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07/01/2019

GROUP BOOKLET-CERTIFICATE FOR MEMBERS OF:

**BANKS COUNTY BOARD OF
COMMISSIONERS**

**ALL MEMBERS
Group Voluntary Critical Illness Insurance**

Print Date: 07/02/2019

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PRINCIPAL LIFE INSURANCE COMPANY
(called Principal Life in this Certificate of Coverage)
Des Moines, Iowa 50392-0002

Certificate of Coverage

Important Notice: This is Critical Illness insurance. It provides a limited specified benefit. It is not a substitute for medical coverage. Please read this Certificate of Coverage carefully to fully understand what it covers, limits, and excludes. Principal Life suggests starting with a review of the terms listed in the DEFINITIONS section. Knowing the meaning of these terms will help with understanding the insurance.

This Certificate of Coverage is part of the Group Policy that is a legal document between Principal Life and the Policyholder to provide benefits to Members and their Dependents, subject to the terms, conditions, limitations and exclusions of the Group Policy. Principal Life issues the Group Policy based on the employer application and payment of the required policy premium. The Group Policy, the incorporated Certificate of Coverage, and the attached employer application, and any Employee applications make up the entire contract.

This insurance has been designed to provide a benefit payment when a covered Critical Illness occurs. The benefits are provided by a Group Policy issued by Principal Life. To the extent that benefits are provided by that Group Policy, the administration and payment of claims will be done by Principal Life as an insurer.

The provisions of the Group Policy determine Members' rights and benefits. This Certificate of Coverage briefly describes those rights and benefits. It outlines what the Member must do to be insured. It explains how to file claims. It is the Member's Certificate of Coverage while insured.

The effective date of insurance is as shown on the Scheduled Benefits Summary.

THIS CERTIFICATE OF COVERAGE REPLACES ANY PRIOR CERTIFICATE OF COVERAGE THAT THE MEMBER MAY HAVE RECEIVED FROM PRINCIPAL LIFE. If there are questions about this new Certificate of Coverage, please contact the Policyholder. In the event of future changes to the Member's insurance, the Member will be provided with a new Scheduled Benefits Summary, Certificate of Coverage or a Certificate of Coverage rider.

This Certificate of Coverage describes all the benefits available under the Group Policy underwritten by Principal Life. However, if the Member has elected to not accept any available benefits, those benefits described in this Certificate of Coverage will not apply to the Member.

The group insurance policy and the Member's insurance under the Group Policy may be discontinued or altered by the Policyholder or Principal Life at any time without the Member's consent.

Principal Life reserves discretion to construe or interpret the provisions of the Group Policy, to determine eligibility for benefits, and to determine the type and extent of benefits, if any, to be provided.

The insurance provided in this Certificate of Coverage is subject to the laws of the state of GEORGIA.

TABLE OF CONTENTS

DEFINITIONS	GH 5712 (CI)
SCHEDULED BENEFITS SUMMARY	GH 5713 (CI)
HOW TO BE INSURED	
Members	GH 5714 (CI)
Dependents	GH 5715 (CI)
CONTINUATION OF COVERAGE	GH 5716 (CI)
REINSTATEMENT	GH 5718 (CI)
DESCRIPTION OF BENEFITS	
Benefit Provisions - Member	GH 5719 (CI)
Benefit Provisions - Dependents	GH 5720 (CI)
Wellness	GH 5721 (CI)
Limitations and Exclusions	GH 5722 (CI)
Portability	GH 5723 (CI)
CLAIM PROCEDURES	GH 5724 (CI)
STATEMENT OF RIGHTS	GH 112 (CI)

DEFINITIONS

Several words and phrases are capitalized whenever they are used in this Group Policy. For the purpose of the Group Policy these words and phrases have specific meaning as explained in this section.

Active Work; Actively at Work

Members are considered Actively at Work if they are able and available for active performance of all regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered Active Work provided a Member is able and available for active performance of all regular duties and was working the day immediately prior to the date of absence.

Age

The age of the Member or Dependent as of the prior Policy Anniversary date.

Cancer One

A malignant tumor characterized by uncontrolled growth of malignant cells and invasion of normal tissue. Cancer One also covers the following blood cancers: Lymphoma, leukemia and multiple myeloma.

The following tumors are excluded from Cancer One:

- Chronic lymphocytic leukemia that has not progressed to at least Rai stage I;
- All tumors that are histologically described as nonmalignant, benign, premalignant, noninvasive, dysplasia (all grades) or carcinoma in situ;
- All skin cancers, unless there is metastasis, or the tumor is a malignant melanoma of greater than 1.0 mm maximum thickness (regardless of Clark level or ulceration) as determined by histological examination using the Breslow method;
- Prostate cancer, unless histologically classified as Gleason score 7 or greater, or TNM classification T1bN0M0 or greater;
- Papillary carcinoma of the thyroid (1 cm or less in diameter) and confined to the thyroid, also known as microcarcinoma of the thyroid;
- Noninvasive papillary cancer of the bladder histologically described as TNM classification TaN0m0 or lower; and
- Evidence of cancer cells or cancer genetic material detected by molecular or biochemical probes only (including but not limited to proteomic or DNA/RNA-based techniques) with no lesion amenable to tissue diagnosis.

