insurance of such individual will become effective as described above.

If request for contributory insurance is made more than 31 days after the date an individual is eligible but during the Annual Enrollment Period described below, insurance for such individual will become effective as described below under "Annual Enrollment Period."

If your request for contributory insurance is made more than 31 days after the date an individual is eligible but during a Special Enrollment Period described below, insurance for such individual will become effective as described below under "Special Enrollment Period".

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 Vision Care Expense Insurance will be subject to the Benefit-Waiting Period provisions described below.

Annual Enrollment Period

An Annual Enrollment Period will be available for any individual who failed to enroll:

- during the first period in which he or she was eligible to enroll, or during any subsequent Special Enrollment Period as described below; or

- during any previous Annual Enrollment Period; or

- within 31 days after the termination date, if the individual was previously insured under the Group Policy but elected to terminate the insurance.

During the Annual Enrollment Period, your Vision Care Expense Insurance will not be subject to the Benefit-Waiting Period provisions described below if your Policyholder offers employees a choice among vision care expense coverages and you elect to transfer from another of the offered coverages to insurance under the Group Policy.

To qualify for enrollment during the Annual Enrollment Period, you or your Dependent:

- must meet the eligibility requirements described in the Group Policy, including satisfaction of any applicable waiting period; and

- may not be covered under an alternate vision care expense coverage offered by the Policyholder, unless the Annual Enrollment Period happens to coincide with a separate open enrollment period established for coverage election.

The Annual Enrollment Period is generally the one-month period immediately prior to the Policy Anniversary date or another period of time requested by the Policyholder and approved by Us. The Annual Enrollment Period is the period from February 1 through February 29.

The effective date for any qualified individual requesting insurance during the Annual Enrollment Period will be on March 1 following completion of the Annual Enrollment Period provided contribution has been received for the requested insurance.

Court Ordered Coverage Under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)

The Actively at Work provisions described in this section will not apply to you if:

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

- you have 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 vision 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 your 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.

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

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

Special Enrollment Period

A Special Enrollment Period, as described below, will be available for you or your Dependent if enrollment is made after the first period in which you or your Dependent are eligible to enroll.

The Special Enrollment Periods are:

- Loss of Other Coverage: A Special Enrollment Period will apply to you or your Dependent if all of the following conditions are met:

  (i) the individual was covered under another group vision care expense coverage at the time of his or her initial eligibility, and declined enrollment solely due to the other coverage; and
  (ii) the other coverage terminated due to loss of eligibility (including loss due to divorce or legal separation, death, termination of employment or reduction in work hours, or if the other coverage was under a COBRA or state continuation provision, due to exhaustion of the continuation); and
  (iii) request for enrollment is made within 31 days after the other coverage terminates.

  The effective date of insurance will be the date of the request for enrollment provided contribution has been received for the requested insurance.

  NOTE: For the purpose of (ii) above:

  "Loss of eligibility" does not include:

  (i) a loss due to failure of the individual to pay premiums on a timely basis or termination of insurance for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the vision care expense coverage); or
  (ii) a loss due to a spouse's voluntary termination of his or her vision care expense coverage; or
  (iii) a loss due to a spouse's voluntary termination of his or her Dependent vision care expense coverage.

- Newly Acquired Dependents: A Special Enrollment Period will apply to you or your Dependent if:

  (i) you are enrolled (or are eligible to be enrolled but have failed to enroll during a previous enrollment period); and
  (ii) a person becomes your Dependent through marriage, birth, adoption or Placement for Adoption; and
  (iii) request for enrollment is made within 31 days after the date of the marriage, birth, adoption or Placement for Adoption, or the date Dependent Vision Care Expense Insurance is available to the Member under the Group Policy, if the request is made on or before the event or within 31 days after the event.

  The effective date of your or your Dependent's insurance will be:

  (i) in the event of marriage, the date of such marriage; or
  (ii) in the event of a Dependent Child's birth, the date of such birth; or
  (iii) in the event of a Dependent Child's adoption or Placement for Adoption, the date of such adoption or Placement for Adoption, whichever is earlier.

During a Special Enrollment Period, your Vision Care Expense Insurance will not be subject to the Benefit-Waiting Period provisions described below.

