1032654

01/01/2013

GROUP POLICY FOR:

MARTIN TRANSPORTATION SYSTEMS, INC.

ALL MEMBERS
Group Vision Care Expense Insurance

Print Date: 03/01/2013

This page left blank intentionally

CHANGE NO. --1-- AMENDMENT TO BE ATTACHED TO AND MADE A PART OF PRINCIPAL LIFE INSURANCE COMPANY GROUP POLICY NO. GVE 1032654 ISSUED TO

MARTIN TRANSPORTATION SYSTEMS, INC.

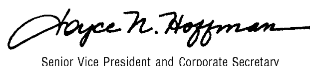
It is agreed that the above Group Policy be amended effective as of January 1, 2013, by striking all pages and replacing such pages with the following updated Group Policy.

The effect of this change is to completely replace the documentation of the contract between the above-named Policyholder and The Principal. Therefore, as of the effective date of this change, all prior versions of that documentation are null and void. This change is not intended to renew the contract between the Policyholder and The Principal in any way which affects the time limits of the coverages or limitations as stated in the original documentation.

The provisions and conditions set forth on any attached page are part of this Amendment the same as if set forth above.

This Amendment will become effective as a written agreement between The Principal and the Policyholder on the first premium due date following the effective date shown above for which premium due under this Group Policy is received by The Principal.

Executed by The Principal as of February 28, 2013.


Senior Vice President and Corporate Secretary

President and Chief Executive Officer

This page left blank intentionally

PRINCIPAL LIFE INSURANCE COMPANY
(called The Principal in this Group Policy)
Des Moines, Iowa 50392-0001

This group insurance policy is issued to:

MARTIN TRANSPORTATION SYSTEMS, INC.
(called the Policyholder in this Group Policy)

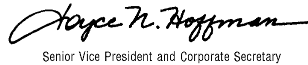
The Date of Issue is January 1, 2013.

In return for the Policyholder's application and payment of all premiums when due, The Principal agrees to provide:

MEMBER VISION CARE EXPENSE INSURANCE

DEPENDENT VISION CARE EXPENSE INSURANCE

subject to the terms and conditions described in this Group Policy.


Senior Vice President and Corporate Secretary

President and Chief Executive Officer

GROUP POLICY NO. GVE 1032654
NON-PARTICIPATING
CONTRACT STATE OF ISSUE: MICHIGAN

This policy has been updated effective January 1, 2013

TABLE OF CONTENTS

PART I - DEFINITIONS

PART II - POLICY ADMINISTRATION

Section A - Contract

Entire Contract	Article 1
Policy Changes	Article 2
Policyholder Eligibility Requirements	Article 3
Policy Incontestability	Article 4
Individual Incontestability and Eligibility	Article 5
Information to be Furnished	Article 6
Certificates	Article 7
Workers' Compensation Not Affected	Article 8
Dependent Rights	Article 9
Electronic Transactions	Article 10
Value Added Service	Article 11

Section B - Premiums

Payment Responsibility; Due Dates; Grace Period	Article 1
Premium Rates	Article 2
Premium Rate Changes	Article 3
Premium Amount	Article 4
Contributions from Members	Article 5

Section C - Policy Termination

Failure to Pay Premium	Article 1
Termination for Cause	Article 2
Termination Without Regard to Cause	Article 3
Policyholder Responsibility to Members	Article 4

Section D - Policy Renewal

Renewal	Article 1

PART III - INDIVIDUAL REQUIREMENTS AND RIGHTS

Section A - Eligibility

This policy has been updated effective January 1, 2013

Member Vision Care Expense Insurance Article 1
Dependent Vision Care Expense Insurance Article 2

Section B - Effective Dates

Member Vision Care Expense Insurance Article 1
Dependent Vision Care Expense Insurance Article 2
Benefit Waiting Period Article 3

Section C - Individual Terminations

Member Vision Care Expense Insurance Article 1
Dependent Vision Care Expense Insurance Article 2

Section D - Continuation

Member Vision Care Expense Insurance Article 1
Dependent Vision Care Expense Insurance Article 2
Federal Required Continuation Article 3

Section E - Reinstatement

Reinstatement Article 1

PART IV - BENEFITS

Section A - Member Vision Care Expense Insurance

Schedule of Insurance Article 1
Benefit Qualification Article 2
Benefits Payable Article 3
Payment Conditions Article 4
Limitations Article 5

Section B - Dependent Vision Care Expense Insurance

Schedule of Insurance Article 1
Benefit Qualification Article 2
Benefits Payable Article 3
Payment Conditions Article 4
Limitations Article 5

Section C - Claim Procedures

Notice of Claim Article 1

This policy has been updated effective January 1, 2013

Claim Forms	Article 2
Proof of Loss	Article 3
Payment, Denial, and Review	Article 4
Facility of Payment	Article 5
Medical Examinations	Article 6
Legal Action	Article 7
Time Limits	Article 8

Section D - Replacement of a Prior Plan

Applicability	Article 1
Benefits Payable	Article 2

Section E - Coordination with Other Benefits

Purpose	Article 1
Definitions	Article 2
Effect on Benefits	Article 3
Order of Benefit Determination	Article 4
Medicare Exception	Article 5
Exchange of Information	Article 6
Facility of Payment	Article 7
Right of Recovery	Article 8

This policy has been updated effective January 1, 2013

PART I - DEFINITIONS

When used in this Group Policy the terms listed below will mean:

Active Work; Actively at Work

The active performance of all of a Member's normal job duties at the Policyholder's usual place or places of business.

Benefit-Waiting Period

The period of time that must pass before an individual is covered for specified benefits under this Group Policy.