Diagnosis of Cancer One must be based on microscopic (histologic) examination of:

- fixed tissues; or
- preparations of blood or bone marrow.

Such examination must be documented in a written report by a Physician who is board certified in pathology, hematology or oncology.

A Clinical Diagnosis will be accepted only if:

- a pathological Diagnosis cannot be made because it is medically inappropriate or life threatening; and
- there is medical evidence to support the Diagnosis; and

- a Physician is treating the Member or Dependent for Cancer One.

Cancer One will be deemed to be Incurred on the date the Diagnosis is made.

Cancer Two

Means the following:

- Chronic lymphocytic leukemia that has not progressed beyond Rai stage 0;
- Carcinoma in situ, which means a malignant neoplasm limited to the epithelium and confined within the basement membrane;
- Early stage melanoma, which means a malignant melanoma of up to 1.0 mm maximum thickness (regardless of Clark level or ulceration) as determined by histological examination using the Breslow method;
- Early stage prostate cancer, which means a localized cancer histologically classified as Gleason score 6 or less, and TNM classification T1aN0M0;
- Papillary microcarcinoma of the thyroid, which means a papillary carcinoma of the thyroid (1 cm or less in diameter) and confined to the thyroid; and
- Noninvasive papillary cancer of the bladder histologically described as TNM classification TaN0m0.

Cancer Two does not include:

- Carcinoma and melanoma in situ of the skin and all skin cancers; or
- Evidence of cancer cells or cancer genetic material detected by molecular or biochemical probes only (including but not limited to proteomic or DNA/RNA-based techniques) with no lesion amenable to tissue diagnosis.

Diagnosis of Cancer Two must be based on microscopic (histologic) examination of:

- fixed tissues; or
- preparations of blood or bone marrow.

Such examination must be documented in a written report by a Physician who is board certified in pathology, hematology or oncology.

A Clinical Diagnosis will be accepted only if:

- a pathological Diagnosis cannot be made because it is medically inappropriate or life threatening; and
- there is medical evidence to support the Diagnosis; and
- a Physician is treating the Member or Dependent for Cancer Two.

Cancer Two will be deemed to be Incurred on the date the Diagnosis is made.

Clinical Diagnosis

An identification of Cancer One or Cancer Two based on observation and history, diagnostic and laboratory studies and symptoms.

Coronary Artery Bypass Graft (CABG)

Major surgery which requires median sternotomy (division of the breast bone) to correct narrowing or blockage of one or more coronary arteries with bypass grafts.

The term does not mean procedures that do not require median sternotomy. These include but are not limited to minimally invasive, endoscopic, and "keyhole" heart surgery, balloon and laser angioplasty, stent procedures and atherectomy.

Proof of Coronary Artery Bypass Graft (CABG) requires submission of medical records. These records must show that it:

- was determined to be medically necessary by a Physician who is a board certified cardiologist or a board certified cardiothoracic surgeon;
- was supported by pre-operative angiographic evidence; and
- has been performed on a Member or Dependent.

The CABG will be deemed to be Incurred on the date it was performed.

Critical Illness

The illnesses or procedures listed under Benefits Payable and defined within this Certificate of Coverage.

Date of Issue

The date the Group Policy is placed in force: July 1, 2019.

Dependent

- A Member's spouse, if that spouse:
 - is legally married to the Member; and
 - is not in the Armed Forces of any country; and
 - is not insured under the Group Policy as a Member.
- A Member's Dependent Child(ren) as defined below.
- A Member's Domestic Partner, if the Member and the Domestic Partner complete and submit a Declaration of Domestic Partnership which is approved by Principal Life.

Dependent Child(ren)

- A Member's natural child, if that child:
 - is not insured under the Group Policy as a Member; and
 - is less than 26 years of age.
- A Member's stepchild, if that child:
 - meets the requirements above; and
 - receives principal support from the Member.
- A Member's foster child, if that child:
 - meets the requirements above; and
 - lives with the Member; and
 - receives principal support from the Member; and
 - is under legal guardianship of the Member or the Member's spouse or Domestic Partner; and
 - is approved in writing by Principal Life as a Dependent Child.

- A Member's adopted child, if that child meets the requirements above and the Member:
 - is a party in a lawsuit in which the Member is seeking the adoption of the child; or
 - has custody of the child under a court order that grants custody of the child to the Member.

An adopted child will be considered a Dependent Child on the earlier of: the date the petition for adoption is filed; or the date of entry of an order granting the adoptive parent custody of the child for the purpose of adoption.

- The Member's Domestic Partner's child who otherwise qualifies above or if the Member or Domestic Partner are the child's guardian by court order.

Developmental Disability

A Dependent Child's substantial disability, as determined by Principal Life, 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.

Diagnosed or Diagnosis

A definitive identification of the Critical Illness made by a Physician (where applicable) specializing in a particular area of medicine and supported by documentation of all appropriate and defined studies:

- based upon the usage of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations; and
- meeting any diagnostic requirements stated in the Group Policy for the particular Critical Illness being diagnosed.