Benefit-Waiting Period (for when you request insurance more than 31 days after (1) the date eligible; or (2) the date you elect to terminate insurance)

Other than during a Annual Enrollment Period or Special Enrollment Period or coverage required under a QMCSO or NMSN as described above, if you request insurance for yourself or your Dependent more than 31 days after the date you or your Dependent are eligible, or you elect to terminate insurance and more than 31 days later request to be insured again, benefits will be limited as follows:

- During the first 12 months, benefits will be payable only for a Complete Visual Analysis.

After insurance has been in force for 12 consecutive months, benefits will be payable for charges incurred for frames, lenses, and contact lenses (subject to Maximum Payment Limits shown under Payment Conditions on GH 102 D).

Effective Date for Benefit Changes

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

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 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

VISION CARE 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 vision care expense coverage or coverages 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.

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 become effective under the same terms 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.

Individual Incontestability and Eligibility

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

Termination

Unless continued as provided below or on GH 117 B, GH 117 C, and GH 117 D, insurance for all of your Dependents will terminate on 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, Vision Care 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 insurance is modified or terminated.

Continuation

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

COBRA CONTINUATION

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

COBRA applies to any employer (except the federal government and religious organizations) that: (a) maintains a 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 vision care 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 vision care 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, vision care 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 vision care plan); or

(5) the date the qualified person becomes covered by and has satisfied the preexisting exclusion provision of another group vision care plan; however, this does not apply to a person who is already covered by the other group vision 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 vision 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 vision 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 period 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 Vision Care Expense Insurance would otherwise cease as provided on GH 125 D; 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 Vision Care 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 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

VISION CARE EXPENSE INSURANCE
(PAYMENT PROVISIONS)

Benefit Qualification

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

- be insured in that class on the date vision Treatment or Service is received; 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 undergo a Complete Visual Analysis or purchase any of the listed vision aids, We will pay the provider's charges to the Maximum Payment Limits as described in the SUMMARY OF BENEFITS Section.

Limitations

Vision Care Expense benefits will not be paid for:

- a visual analysis or vision aids that are not for Medically Necessary Care; or
- a visual analysis performed by other than a Physician or Optometrist; or
- vision aids not prescribed by a Physician or Optometrist; or
- a visual analysis or vision aids provided by any person in your Immediate Family or any person in your Dependent's Immediate Family; or
- sunglasses (prescribed or not); or
- duplication or replacement of a vision aid that is broken, lost, or stolen; or
- more than one Complete Visual Analysis in any period of 12 consecutive months; or
- more than two lenses (one pair) in any period of 12 consecutive months or more than one set of frames in any period of 24 consecutive months; or
- a visual analysis or vision aids for which you have no financial liability or that would be provided at no charge in the absence of coverage; or
- a visual analysis or vision aids paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or
- a visual analysis or vision aids provided as the result of a sickness or injury due to war or act of war; or
- a visual analysis or visions aids provided as the result of participation in criminal activities; or
- a visual analysis or vision aids provided as the result of:
    - an injury arising out of or in the course of any employment for wage or profit if you are 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 of the Policyholder who are not covered by a Workers' Compensation Act or other similar law; or
    - a sickness covered by a Workers' Compensation Act or other similar law; or
- a visual analysis or vision aids provided outside the United States, unless you are outside the United States for one of the following reasons:
    - travel, provided the travel is for a reason other than securing vision care diagnosis or treatment, and travel is for a period of six months or less; or

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

- Full-Time Student status, provided you are 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

- medical or surgical treatment of the eyes.

DESCRIPTION OF BENEFITS

DEPENDENT VISION CARE EXPENSE INSURANCE

Payment Conditions

If one of your Dependents undergoes a Complete Visual Analysis or purchases any of the listed vision aids, We will pay the provider's charges to the Maximum Payment Limits as described in the SUMMARY OF BENEFITS Section.