Complete Visual Analysis

A Complete Visual Analysis includes:

a. case history and professional consultation; and

b. examination for disease or abnormalities; and

c. determination of the ranges of clear single vision; and

d. measurement of refraction, eye muscle coordination, and balance; and

e. special working distance analysis.

Date of Issue

The date this Group Policy is placed in force: January 1, 2013.

Dependent

a. A Member's spouse, if that spouse:

   (1) is not in the Armed Forces of any country; and
   (2) is not insured under this Group Policy as a Member.

b. A Member's Dependent Child (or Children) as defined below.

Dependent Child; Dependent Children

This policy has been updated effective January 1, 2013

a. A Member's natural or legally adopted child, if that child:

   (1) is not in the Armed Forces of any country; and
   (2) is not insured under this Group Policy as a Member; and
   (3) is less than 26 years of age.

b. A Member's stepchild, if that child:

   (1) meets the requirements in a. (1), (2), and (3) above; and
   (2) receives principal support from the Member.

c. A Member's foster child, if that child:

   (1) meets the requirements in a. (1), (2), and (3) above; and
   (2) lives with the Member; and
   (3) receives principal support from the Member; and
   (4) is approved in Writing by The Principal as a Dependent Child.

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 this Group Policy, provided the child meets this Group Policy's definition of a Dependent Child.

Developmental Disability

A Dependent Child's substantial handicap, as determined by The Principal, which:

a. results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder; and

b. is diagnosed by a Physician as a permanent or long-term continuing condition.

Full-Time Employee

Any person who is regularly scheduled to work for the Policyholder for at least 30 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 this Group Policy, provided he or she is regularly scheduled to work for the Policyholder for at least 30 hours a week and otherwise meets the definition of Full-Time Employee.

Full-Time Student

This policy has been updated effective January 1, 2013

A Member's Dependent Child attending a school that has a regular teaching staff, curriculum and student body and who:

a. attends school on a full-time basis, as determined by the school's criteria; and

b. is dependent on the Member for principal support.

Generally Accepted

Treatment or Service, which is the subject of the claim, that:

a. 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

b. is in general use in the relevant vision community; and

c. is not under scientific testing or research.

Group Policy

The policy of group insurance issued to the Policyholder by The Principal which describes benefits and provisions for Members and Dependents.

Immediate Family

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.

Insurance Month

Calendar month.

Member

Any PERSON who is a Full-Time Employee of the Policyholder.

Optometrist

A person who is licensed to practice optometry.

Physical Handicap

This policy has been updated effective January 1, 2013

A Dependent Child's substantial physical or mental impairment, as determined by The Principal, which:

a. results from injury, accident, congenital defect, or sickness; and

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

Physician

A licensed Doctor of Medicine (M.D.) or Osteopathy (D.O.).

Placement for Adoption; Placement

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.

Policy Anniversary

January 1, 2014, and the same day of each following year.

Policyholder

The entity to whom this Group Policy is issued (see Title Page).

Prior Plan

The group vision care insurance coverage of the Policyholder for which this Group Policy is a replacement.

Signed or Signature

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 The Principal.

Treatment or Service

When used in this Group Policy, the term "Treatment or Service" will be considered to mean: "treatment, service, substance, material, or device".

Written or Writing

A record which is on or transmitted by paper or electronic media, and which is consistent

This policy has been updated effective January 1, 2013

with applicable law.

This policy has been updated effective January 1, 2013

PART II - POLICY ADMINISTRATION

Section A - Contract

Article 1 - Entire Contract

This Group Policy, the current Certificate, the attached Policyholder application, and any Member applications make up the entire contract. The Principal is obligated only as provided in this Group Policy and is not bound by any trust or plan to which it is not a signatory party.

Article 2 - Policy Changes

Insurance under this Group Policy runs annually to the Policy Anniversary, unless sooner terminated. No agent, employee, or person other than an officer of The Principal has authority to change this Group Policy, and, to be effective, all such changes must be in Writing and Signed by an officer of The Principal.

The Principal reserves the right to change this Group Policy as follows:

a. Any or all provisions of this Group Policy may be amended or changed at any time, including retroactive changes, to the extent necessary to meet the requirements of any law or any regulation issued by any governmental agency to which this Group Policy is subject.

b. Any or all provisions of this Group Policy may be amended or changed at any time when The Principal determines that such amendment is required for consistent application of policy provisions.

c. By Written agreement between The Principal and the Policyholder, this Group Policy may be amended or changed at any time as to any of its provisions.

Any change to this Group Policy, including, but not limited to, those in regard to coverage, benefits, and participation privileges, may be made without the consent of any Member or Dependent.

Payment of premium beyond the effective date of the change constitutes the Policyholder's consent to the change.

Article 3 - Policyholder Eligibility Requirements

To be an eligible group and to remain an eligible group, the Policyholder must:

a. be actively engaged in business for profit within the meaning of the Internal Revenue Code, or be established as a legitimate nonprofit corporation within the meaning of the Internal Revenue Code; and

b. make at least the level of premium contributions required for insurance on its eligible Members. The Policyholder must contribute at least 0% of the required premium for all Members (including disabled Members, if any); and

c. if the Member is to contribute part of the premium, maintain the following participation with respect to eligible employees:

    Employees: maintain the greater of 20% participation or five participants with respect to eligible employees.

If a Policyholder had prior coverage with The Principal which coverage terminated due to nonpayment of premium, The Principal will not accept application from that Policyholder within 12 months after the date of such termination.

Article 4 - Policy Incontestability

In the absence of fraud, after this Group Policy has been in force two years, The Principal may not contest its validity except for nonpayment of premium.