Domestic Partner

A Member's opposite sex or same sex life partner, provided:

- the partner is not in the Armed Forces of any country; and
- the partner is not insured under the Group Policy as a Member; and
- the partner is at least 18 years of age; and
- neither the partner nor the Member are married; and
- neither the partner nor the Member have had another Domestic Partner in the six-month period preceding the date of the signed Declaration of Domestic Partnership; and
- the partner is not the Member's blood relative; and
- the partner and the Member have shared the same residence for at least six consecutive months and continue to do so; and
- the partner and the Member are each other's sole life partner and intend to remain so indefinitely; and
- the partner and the Member are jointly responsible for each other's financial welfare; and
- the partner and the Member are not in the relationship solely for the purpose of obtaining insurance coverage.

Employee

Any PERSON who is residing in the United States, who is a U.S. Citizen or is legally working in the United States, and who regularly works at least 30 hours per week for the Policyholder. The Employee must be compensated by the Policyholder and the Policyholder or Employee must be able to show taxable income on federal or state tax forms. Work must be at the Policyholder's usual place or places of business, at an alternative worksite at the direction of the Policyholder, or at another place to which the Employee must travel to perform his or her regular duties. This excludes any person who is scheduled to work for the Policyholder on a seasonal, temporary, contracted, or part-time basis. A person is considered to be residing in the United States if his or her main home or permanent address is in the United States or if the person is in the United States for six months or more during any 12-month period.

First Occurrence

The first time the Member or Dependent meets the definition of a Critical Illness after being insured under the Group Policy.

Grace Period

The first 31 day period following a premium due date.

Group Policy

The policy of group insurance issued to the Policyholder by Principal Life, which describes benefits and provisions for Members and Dependents. The Group Policy is divided into two sections:

- the Policyholder provision; and
- the Certificate of Coverage provisions for the Member and Dependent.

Heart Attack

Death of heart muscle due to inadequate blood supply. All of the following criteria must be satisfied:

- typical clinical symptoms, for example central chest pain; and
- diagnostic increase of specific cardiac markers for myocardial infarction; and
- new electrocardiographic changes of infarction.

Heart Attack does not include any heart attack that occurred during or within 24 hours after a cardiac or coronary artery procedure.

Proof of Heart Attack requires submission of medical records.

The Heart Attack will be deemed to be Incurred on the date it is Diagnosed by a Physician who is a board certified cardiologist.

Home Confined

Due to sickness or injury, the Dependent is unable to carry on the regular and usual activities of a healthy person of the same age and sex and unable to leave his or her home except to receive medical treatment.

Hospital

An institution that is licensed as a Hospital by the proper authority of the state in which it is located, but not including any institution, or part thereof, that is used primarily as a clinic, Skilled Nursing Facility, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center.

Immediate Family

A Member's spouse, Domestic Partner, 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.

Incur or Incurred

An event or incident as defined within each Critical Illness for the purposes of the Group Policy.

Insurance Month

Calendar month.

Major Organ Failure

Irreversible end-stage failure of bone marrow, heart, kidney, liver, lung, or pancreas, and

- For kidney failure only, dialysis (either hemo or peritoneal) is initiated; or
- For all organs listed above, a transplant is recommended as soon as an appropriate donor is located, and the Member or Dependent is either listed with the United Network of Organ Sharing (UNOS) or a suitable donor is found without a UNOS listing.

The following are excluded:

- Bone marrow failure that results from the treatment process for cancer; and
- Failure of any other organ not listed above.

Proof of Major Organ Failure requires submission of medical records documenting major organ failure from a Physician who is board certified in a medical specialty that is appropriate to the organ involved, and except for kidney failure on dialysis, documentation of either listing with the UNOS or documentation that a suitable donor has been found without a UNOS listing.

Major Organ Failure will be deemed to be Incurred:

- For kidney failure only, the date dialysis is initiated; or
- For all organs listed above, the date the Member or Dependent is either listed with the UNOS or a suitable donor is found without a UNOS listing.

Member

An Employee of the Policyholder who is insured under the Group Policy.

Period of Limited Activity

Any period of time during which a Dependent is:

- confined in a Hospital for any cause or confined in a Skilled Nursing Facility; or
- Home Confined.

Physical or Mental Disability

A Dependent Child's substantial Physical or Mental Disability, as determined by Principal Life, 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

- A licensed Doctor of Medicine (M.D.) or Osteopathy (D.O.); or
- any other licensed health care practitioner that state law requires be recognized as a Physician under the Group Policy.

The term Physician does not include the Member, one of the Member's employees, the Member's business or professional partner or associate, any person who has a financial affiliation or business interest with the Member, anyone related to the Member by blood or marriage, or anyone living in the Member's household.

Policy Anniversary

July 1, 2020 and the same day of each following year.

Policyholder

BANKS COUNTY BOARD OF COMMISSIONERS.

Premium Period

A monthly basis on which the premium is due.

Proof of Good Health

Written evidence that a Member or Dependent is insurable under Principal Life underwriting standards. This proof must be provided in a form satisfactory to Principal Life.

Scheduled Benefits Summary

The page, which is issued as part of a Member's Certificate of Coverage, that contains benefit and other information pertaining to insurance under the Group Policy.

Skilled Nursing Facility

An institution (including one providing sub-acute care), or distinct part thereof, that is licensed by the proper authority of the state in which it is located to provide skilled nursing care and that:

- is supervised on a full-time basis by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) or a licensed registered nurse (R.N.); and
- has transfer arrangements with one or more Hospitals, a utilization review plan, and operating policies developed and monitored by a professional group that includes at least one M.D. or D.O.; and
- has an existing contract for the services of an M.D. or D.O., maintains daily records on each patient, and is equipped to dispense and administer drugs; and
- provides 24-hour nursing care and other medical treatment.