Limitations

Vision Care Expense benefits will not be paid for:

- a visual analysis or vision aids that are not for Medically Necessary Care; or
- a visual analysis performed by other than a Physician or Optometrist; or
- vision aids not prescribed by a Physician or Optometrist; or
- a visual analysis or vision aids provided by any person in your Immediate Family or any person in your Dependent's Immediate Family; or
- sunglasses (prescribed or not); or
- duplication or replacement of a vision aid that is broken, lost, or stolen; or
- more than one Complete Visual Analysis in any period of 12 consecutive months; or
- more than two lenses (one pair) in any period of 12 consecutive months or more than one set of frames in any period of 24 consecutive months; or
- a visual analysis or vision aids for which you have no financial liability or that would be provided at no charge in the absence of coverage; or
- a visual analysis or vision aids paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or
- a visual analysis or vision aids provided as the result of a sickness or injury due to war or act of war; or
- a visual analysis or visions aids provided as the result of participation in criminal activities; or
- a visual analysis or vision aids provided as the result of:
    - an injury arising out of or in the course of any employment for wage or profit if your Dependent is are 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 of the Policyholder who are not covered by a Workers' Compensation Act or other similar law; or
    - a sickness covered by a Workers' Compensation Act or other similar law; or
- a visual analysis or vision aids provided outside the United States, unless your Dependent is outside the United States for one of the following reasons:
    - travel, provided the travel is for a reason other than securing vision care diagnosis or treatment, and travel is for a period of six months or less; or

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

- Full-Time Student status, provided your Dependent 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

- medical or surgical treatment of the eyes.

COORDINATION WITH OTHER BENEFITS

VISION CARE EXPENSE INSURANCE

Applicability

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

If the COB provision applied, 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, vision care or treatment:

- 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 vision 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.

Also, the term Plan will apply separately to those parts of any program that contain provisions for coordination of benefits with other Plans and separately to those parts of any program which do not contain such provisions.

"This Plan" is the vision 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 vision 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.

"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. Also, 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 Plan 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 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 child of legally separated or divorced parents is covered under two or more Plans, benefits for the 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 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 child, the Plans covering the 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 vision 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 $100.00 with both Company A and Company B. Company A insures Mrs. Smith as an employee under a plan which pays 50% of covered charges. 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	$	100.00
Less Frame Benefit	-	50.00
Benefit Payable	$	50.00

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	$	100.00
Less Company A's benefit	-	50.00
Benefit Payable	$	50.00

CLAIM PROCEDURES

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 the 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.

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 our 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.

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

Facility of Payment

We will normally pay all benefits to you. However, if the claimed benefits result from a Dependent's sickness or injury, We may make payment to the Dependent. 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 vision 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.

Medical Examinations

We may have you or your Dependent whose loss is the basis for claim examined by a Physician. We will pay for these examinations and will choose the Physician to perform them.

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.

Time Limits

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

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.

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

Benefit-Waiting Period means the period of time that must pass before an individual is covered for specified benefits under the Group Policy.

Complete Visual Analysis includes:

- case history and professional consultation; and
- examination for disease or abnormalities; and
- determination of the ranges of clear single vision; and
- measurement of refraction, eye muscle coordination, and balance; and
- special working distance analysis.

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 that 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 that child receives principal support from you and is a Full-Time Student, as defined.

- Your child 19 years but less than 25 years of age, if that child is a Mormon missionary for a period of two years or less; and

    - otherwise qualifies above; and

    - receives principal support from you.

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.

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.

Generally Accepted means that the Treatment or Service which is the subject of the claim that:

- has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed vision and scientific literature; and

- is in general use in the relevant vision community; and

- is not under scientific testing or research.

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 spouse, natural or adoptive parent, natural or adoptive child, sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild or spouse of grandparent or grandchild.

Medically Necessary Care means as determined by Us, any Treatment or Service that is prescribed by a Physician and considered to be necessary and appropriate and not in conflict with Generally Accepted medical standards.

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

Optometrist means a person who is licensed to practice optometry.

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).

Placement for Adoption; Placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adopting the child. The child's placement with the person terminates upon the termination of such legal obligation.

Policyholder means PICKERING ASSOCIATES, INC..

Signed or Signature means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper or electronic media, and which is consistent with applicable law and is agreed to by Us.

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.

Written or Writing means a record which is on or transmitted by paper or electronic media, and which is consistent with applicable law.

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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