Article 5 - Individual Incontestability and Eligibility

All statements made by any individual insured under this Group Policy will be representations and not warranties. In the absence of fraud, these statements may not be used to contest an insured person's insurance unless:

a. the insured person's insurance has been in force for less than two years during the insured person's lifetime; and

b. the statement is in Written form Signed by the insured person; and

c. 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, these provisions will not preclude the assertion at any time of defenses based upon the person's ineligibility for insurance under this Group Policy or upon the provisions of this Group Policy.

This policy has been updated effective January 1, 2013

In addition, if an individual's age is misstated, The Principal may at any time adjust premium and benefits to reflect the correct age.

The Principal may at any time terminate a person's eligibility under this Group Policy:

a. 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

b. 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

c. 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.

Article 6 - Information to be Furnished

The Policyholder must, upon request, give The Principal all information needed to administer this Group Policy. If a clerical error is found in this information, The Principal may at any time adjust premium to reflect the facts. An error will not invalidate insurance that would otherwise be in force. Neither will an error continue insurance that would otherwise be terminated.

The Principal may inspect, at any reasonable time, all Policyholder records which relate to this Group Policy.

Article 7 - Certificates

The Principal will give the Policyholder Certificates for delivery to insured Members. The delivery of such Certificates will be in either paper or electronic format. The Certificates will be evidence of insurance and will describe the basic features of the benefit plan. They will not be considered a part of the Group Policy.

Article 8 - Workers' Compensation Not Affected

This Group Policy is not in place of and does not affect nor fulfill the requirements for Workers' Compensation Insurance.

Article 9 - Dependent Rights

A Dependent will have no rights under this Group Policy except as set forth in PART III, Section D, Article 2.

Article 10 - Electronic Transactions

Any transaction relating to this Group Policy may be conducted by electronic means if performance of the transaction is consistent with applicable state and federal law.

Any notice required by the provisions of this Group Policy given by electronic means will have the same force and effect as notice given in writing.

Article 11 - Value Added Service

The Principal reserves the right to offer or provide to a Policyholder a vision discount plan or any other value added service for the employees of the Policyholder. In addition, The Principal may arrange for third party service providers (i.e. optometrists, health clubs), to provide discounted goods and services to those Policyholders of The Principal. While The Principal has arranged these goods, services and third party provider discounts, the third party service providers are liable to the Members for the provisions of such goods and services. The Principal is not responsible for the provision of such goods or services nor is it liable for the failure of the provision of the same. Further, The Principal is not liable to the Members for the negligent provisions of such goods and/or services by the third party service providers.

Section B - Premiums

Article 1 - Payment Responsibility; Due Dates; Grace Period

The Policyholder is responsible for collection and payment of all premiums due while this Group Policy is in force. Payments must be sent to the home office of The Principal in Des Moines, Iowa.

The first premium is due on the Date of Issue of this Group Policy. Each premium thereafter will be due on the first of each Insurance Month. Except for the first premium, a Grace Period of 31 days will be allowed for payment of premium. "Grace Period" means the first 31-day period following a premium due date. The Group Policy will remain in force until the end of the Grace Period, unless this Group Policy has been terminated by notice as described in this PART II, Section C. The Policyholder will be liable for payment of the premium for the time this Group Policy remains in force during the Grace Period.

Article 2 - Premium Rates

The premium rates for each Member insured for Vision Care Expense Insurance will be:

Member Without Dependents	$8.09
Member With Dependent Spouse	$16.15
Member With Dependent Children	$15.19
Member and All Dependents	$23.25

Article 3 - Premium Rate Changes

The Principal may change a premium rate:

a. on any premium due date, if the rate has then been in force 12 months or more and if Written notice is given to the Policyholder at least 31 days before the date of change; or

b. on any date the definition of Member or Dependent is changed; or

c. on any date that a schedule of insurance or class of insured Members is changed.

Article 4 - Premium Amount

The amount of premium to be paid on each due date will be the sum of the premium rates then in effect for all Members then insured.

This policy has been updated effective January 1, 2013

If a Member is added or a present Member's insurance is increased or terminated on other than the first day of an Insurance Month, premium for that Member will be adjusted and applied as if the change were to take place on the first of the next following Insurance Month.

Article 5 - Contributions from Members

Members are required to contribute all of the premium for their insurance under this Group Policy.

Members are required to contribute all of the premium for their Dependent's insurance under this Group Policy.

This policy has been updated effective January 1, 2013

Section C - Policy Termination

Article 1 - Failure to Pay Premium

This Group Policy will terminate at the end of a Grace Period if total premium due has not been received by The Principal before the end of the Grace Period. Failure by the Policyholder to pay the premium within the Grace Period will be deemed notice by the Policyholder to The Principal to discontinue this Group Policy at the end of the Grace Period.

Article 2 - Termination for Cause

The Principal may terminate this Group Policy for cause by giving the Policyholder 31 days advance notice in Writing, with "cause" defined to be:

a. the Policyholder ceases to be an eligible group as described in this PART II, Section A; or

b. the Policyholder has made a material misrepresentation to or committed an act of fraud against The Principal.

Article 3 - Termination Without Regard to Cause

The Policyholder may terminate this Group Policy effective on the day before any premium due date by giving Written notice to The Principal prior to that premium due date. The Policyholder's issuance of a stop-payment order for any amounts used to pay premiums for the Policyholder's insurance will be considered Written notice from the Policyholder.

The Principal may terminate this Group Policy without regard to cause by giving the Policyholder 31 days advance notice in Writing.

The Principal may terminate the Policyholder's coverage on any premium due date if the Policyholder relocates to a state where this Group Policy is not marketed, by giving the Policyholder 31 days advance notice in Writing.

Article 4 - Policyholder Responsibility to Members

If this Group Policy terminates for any reason, the Policyholder must:

a. notify each insured Member of the effective date of the termination; and

b. refund or otherwise account to each Member all contributions received or withheld from Members for premiums not actually paid to The Principal.