Not included are rest homes, homes for the aged, nursing homes, or places for treatment of mental disease, drug addiction, or alcoholism.

Stroke

Death of brain tissue due to an acute cerebrovascular event. All of the following criteria for Stroke must be satisfied:

- clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage;
- clear evidence on a CT, MRI or similar imaging technique that a stroke has occurred; and

- permanent neurologic deficit measured thirty days or more after the event that results in a score of 2 or higher on the Modified Rankin Scale for stroke outcome.

Stroke does not include symptoms due to transient ischemic attack, migraine, hypoxia, traumatic injury to brain tissue or blood vessels, and vascular disease affecting the eye, optic nerve or vestibular functions.

Diagnosis of stroke with permanent neurological deficit must be confirmed in writing by a Physician who is board certified in neurology and requires submission of medical records.

The Stroke will be deemed to be Incurred on the date of the event.

**SCHEDULED BENEFITS SUMMARY AS OF
GROUP VOLUNTARY CRITICAL ILLNESS INSURANCE**

Member:
Address:

Certificate of Coverage Number:
Certificate of Coverage Effective Date:
Certificate of Coverage Anniversary Date:

CURRENT SUMMARY

AMOUNT

Member Critical Illness Scheduled Benefit	\$
Maximum Lifetime Benefit	\$
Dependent Critical Illness Scheduled Benefit	
Dependent spouse or Domestic Partner	\$
Maximum Lifetime Benefit	\$
Dependent Child(ren)	\$
Maximum Lifetime Benefit	\$

Current Smoker Status - Member

Current Smoker Status - Dependent spouse or Domestic Partner

Policyholder:

Please attach this Scheduled Benefits Summary to the Member's Certificate of Coverage. It replaces any previously issued Scheduled Benefits Summary. If there are any questions, call Principal Life at 1-800-843-1371 (Des Moines Area) 7:00 am - 7:00 pm C.T. Monday-Friday.

HOW TO BE INSURED - MEMBERS

MEMBER CRITICAL ILLNESS INSURANCE

Eligibility

Only Employees will be eligible for insurance.

DEPT HEADS

Anyone meeting the definition of Employee will be eligible on the first of the Insurance Month coinciding with or next following the date the Employee completes 30 consecutive days of continuous Active Work.

ALL OTHER MBRS

Anyone meeting the definition of Employee will be eligible on the first of the Insurance Month coinciding with or next following the date the Employee completes 60 consecutive days of continuous Active Work.

Effective Dates - Actively at Work

If a Member is not Actively at Work on the date insurance would otherwise be effective, insurance will not be effective until the day the Member returns to Active Work.

This Actively at Work requirement will be waived for the Member who:

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

Incontestability

All statements made by any Member or Dependent will be representations and not warranties. In the absence of fraud, these statements may not be used to contest a claim unless:

- the insurance has been in force for less than two years during the Member's or Dependent's lifetime when the Critical Illness was Incurred; and
- the statement is in written form signed by the Member or Dependent; and
- a copy of the form, which contains the statement, is given to the Member or Dependent or their beneficiary at the time insurance is contested.

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

In addition, if a Member's or Dependent's age is misstated, Principal Life may, at any time, adjust premium and benefits to reflect the correct age.

Proof of Good Health

In some instances, Proof of Good Health will be required to place an Employee's insurance in force. Principal Life will determine the type and form of required proof. An Employee will need to file Proof of Good Health:

- If insurance is requested more than 31 days after the date an Employee is eligible including any insurance they refuse and later request.

- If an Employee failed to provide required Proof of Good Health or has been refused insurance under the Group Policy at any prior time.
- If a Member elects to terminate insurance and, more than 31 days later, requests to be insured again.
- To make effective any Member Critical Illness Scheduled Benefit that is in excess of \$15,000.
- If less than 10% of the Employees participate or less than five Members are insured, to make effective any Scheduled Benefit for Members or Dependents.
- To make effective any request for a Scheduled Benefit increase.

**Effective Date for Initial Insurance
(Proof of Good Health Not Required)**

An Employee must request initial insurance in a form provided by Principal Life.

Insurance will normally be effective on:

- the date the Employee is eligible, if the request is made on or before that date; or
- the first of the Insurance Month coinciding with or next following the date the Employee is eligible, if the request is made within 31 days after the date eligible.

However, if the Employee is not Actively at Work on the date insurance would otherwise be effective, insurance will not be effective until the day the Employee returns to Active Work.

**Effective Date for Initial Insurance
(Proof of Good Health Required)**

If Proof of Good Health is required, and approved by Principal Life, insurance will normally be effective on the later of:

- the date insurance would have been effective had Proof of Good Health not been required; or
- the first of the Insurance Month coinciding with or next following the date Proof of Good Health is approved by Principal Life.

However, if the Employee is not Actively at Work on the date insurance would otherwise be effective, insurance will not be effective until the day the Employee returns to Active Work.

Scheduled Benefit Changes

A Member's benefits may be changed due to:

- Change in insurance class; or
- Changes by policy amendment; or
- Change in the Member's family status:

A Member may request an increase in Scheduled Benefits, or the addition of Scheduled Benefits for which they were not previously insured if a change in family status as described below has occurred, provided a request is made in writing within 31 days after the date of the change in family status:

- marriage or declaration of a Domestic Partner relationship or divorce or termination of a Domestic Partner relationship;
- death of a spouse or Domestic Partner or child;

- birth or adoption of a child;
- termination of employment by the Member's spouse or Domestic Partner or a change in the Spouse's or Domestic Partner's employment that causes loss of group Critical Illness coverage.

Effective Date for Scheduled Benefit Changes

A change in the Scheduled Benefit for which Proof of Good Health is not required (see above) will normally be effective on the first of the Insurance Month coinciding with or next following the date the Member is eligible.

Effective Date for Changes Requested by the Member for any other Reason

A change requested by the Member for which Proof of Good Health is not required (see above) will normally be effective on the first of the Insurance Month coinciding with or next following the date of the request.

Effective Date for Changes (Proof of Good Health Required)

A change requested by the Member for which Proof of Good Health is required (see above) will be effective on the later of:

- the date the change would otherwise be effective if Proof of Good Health had not been required; or
- the first of the Insurance Month coinciding with or next following the date Proof of Good Health is approved by Principal Life.

Effective Date for Changes - Actively at Work

If the Member is not Actively at Work on the date the change would otherwise be effective, the change will not be effective until the day the Member returns to Active Work. Exception: Any Scheduled Benefit decrease will be effective as noted above, whether or not the Member is Actively at Work.

Termination

The Member's insurance under the Group Policy will cease on the earliest of:

- the date the Group Policy terminates; or
- the date the Member's Maximum Lifetime Benefit, as shown on GH 5719 (CI), is paid; or
- the end of the Insurance Month for which the last premium is paid for the Member's insurance; or
- the end of any Insurance Month, if requested by the Member before that date; or
- the end of the Insurance Month in which the Member ceases to be an Employee, as defined in GH 5712 (CI); or
- the end of the Insurance Month in which the Member ceases to belong to a class for which insurance is provided; or
- the date the Member retires; or
- the end of the Insurance Month in which the Member ceases Active Work.

Insurance While Outside of the United States

If a Member or Dependent is temporarily outside the United States for foreign travel, the Member or Dependent may choose to continue his or her insurance, subject to premium payment.

For the purpose of this provision, "travel" will not include "residency" or relocation for employment. An individual who is absent from the United States for more than one hundred eighty (180) consecutive days and has established a residence in a foreign country during that period is considered to be residing in that country. Residency in a foreign country is not considered "foreign travel" for purposes of this provision.

If the Member or Dependent is outside the United States for relocation for employment or for "residency", as defined above, coverage for the person concerned will automatically terminate.

HOW TO BE INSURED - DEPENDENTS

DEPENDENT CRITICAL ILLNESS INSURANCE

Eligibility

Members will be eligible for insurance for their Dependents on the later of:

- the date the Member is eligible for Member Critical Illness Insurance; or
- the date the Member first acquires a Dependent.

Effective Date

Dependent Critical Illness Insurance is available only with respect to Dependents of Members. Dependent Critical Illness Insurance will be in force under the same terms as described earlier for Member Critical Illness Insurance, except:

- In no event will Dependent Critical Illness Insurance be in force if the Employee is not insured for Member Critical Illness Insurance.
- If a Dependent is in a Period of Limited Activity on the date initial Dependent Critical Illness Insurance or an increase in Dependent Critical Illness Insurance Scheduled Benefit would otherwise be effective, the Dependent will not be insured or an increase will not be effective until the Period of Limited Activity ends.
- If a Member requests insurance for a Domestic Partner, insurance for a Domestic Partner will be in force on the later of:
 - the date insurance would otherwise become effective for a Dependent under the terms of the Group Policy; or
 - the date Principal Life approves the Domestic Partner's status as a Dependent.
- If Dependent Critical Illness Insurance is then in force for any other Dependent, a new Dependent (other than a newborn child) will be insured on the date acquired, provided the new Dependent is not in a Period of Limited Activity. Requests for insurance and Proof of Good Health are not required provided Principal Life has been notified of the new Dependent within 31 days after the date the Dependent is acquired.
- If Dependent Critical Illness Insurance is then in force for any other Dependent, a newly born child will be insured from the moment of live birth, provided the child meets the definition of a Dependent Child.

Proof of Good Health

In some instances, Proof of Good Health will be required to place Dependent insurance in force. Principal Life will determine the type and form of required proof. Any required Proof of Good Health will be with respect to the health of the Dependent(s). The Member will need to file Proof of Good Health for Dependent Insurance:

- If insurance is requested more than 31 days after the date the Dependent is eligible including any insurance the Dependent refuses and later requests.
- If a Dependent failed to provide required Proof of Good Health or has been refused insurance under the Group Policy at any prior time.
- If a Dependent elects to terminate insurance and, more than 31 days later, requests to be insured again.

- To make effective any Scheduled Benefit for the Dependent spouse or Domestic Partner that is in excess of \$7,500.
- If less than 10% of the Employees participate or less than five Members are insured, to make effective any Scheduled Benefit for the Dependent.
- To make effective any request for a Scheduled Benefit increase.