This policy has been updated effective January 1, 2013

Section D - Policy Renewal

Article 1 - Renewal

Insurance under this Group Policy runs annually to the Policy Anniversary, unless sooner terminated.

While this Group Policy is in force, and subject to the provisions in this PART II, Section C, the Policyholder may renew at the applicable premium rates in effect on the Policy Anniversary.

Section A - Eligibility

Article 1 - Member Vision Care Expense Insurance

A person will be eligible for Member Vision Care Expense Insurance on the first of the Insurance Month coinciding with or next following the date the person completes 90 consecutive days of continuous Active Work as a Member.

If a Member elects to waive coverage under this Group Policy because he or she is covered under group vision care expense coverage or coverages provided by the Dependent's employer, the date such coverage terminates because the Dependent is no longer eligible under his/her employer's coverage will be considered the date the Member is eligible to request insurance as described in PART III, Section B of this Group Policy.

Article 2 - Dependent Vision Care Expense Insurance

A person will be eligible for Dependent Vision Care Expense Insurance on the later of:

a. the date the person is eligible for Member Vision Care Expense Insurance; or

b. the date the person first acquires a Dependent.

If a Member's Dependent is employed and covered under group vision care expense coverage or coverages provided by the Dependent's employer, the date such coverage terminates because the Dependent is no longer eligible under his/her employer's coverage will be considered the date the Member first acquires that Dependent (and any other Dependent who was also covered under such group coverage or coverages).

Article 1 - Member Vision Care Expense Insurance

a. Actively at Work

A Member's effective date for Member Vision Care Expense Insurance will be as explained in this section, if the Member is Actively at Work on that date. If the Member is not Actively at Work on the date insurance would otherwise be effective, such insurance will not be in force until the day of return to Active Work.

However, this Actively at Work requirement will be waived for Members who:

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

This Actively at Work requirement may also be waived as described in Replacement of a Prior Plan in PART IV, Section D, of this Group Policy.

b. Effective Date

Insurance must be requested in a form approved by The Principal. The effective date of the requested insurance will be based on the Member's date of request.

(1) Request on or before the date eligible or within 31 days after the date eligible

Insurance will be in force on the first of the Insurance Month coinciding with or next following the date the Member is eligible if request is made on or before the date the Member is eligible or the date coverage is requested if requested within 31 days of the date the Member is eligible.

(2) Request more than 31 days after the date eligible

Insurance will be in force on the first of the Insurance Month coinciding with or next following the date of the Member's request.

However, benefits will be limited as described under this Section B, Article 3.

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 for 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 an Annual Enrollment Period as described in c. below, insurance for such individual will become effective as described in c. below.

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) as described in d. below, insurance for such individual will become effective as described in d. below.

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

(3) Request more than 31 days after the date insurance terminates at the Member's request

Insurance will be in force on the first of the Insurance Month coinciding with or next following the date of the Member's request.

However, benefits will be limited as described under this Section B, Article 3.

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 for 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 an Annual Enrollment Period as described in c. below, insurance for such individual will become effective as described in c. below.

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) as described in d. below, insurance for such individual will become effective as described in d. below.

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

below.

c. Annual Enrollment Period

An Annual Enrollment Period will be available for any Member or Dependent who failed to enroll:

(1) during the first period in which he or she was eligible to enroll, or during any subsequent Special Enrollment Period, as described in e. below; or
(2) during any previous Annual Enrollment Period; or
(3) within 31 days after the termination date, if the individual was previously insured under this Group Policy but elected to terminate such insurance.

For any Member or Dependent not previously insured under this Group Policy, the Benefit-Waiting Period provisions described in this Section B, Article 3 do not apply during the Annual Enrollment Period if the Policyholder offers employees a choice among vision care expense coverages and the Member elects to transfer from another of the offered coverages to coverage under this Group Policy.

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

(1) must meet the eligibility requirements described in this Group Policy, including satisfaction of any applicable waiting period; and
(2) may not be covered under an alternate vision care expense plan 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 accepted by The Principal. The Annual Enrollment Period is the period from December 1 through December 31.

The effective date for any qualified individual requesting insurance during the Annual Enrollment Period will be January 1 following completion of the Annual Enrollment Period provided premium has been paid for the requested insurance.

d. Court-Ordered Coverage Under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN): Benefit-Waiting Period provisions as described under this Section B, Article 3 will not apply to a Member or Dependent Child if:

(1) the Member is enrolled (or is eligible to be enrolled but has failed to enroll during a previous enrollment period); and
(2) the Member has failed to enroll the Dependent Child during a previous enrollment

period; and

(3) the Member is required by a QMCSO or NMSN as defined by applicable federal law and state insurance laws to provide vision coverage for the Dependent Child.

The request for enrollment:

(1) may be made at any time after the issue date of the QMCSO or NMSN; and
(2) will apply only to the Member and/or Dependent Child(ren) listed in the QMCSO or NMSN.

The effective date of the Member's or Dependent Child's insurance:

(1) will be the first of the Insurance Month coinciding with or next following the date of the request for enrollment; and

(2) 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.

e. Special Enrollment Period

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

The Special Enrollment Periods are:

(1) Loss of Other Coverage: A Special Enrollment Period will apply to a Member or Dependent if all of the following conditions are met:

(i) the individual (Member or Dependent) 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 COBRA or a 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 first of the Insurance Month coinciding with or next following the date of the request for enrollment provided premium has been paid for the requested insurance.

NOTE: For the purpose of (1) (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 coverage 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.

(2) Newly Acquired Dependents: A Special Enrollment Period will apply to a Member or Dependent if:

(i) the Member is enrolled (or is eligible to be enrolled but has failed to enroll during a previous enrollment period); and
(ii) a person becomes a Dependent of the Member 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 this Group Policy, if the request is made on or before the event or within 31 days after the event.