Incontestability

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

Termination

Insurance for Dependents will terminate on the earliest of:

- the date Member Critical Illness Insurance ceases; or
- for a Dependent spouse or Domestic Partner the date the Maximum Lifetime Benefit, as shown on GH 5720 (CI) is paid; or
- for each Dependent Child, the date the Maximum Lifetime Benefit, as shown on GH 5720 (CI), is paid; or
- the date Dependent Critical Illness Insurance is removed from the Group Policy; or
- the end of the Insurance Month for which the last premium is paid for a Dependent's insurance; or
- the end of any Insurance Month, if requested by the Member before that date.

Insurance for any one Dependent will terminate on the last day of the Insurance Month in which he or she ceases to be a Dependent.

However, insurance will be continued beyond the maximum age for a Dependent Child who is incapable of self-support because of a Developmental or Physical Disability and is dependent on the Member for primary support. The Member must apply for this continuation within 31 days after the Dependent Child reaches the maximum age.

Insurance While Outside of the United States

Dependents will be subject to the Insurance While Outside of the United States provisions as described earlier for Member insurance.

CONTINUATION OF COVERAGE

FMLA and Other Continuation Provisions

If Active Work ends due to an approved leave of absence under FMLA, the Policyholder may choose to continue the Member's insurance, subject to premium payment.

If the continuation portion of the FMLA applies to the Member's insurance, 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 Certificate of Coverage for sickness, injury, layoff, or approved leave of absence, if any.

If continuation qualifies for both state and FMLA continuation, the continuation period will be counted concurrently toward satisfaction of the continuation period under both the state and FMLA continuation periods.

Sickness or Injury

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

- the date insurance would otherwise cease as provided in GH 5714 (CI); or
- the end of the Insurance Month in which the Member recovers; or
- the end of the Insurance Month after coverage has been continued under this section for 90 consecutive days.

Layoff or Approved Leave of Absence

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

- the date insurance would otherwise cease as provided in GH 5714 (CI); or
- the end of the Insurance Month in which the layoff or approved leave of absence ends; or
- the date the Member becomes eligible for any other critical illness coverage; or
- the date one month after the end of the Insurance Month in which Active Work ends.

Dependent Insurance - Developmentally, Physically or Mentally Disabled Children

Qualification

Dependent Critical Illness Insurance for a child may be continued after the child reaches the maximum age for Dependent Children as defined in GH 5712 (CI) of this Certificate of Coverage, provided that:

- the child is incapable of self-support as the result of a Developmental, Physical or Mental Disability and they 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 GH 5712 (CI); and
- proof of the child's incapacity is sent to Principal Life 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 Principal Life requests; and
- the child undergoes examination by a Physician when Principal Life requests. Principal Life will pay for these examinations and will choose the Physician to perform them.

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 above.

REINSTATEMENT

Terminated insurance will be reinstated if:

- insurance ceased because of layoff or approved leave of absence; and
- the Member returned to Active Work for the Policyholder within six months of the date insurance ceased.

Reinstated insurance will be in force on the date of return to work. However, the Actively at Work and Period of Limited Activity provisions defined on GH 5712 (CI) will apply. Also, Proof of Good Health will be required to place in force any Scheduled Benefit that would have been subject to Proof of Good Health had the Member remained continuously insured.

Only the period of time during which the Member is actually insured will be included in determining the length of continuous coverage under this Certificate of Coverage. For this purpose the period of time during which insurance was not in force:

- will not be considered an interruption of continuous coverage; and
- will not be used to satisfy any provision of the Group Policy which pertains to a period of continuous coverage.

In addition, a longer reinstatement period may be allowed for an approved leave of absence taken in accordance with the provisions of the federal law regarding the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Reinstated insurance will be the Scheduled Benefit in force on the date insurance ceased.

Federal Required Family and Medical Leave Act (FMLA)

An eligible employee's terminated insurance may be reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA), subject to the Actively at Work and Period of Limited Activity requirements of the Group Policy.

Reinstatement of Insurance for a Member or Dependent When Insurance Ends due to Living Outside of the United States

If insurance for a Member or Dependent terminates because the Member or Dependent are outside of the United States, the Member or Dependent may become eligible again for insurance under the Group Policy, but only if:

- the Member or Dependent return to the United States within six months of the date on which insurance terminated because they were outside of the United States; and
- for the Member, the Member returns to Active Work in the United States for the Policyholder for a period of at least 30 consecutive days. The Member will be eligible for insurance on the day immediately following completion of the 30 consecutive days of Active Work; and
- for the Dependent, he or she remains in the United States for 30 consecutive days. If the Dependent does so, he or she will be eligible for reinstatement of insurance on the day after completion of the 30 consecutive days of residence.

The reinstated insurance will be on the same basis as that being provided on the date insurance is reinstated. However, any restrictions on this insurance, which were in effect before reinstatement, will continue to apply. If the Member or Dependent do not complete the 30 consecutive days of residence, the insurance for the Member or Dependent will not be reinstated.

**DESCRIPTION OF BENEFITS
BENEFIT PROVISIONS**

MEMBER CRITICAL ILLNESS INSURANCE

Schedule of Insurance

The Group Policy will pay the benefits described below if the Member Incurs a listed Critical Illness on or after the date the Member becomes insured by the Group Policy.