The effective date of the Member's or 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.

The Benefit-Waiting Period provisions described in this Section B, Article 3 do not apply during the Special Enrollment Period.

f. Effective Date for Benefit Changes - Change in Member Status

A change in a Member's Scheduled Benefits because of a change in the Member's status (insurance class) will normally be effective on the first of the Insurance Month coinciding with or next following the date of the change in status. However, if the Member is not Actively at Work on the date a Scheduled Benefit change would otherwise be effective, the Scheduled Benefit change will not be in force until the date the Member returns to Active Work.

Any termination of Scheduled Benefits due to a change in a Member's status (insurance

class) will be effective on the date of the change in status, whether or not the Member is Actively at Work.

g. Effective Date for Benefit Changes - Change by Policy Amendment

A change in the amount of a Member's Scheduled Benefits because of a change in the Schedule of Insurance (as described in PART IV, Section A) by amendment to this Group Policy will be effective on the first of the Insurance Month coinciding with or next following the date of change. However, if the Member is not Actively at Work on the date a Scheduled Benefit change would otherwise be effective, the Scheduled Benefit change will not be in force until the date the Member returns to Active Work.

h. Effective Date for Benefit Changes - Change in Benefits Made by The Principal

A change in a Member's Scheduled Benefit because of a change made by The Principal will normally be effective on the Policyholder's Policy Anniversary (or as otherwise determined by The Principal). However, if the Member is not Actively at Work on the date a Scheduled Benefit change would otherwise be effective, the Scheduled Benefit change will not be in force until the date the Member returns to Active Work.

Article 2 - Dependent Vision Care Expense Insurance

Dependent Vision Care Expense Insurance is available only with respect to Dependents of Members currently insured for Member Vision Care Expense Insurance. If a Member is eligible for Dependent Vision Care Expense Insurance, such insurance will become effective under the same terms as set forth for Member Vision Care Expense Insurance in this Section B, Article 1, except as described below:

a. In no event will Dependent Vision Care Expense Insurance be in force for a Member who is not insured for Member Vision Care Expense Insurance.

b. A Member will be insured with respect to a new Dependent on the date the Dependent is acquired, if Dependent Vision Care Expense Insurance is then in force for any other Dependent of the Member.

c. The Actively at Work requirement will apply only to Member insurance.

However, benefits for the Dependent will be limited as described under this Section B, Article 3.

Article 3 - Benefit Waiting Period (for when the Member requests insurance more than 31 days after (1) the date eligible; or (2) the date the Member elects to terminate insurance

Other than during an Annual Enrollment Period or a Special Enrollment Period or coverage as required by a QMCSO or NMSN as described in this Section B, Article 1, if the Member requests Member or Dependent insurance more than 31 days after the date the person is eligible under this Group Policy or the Member elects to terminate insurance and more than 31 days later requests to be insured again, benefits payable under this Group Policy 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 in PART IV, Section A).

Section C - Individual Terminations

Article 1 - Member Vision Care Expense Insurance

Unless continued as provided in Section D - Continuation, a Member's coverage under this Group Policy will terminate on the earliest of:

a. the date this Group Policy is terminated; or

b. the end of the Insurance Month for which the last premium is paid for the Member's insurance; or

c. for contributory insurance, the end of any Insurance Month desired, if requested by the Member before that date; or

d. the end of the Insurance Month in which the Member ceases to be a Member as defined in PART I; or

e. the end of the Insurance Month in which the Member ceases to be in a class for which Member Vision Care Expense Insurance is provided; or

f. the end of the Insurance Month in which the Member ceases Active Work.

Article 2 - Dependent Vision Care Expense Insurance

Unless continued as provided in Section D - Continuation, a Member's coverage under the Group Policy for a Dependent will terminate on the earliest of:

a. the date his or her Member Vision Care Expense Insurance ceases; or

b. the end of the Insurance Month for which the last premium is paid for the Member's Dependent Vision Care Expense Insurance; or

c. for contributory insurance, the end of any Insurance Month desired, if requested by the Member before that date; or

d. for a spouse or each Dependent Child, on the last day of the Insurance Month in which that spouse or Dependent Child ceases to be a Dependent as defined in PART I. However, a spouse who no longer resides with the Member will not cease to be a Dependent until legally separated or divorced, provided the spouse otherwise continues to be a Dependent as defined in PART I.

Article 1 - Member Vision Care Expense Insurance

a. Sickness or Injury

If Active Work ends because a Member is sick or injured, insurance for that Member may be continued until the earliest of:

(1) the date insurance would otherwise cease as provided in this PART III, Section C; or
(2) the end of the Insurance Month in which insurance has been continued for 12 consecutive months; or
(3) the end of the Insurance Month in which the Member recovers; or
(4) the end of the Insurance Month in which the Member is covered under the USERRA continuation provision.

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

b. Layoff or Approved Leave of Absence

If Active Work ends because a Member is on layoff or approved leave of absence, insurance for that Member may be continued until the earliest of:

(1) the date insurance would otherwise cease as provided in this PART III, Section C; or
(2) the end of the Insurance Month in which the layoff or approved leave of absence ends; or
(3) the date the Member becomes eligible for any other group vision care coverage; or
(4) the date one month after the end of the Insurance Month in which Active Work ends.