The specific Scheduled Benefit for the Member will be shown on the Scheduled Benefits Summary.

Class	*Scheduled Benefit
All Members	An amount in increments of \$5,000 as applied for by the Member and approved by Principal Life. The Scheduled Benefit amount will not exceed \$100,000, subject to the provisions below.

*The Scheduled Benefit is subject to the Proof of Good Health requirements as shown in GH 5714 (CI). Because of the Proof of Good Health requirements, the amount of insurance approved by Principal Life may be different than the Scheduled Benefit. If the approved amount of insurance is different than the Scheduled Benefit, the approved amount will apply.

Benefits Payable

Critical Illness	% of Scheduled Benefit for First Occurrence	% of Scheduled Benefit for Additional Occurrences
Cancer One	100%	100%
Cancer Two	25%	25%
Coronary Artery Bypass Graft (CABG)	25%	25%
Heart Attack	100%	100%
Major Organ Failure	100%	100%
Stroke	100%	100%

Benefits for a First Occurrence of a different Critical Illness will be payable if the Critical Illness is Incurred more than 6 months from the date the preceding Critical Illness was Incurred.

Benefits for additional occurrences of the same Critical Illness will be payable if the Critical Illness is Incurred more than 6 months from the date the preceding Critical Illness was Incurred and the Member has not received treatment for that Critical Illness for at least 12 consecutive months prior to the last occurrence. For the purpose of this provision, treatment does not include preventive medications in the absence of disease or routine scheduled follow-up visits to a Physician. No benefits will be payable for additional occurrences of renal failure (kidney failure).

Maximum Lifetime Benefit

The maximum total lifetime benefit paid to the Member under the Group Policy will be two times the Member Critical Illness Scheduled Benefit.

**DESCRIPTION OF BENEFITS
BENEFIT PROVISIONS**

DEPENDENT CRITICAL ILLNESS INSURANCE

Schedule of Insurance

The Group Policy will pay the benefits described below if a Dependent Incurs a listed Critical Illness on or after the date the Dependent becomes insured by the Group Policy.

The specific Scheduled Benefit is shown on the Scheduled Benefits Summary.

Class

All Members

Dependent

***Scheduled Benefit**

Spouse or Domestic Partner

An amount in increments of \$2,500 as applied for by the Member and approved by Principal Life. The spouse's or Domestic Partner's Scheduled Benefit will not exceed \$50,000, subject to the provisions below.

Child(ren)

\$2,500

*The Scheduled Benefit is subject to the Proof of Good Health requirements as described on GH 5715 (CI). Because of the Proof of Good Health requirements, the amount of insurance approved by Principal Life may be different than the Scheduled Benefit. If the approved amount of insurance is different than the Scheduled Benefit, the approved amount will apply.

In no event will a Dependent's Scheduled Benefit be more than 50% of the Member's Scheduled Benefit. If the Member elects a Dependent Critical Illness benefit in excess of 50% of the Member's Scheduled Benefit amount, the Dependent will be given the highest amount available, not to exceed 50%.

Benefits Payable

Critical Illness	% of Scheduled Benefit for First Occurrence	% of Scheduled Benefit for Additional Occurrences
Cancer One	100%	100%
Cancer Two	25%	25%
Coronary Artery Bypass Graft (CABG)	25%	25%
Heart Attack	100%	100%
Major Organ Failure	100%	100%
Stroke	100%	100%

Benefits for a First Occurrence of a different Critical Illness will be payable if the Critical Illness is Incurred more than 6 months from the date the preceding Critical Illness was Incurred.

Benefits for additional occurrences of the same Critical Illness will be payable if the Critical Illness is Incurred more than 6 months from the date the preceding Critical Illness was Incurred and the Dependent has not received treatment for that Critical Illness for at least 12 consecutive months prior to the last occurrence. For the purpose of this provision, treatment does not include preventive medications in the absence of disease or routine scheduled follow-up visits to a Physician. No benefits will be payable for additional occurrences of renal failure (kidney failure).

Maximum Lifetime Benefit

The maximum total lifetime benefit paid to any Dependent under the Group Policy will be two times the Dependent's Critical Illness Scheduled Benefit.

DESCRIPTION OF BENEFITS

WELLNESS

The Group Policy will pay a wellness benefit if the Member or Dependent spouse or Domestic Partner has one of the following wellness tests or procedures performed. No wellness benefits are payable for Dependent Child(ren).

One wellness benefit for the flat amount of \$50 will be payable once per calendar year for either the Member or the Dependent spouse or Domestic Partner.

The Member or Dependent spouse or Domestic Partner must submit proof of the test or procedure performed. The Group Policy will pay a wellness benefit regardless of the results or the cost of the test or procedure.

The wellness benefit does not count toward the Critical Illness Maximum Lifetime Benefit.

Wellness tests or procedures covered are limited to:

- Bone marrow cancer screening (serum protein electrophoresis); or
- Breast cancer screening (CA 15-3, clinical breast exam, mammogram, MRI, ultrasound); or
- Chest x-ray; or
- Colorectal cancer screening (CEA, colonoscopy, fecal occult blood test, sigmoidoscopy); or
- Completion of a smoking cessation program; or
- Completion of a weight reduction program; or
- Diabetes testing (fasting blood glucose test, hemoglobin A1c); or
- Electrocardiogram (ECG) - resting or stress; or
- Standard blood chemistry profile or lipid panel (cholesterol, triglycerides, HDL, LDL); or
- Ovarian cancer screening; or
- Pap Smear; or
- Prostate cancer screening (digital rectal exam, PSA blood test); or
- Skin cancer screening.