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

Article 2 - Dependent Vision Care Expense Insurance

a. During Continuation of Member Insurance

Except as otherwise provided in this PART III, Section C, Dependent Vision Care Expense Insurance may remain in force during any period that Member Vision Care

Expense Insurance is continued.

b. Developmentally Disabled or Physically Handicapped Children

(1) Qualification

Dependent Vision Care Expense Insurance for a child may be continued after the child reaches the maximum age for Dependent Children as defined in PART I of this Group Policy, provided that:

- the child is incapable of self-support as the result of a Developmental Disability or Physical Handicap and became so before reaching the maximum age and is dependent on the Member for primary support; and
- except for age, the child continues to be a Dependent Child as defined in PART I; and
- proof of the child's incapacity is sent to The Principal within 31 days after the date the child reaches the maximum age; and
- further proof that the child remains incapable of self-support is provided when The Principal requests; and
- the child undergoes examination by a Physician when The Principal requests. The Principal will pay for these examinations and will choose the Physician to perform them.

(2) Period of Continuation

Insurance for a Dependent Child who qualifies as set forth above may be continued until the earlier of:

- the date insurance would cease for any reason other than the child's attainment of the maximum age; or
- the date the child becomes capable of self-support or otherwise fails to qualify as set forth in (1) above.

Article 3 - Federal Required Continuation

a. Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA applies to any employer (excepting the federal government and religious organizations) who:

(1) maintains a group vision coverage; and
(2) 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.

Federal law requires that certain group health plans allow qualified persons who would otherwise lose coverage under this Group Policy as a result of a qualifying event, to elect to continue group coverage under this Group Policy. If coverage under this Group Policy is continued under Article 1 or Article 2, above, the continuation coverage provided under COBRA will run concurrently with such continuation provisions.

A full description of the COBRA continuation provisions is included in the administration material provided to the Policyholder and in the booklet-certificate.

b. Family and Medical Leave Act (FMLA)

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 this Group Policy. A full description of the FMLA continuation provisions is included in the administration material provided to the Policyholder.

(1) FMLA and Other Continuation Provisions

These FMLA continuation provisions:

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

(2) 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 work weeks in the current or preceding calendar year.

(3) 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 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).

(4) Mandated Unpaid Leave

a. 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; or
- because of a "qualifying exigency" arising out of a spouse, son, daughter or parent on active duty or having been notified of a call to active duty.

b. Eligible Employers are required to allow up to a total of 26 workweeks of unpaid leave during any 12 month period to eligible employees to care for a "covered service member" with a "serious injury or illness".

(5) Reinstatement

An Eligible Employee's terminated insurance may be reinstated in accordance with the provisions of the FMLA, subject to the Actively at Work provision described in this PART III, Section B.

c. Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA)

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

Such continued insurance will terminate on the earliest of:

(1) for a Member and his or her Dependents:

- the date this Group Policy is terminated; or
- the end of the premium period for which premium is paid if the Member fails to make timely payment of a required premium; or

- the date 24 months after the date the Member enters active military duty; or
- the date after the day in which the Member fails to return to Active Work or apply for reemployment with the Policyholder.

(2) for a Member's Dependents:

- the date Dependent Vision Care Expense Insurance would otherwise cease as provided in this PART III, Section C; or
- the end of any Insurance Month desired, if requested by the Member before that date.

Continuation provisions described in this Group Policy for sickness, injury, layoff, or approved leave of absence, if any, may apply. These continuation provisions, however, will terminate on the end of the Insurance Month in which the Member is covered under the USERRA continuation provision. If the Member qualifies for USERRA or COBRA, the election of one means the rejection of the other.

The reinstatement time period, as provided in this PART III, Section E, 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 this PART III, Section B, will not apply to the reinstated insurance.

This is a general summary of the USERRA and how it affects this Group Policy. A full description of the USERRA continuation provisions is included in the administration material provided to the Policyholder.

Section E - Reinstatement

Article 1 - Reinstatement

A Member's terminated insurance will be reinstated if:

a. insurance ceased because of layoff or approved leave of absence; and

b. the Member returns to Active Work for the Policyholder within twelve months of the date insurance ceased.

The Member's reinstated insurance will be in force on the date of return to Active Work. However, the Actively at Work provision discussed in the PART III, Section B, will apply.

Only the period of time during which a Member is actually insured will be included in determining the length of his or her continuous coverage under this Group Policy. For this purpose the period of time during which a reinstated Member's insurance was not in force:

a. will not be considered an interruption of continuous coverage; and

b. will not be used to satisfy any provision of this Group Policy which pertains to a period of continuous coverage.

PART IV - BENEFITS

Section A - Member Vision Care Expense Insurance

Article 1 - Schedule of Insurance

Insurance Class

Subject to the Effective Date provisions of PART III, Section B, Scheduled Benefits for insured Members will be:

Class	Scheduled Benefits
All Members	All benefits as described in this PART IV, Section A

Article 2 - Benefit Qualification

A Member will qualify for payment of the benefits provided for an insurance class if:

a. he or she is insured in that class on the date vision Treatment or Service is received; and

b. the claim requirements of this PART IV, Section C, are satisfied.

Article 3 - Benefits Payable

Benefits payable under this Group Policy will be as described in this PART IV, Section A, subject to:

a. the limitations listed in this section; and

b. the terms and conditions set forth in Coordination with Other Benefits in this PART IV, Section E.

Article 4 - Payment Conditions

If a Member undergoes a Complete Visual Analysis or purchases any of the vision aids listed below, The Principal will pay the actual cost charged to the Member by the provider, but not more than the Maximum Payment Limits shown.

	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 Contact 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.

Article 5 - Limitations

No benefits will be paid for:

a. a visual analysis performed by other than a Physician or Optometrist; or

b. vision aids not prescribed by a Physician or Optometrist; or

c. a visual analysis or vision aids provided by a person in the Member's or Dependent's

Immediate Family; or

d. sunglasses (prescribed or not); or

e. duplication or replacement of a vision aid that is broken, lost, or stolen; or

f. more than one Complete Visual Analysis in any period of 12 consecutive months; or

g. more than two lenses (one pair) in any period of 12 consecutive months or one set of frames in any period of 24 consecutive months; or

h. a visual analysis or vision aids for which the Member has no financial liability or that would be provided at no charge in the absence of insurance; or

i. a visual analysis or vision aids 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

j. a visual analysis or vision aids provided as the result of a sickness or injury due to war or act of war or participation in criminal activities; or

k. a visual analysis or vision aids provided as the result of:

  (1) an injury arising out of or in the course of any employment for wage or profit if the Member is eligible to be covered under a Workers' Compensation Act or other similar law; except 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
  (2) a sickness covered by a Workers' Compensation Act or other similar law; or

l. a visual analysis or vision aids provided outside the United States, unless the Member is outside the United States for one of the following reasons:

  (1) 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
  (2) a business assignment, provided the Member is temporarily outside the United States for a period of six months or less; or
  (3) 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

m. medical or surgical treatment of the eyes.

Section B - Dependent Vision Care Expense Insurance

Article 1 - Schedule of Insurance

Insurance Class

Subject to the Effective Date provisions of PART III, Section B, Scheduled Benefits for insured Dependents will be:

Class	Scheduled Benefits
All Dependents	All benefits as described in this PART IV, Section B

Article 2 - Benefit Qualification

A Dependent will qualify for payment of the benefits provided for an insurance class if:

a. he or she is insured in that class on the date vision Treatment or Service is received; and

b. the claim requirements of this PART IV, Section C, are satisfied.

Article 3 - Benefits Payable

Benefits payable under this Group Policy will be as described in this PART IV, Section B, subject to:

a. the limitations listed in this section; and

b. the terms and conditions set forth in Coordination with Other Benefits in this PART IV, Section E.

Article 4 - Payment Conditions

If a Dependent undergoes a Complete Visual Analysis or purchases any of the vision aids listed below, The Principal will pay the actual cost charged to the Dependent by the provider, but not more than the Maximum Payment Limits shown.

	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 Contact 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.

Article 5 - Limitations

No benefits will be paid for:

a. a visual analysis performed by other than a Physician or Optometrist; or

b. vision aids not prescribed by a Physician or Optometrist; or

c. a visual analysis or vision aids provided by a person in the Member's or Dependent's

Immediate Family; or

d. sunglasses (prescribed or not); or

e. duplication or replacement of a vision aid that is broken, lost, or stolen; or

f. more than one Complete Visual Analysis in any period of 12 consecutive months; or

g. more than two lenses (one pair) in any period of 12 consecutive months or one set of frames in any period of 24 consecutive months; or

h. a visual analysis or vision aids for which the Dependent has no financial liability or that would be provided at no charge in the absence of insurance; or

i. a visual analysis or vision aids 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

j. a visual analysis or vision aids provided as the result of a sickness or injury due to war or act of war or participation in criminal activities; or

k. a visual analysis or vision aids provided as the result of:

  (1) an injury arising out of or in the course of any employment for wage or profit if the Dependent is eligible to be covered under a Workers' Compensation Act or other similar law; except 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
  (2) a sickness covered by a Workers' Compensation Act or other similar law; or

l. a visual analysis or vision aids provided outside the United States, unless the Member is outside the United States for one of the following reasons:

  (1) 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
  (2) a business assignment, provided the Dependent is temporarily outside the United States for a period of six months or less; or
  (3) 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

m. medical or surgical treatment of the eyes.

This policy has been updated effective January 1, 2013

Section C - Claim Procedures

Article 1 - Notice of Claim

Written notice must be sent to The Principal by or for a Member or Dependent who wishes to file claim for benefits under this Group Policy. This notice must be sent within 20 calendar days after the date of loss for which claim is being made. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

Article 2 - Claim Forms

The Principal, when it receives notice of claim, will provide appropriate claim forms for filing proof of loss. If the forms are not provided within 15 calendar days after The Principal receives notice of claim, the person 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.

Article 3 - Proof of Loss

Written proof of loss must be sent to The Principal within 90 calendar days after the date of the loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when The Principal receives proof of loss. Proof of loss includes the patient's name, Member's name (if different from the patient's name), provider of services, dates of service, diagnosis, description of Treatment or Service provided and the extent of the loss. The Principal may request additional information to substantiate loss or require a Signed unaltered authorization to obtain that information from the provider. Failure to comply with The Principal's request could result in declination of the claim.

Article 4 - 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, The Principal 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 Principal 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 this Group Policy may be payable sooner, provided The Principal receives complete and proper proof of loss. If a claim is not payable or cannot be processed, The Principal 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 The Principal within 180 calendar days of receipt of notice of the denial. The Principal will make a full and fair review of the claim. The Principal may require additional information to make the review. The Principal 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. The Principal 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, The Principal 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 The Principal 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 this Group Policy. The Principal offers 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 Member or Dependent.

Article 5 - Facility of Payment

The Principal will normally pay all benefits to the Member. However, if the claim benefits result from a Dependent's Treatment or Service, The Principal may make payment to the Dependent. Also, in the special instances listed below, payment will be as indicated. All payments so made will discharge The Principal to the full extent of those payments.

a. If payment amounts remain due upon a Member's death, those amounts may, at The Principal's option, be paid to the Member's estate, spouse, child, parent, or provider of vision services.

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

Article 6 - Medical Examinations

The Principal may have the person whose loss is the basis for claim examined by a Physician during the course of a claim. The Principal will pay for these examinations and will choose the Physician to perform them.

Article 7 - Legal Action

Legal action to recover benefits under this Group Policy may not be started earlier than 60 calendar days after required proof of loss has been filed and before the appeal procedures have been exhausted. Further, no legal action may be started later than three years after that proof is required to be filed.

Article 8 - Time Limits

Any time limit listed in this section will be adjusted as required by law.

Section D - Replacement of a Prior Plan

Article 1 - Applicability

When insurance under this Group Policy replaces coverage under a Prior Plan, this section will apply to those Members and Dependents who:

a. are eligible and enrolled under this Group Policy on its Date of Issue; and

b. were covered under the Prior Plan on the date of its termination.

Article 2 - Benefits Payable

Benefits may be payable under this section when benefits under this Group Policy would otherwise be denied solely because of the Actively at Work provision, provided that:

a. benefits would have been paid under the Prior Plan had it remained in force; and

b. benefits are not paid under the Prior Plan due to its termination.

For Members who are not Actively at Work on the Date of Issue of this Group Policy and have not been Actively at Work since then the benefits payable, if any, under this section will be the lesser of:

a. the benefits of this Group Policy; or

b. the benefits that would have been paid by the Prior Plan had it remained in force.

For Members who are Actively at Work on the Date of Issue of this Group Policy, the benefits payable under this section will be the benefits of this Group Policy.

In no event will benefits be paid for any Treatment or Service:

a. received before the Date of Issue of this Group Policy; or

b. for which benefits are paid under the Prior Plan; or

c. for which benefits would have been paid under the Prior Plan (including that plan's extended benefit provision) in the absence of this section.

Section E - Coordination with Other Benefits

Article 1 - Purpose

The intent of this section is to provide that the sum of benefits paid under this Group Policy plus benefits paid under all other Plans will not exceed the actual cost charged for a Treatment or Service.

Article 2 - Definitions

As used in this section, the terms listed below will mean:

a. Plan

Any vision care expense benefits provided under:

(1) any insured or noninsured group, service, prepayment, or other program arranged through an employer, trustee, union, or association; and
(2) any program required or established by state or Federal law (including Medicare Parts A and B); and
(3) any program sponsored by or arranged through a school or other educational agency; and
(4) 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 a student accident policy, nor will the term Plan include benefits provided under a state medical assistance program where eligibility is based on financial need.

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.

b. Allowable Expense

The necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part under at least one of the Plans then in force for the person for whom benefits are claimed.

c. Claim Determination Period

The part of a calendar year during which a Member or Dependent would receive benefit payments under this Group Policy if this section were not in force.

Article 3 - Effect on Benefits

Benefits otherwise payable under this Group Policy for Allowable Expenses during a Claim Determination Period may be reduced if:

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

b. the rules listed in Article 4 below provide that benefits payable under the other Plan are to be determined before the benefits payable under this Group Policy.

The reduction will be the amount needed to provide that the sum of payments under this Group Policy plus benefits payable under the other Plan(s) is not more than the total of Allowable Expenses. Each benefit that would be payable in the absence of this section will be reduced proportionately. Any such reduced amount will be charged against any applicable benefit limit of this Plan.

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.

Article 4 - Order of Benefit Determination

Except as described in Article 5 below, the benefits payable of a Plan that does not have a coordination of benefits provision substantially 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:

a. Nondependent/Dependent. The benefits of a Plan which covers the person for whom benefits are claimed as an employee, Member, or subscriber (that is, other than as a Dependent) are determined before the benefits of a 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:

   (1) secondary to the Plan covering the person as a Dependent; and
   (2) 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.

b. Dependent Child--Parents Not Separated or Divorced. Except as stated in paragraph c. below, when this Group Policy and another Plan cover the same child as a Dependent of different persons called "parents," the benefits of the Plan of the parent whose birthday falls earlier in a calendar year are determined before those of the Plan of the parent whose birthday falls later in that year; but if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if another Plan does not have the rule described above, but instead has a rule based on 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.

c. Dependent Child--Separated or Divorced Parents. If two or more Plans cover a Dependent Child of divorced or separated parents, benefits for the child are determined in this order:

(1) first, the Plan of the parent with custody of the child;
(2) then, the Plan of the spouse of the parent with custody of the child; and
(3) 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 with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. Active/Inactive Employee. The benefits of a Plan which covers the person for whom benefits are claimed as an employee who is neither laid off nor retired, or as that employee's Dependent, are determined before the benefits of a Plan which covers that person as a laid-off or retired employee or as that employee's Dependent. 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.

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

(1) first, the benefits of a Plan covering the person as an employee, Member or subscriber (or as that person's Dependent);
(2) 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.

f. Longer/Shorter Length of Coverage. If none of the above rules determine the order of benefits, the benefits of the Plan which covered the person for whom benefits are claimed longer are determined before those of the Plan which covered that person for the shorter time.

Article 5 - Medicare Exception

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

Article 6 - Exchange of Information

Any person who claims benefits under this Group Policy must, upon request, provide all information The Principal believes is needed to coordinate benefits as described in this section.

In addition, all information The Principal believes is needed to coordinate benefits may be exchanged with other companies, organizations, or persons.

Article 7 - Facility of Payment

The Principal may reimburse any other Plan if:

a. benefits were paid by that other Plan; but

b. should have been paid under this Group Policy in accordance with this section.

In such instances, the reimbursement amounts will be considered benefits paid under this Group Policy and, to the extent of those amounts, will discharge The Principal from liability.

Article 8 - Right of Recovery

If, in accordance with this section, it is determined that benefits paid under this Group Policy should have been paid by any other Plan, The Principal will have the right to recover those payments from:

a. the person to or for whom the benefits were paid; and/or

b. the other companies or organizations liable for the benefit payments.

This policy has been updated effective January 1, 2013

This page left blank intentionally

Principal Life Insurance Company
Des Moines, Iowa 50392-0002

Principal Life Insurance Company
Des Moines, Iowa 50392-0002