DESCRIPTION OF BENEFITS

CRITICAL ILLNESS LIMITATIONS AND EXCLUSIONS

Limitations

Benefits will not be paid for a Critical Illness caused by, contributed to, or resulting from:

- willful self-injury or self-destruction, while sane or insane; or
- war or act of war; or
- voluntary participation in a felony, insurrection, or riot; or
- duty as a member of a military organization; or
- conditions diagnosed outside of the United States unless the diagnosis can be confirmed by a licensed Physician in the United States; or
- the use of any drug, narcotic, or hallucinogen not prescribed for the Member or Dependent by a licensed Physician, or if prescribed, not used in a manner consistent with that prescription; or
- the use of alcohol, including the operation of a motor vehicle if, at the time of operation, the operator's alcohol concentration exceeds the legal limit allowed by the jurisdiction where the injury occurs; or
- a cosmetic surgery or other elective procedures that are not medically necessary.

Exclusions

No benefits will be paid for any Critical Illness:

- Incurred while residing outside the United States for more than six months; or
- Incurred while incarcerated in any type of penal or detention facility; or
- unless the Critical Illness is Diagnosed while the Member or Dependent is alive; or
- for which proof is submitted by a Physician who is part of the Member's or Dependent's Immediate Family.

DESCRIPTION OF BENEFITS

PORTABILITY

When insurance would otherwise end under the Group Policy as described below, the Member may be eligible to continue insurance under a Group Critical Illness Portability Insurance Policy underwritten by Principal Life. The Group Critical Illness Portability Insurance Policy will contain provisions that differ from the Group Policy. If a Member elects to continue insurance under this option, they will receive a certificate outlining the Group Critical Illness Portability Insurance Policy provisions.

Member and Dependent Critical Illness Portability Insurance

Eligibility

If Member Critical Illness Insurance under the Group Policy ends because the Member ceases to meet the definition of an Employee, they may be eligible to continue such insurance under the Group Critical Illness Portability Insurance Policy without submitting Proof of Good Health.

In order to continue insurance under the Group Critical Illness Portability Insurance Policy:

- the Member must have been insured under the Group Policy for 12 consecutive months; and
- for any Dependent, Member Critical Illness must be continued.

Insurance may not be continued, for the Member or any Dependent, under the Group Critical Illness Portability Insurance Policy if:

- insurance under the Group Policy ends because the Group Policy terminates and is replaced by another group policy; or
- a Critical Illness was Incurred, regardless of whether a benefit was payable, other than for Wellness; or
- For Dependent Critical Illness Portability Insurance, the Dependent ceases to be a Dependent as defined in GH 5712 (CI); or
- the Member dies.

Ported Coverage

The insurance that is available for continuation will be the benefits as shown on GH 5713 (CI), GH 5719 (CI) and GH 5720 (CI) that are in force on the date insurance terminates under the Group Policy. Wellness benefits are not portable.

Termination of Ported Coverage

Ported insurance under the Group Critical Illness Portability Insurance Policy will terminate on the earliest of:

- the date ending the period for which the last premium is paid; or
- for Dependent insurance, the date the Dependent no longer qualifies as a Dependent, due to divorce or termination of a Domestic Partner relationship or the Member's death; or
- for Dependent insurance for a Dependent Child(ren), the date the child(ren) no longer meets the definition of a Dependent Child(ren); or
- the date the Maximum Lifetime Benefit, as shown on GH 5719 (CI) and GH 5720 (CI) is paid; or
- for Dependent insurance, the date Member Critical Illness Insurance ceases.

Application/Effective Date

Notice of the Portability option must be given to the Member by the Policyholder before insurance under the Group Policy terminates, or as soon as reasonably possible thereafter.

The Member must apply for insurance and pay the first premium within 60 days of the termination date. Any continued coverage under the Portability option will be in force on the day following termination of insurance under the Group Policy.

CLAIM PROCEDURES

Notice of Claim

Written notice of claim must be given to Principal Life within 20 days after the date the Critical Illness was Incurred. 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 the claim must be filed with Principal Life in order to obtain payment of benefits. The Policyholder will provide forms to assist the Member in filing claims. If the forms are not provided within 10 working days after Principal Life receives such notice, the Member will be considered to have complied with the requirements of the Group Policy upon submitting, within the time specified below for filing proof of the Critical Illness, written proof covering the occurrence, character and extent of the Critical Illness.

Proof of Critical Illness

Completed claim forms and other information needed to prove the Critical Illness should be filed promptly. Written proof of the Critical Illness should be sent to Principal Life within 180 days after the date the Critical Illness was Incurred. Proof required includes the date, nature, and extent of the Critical Illness. Principal Life may request additional information to substantiate a Critical Illness or require a signed unaltered authorization to obtain that information from the provider. Failure to comply with such request could result in declination of the claim. For purposes of satisfying the claims processing timing requirements of the Employee Retirement Income Security Act (ERISA), receipt of claim will be considered to be met when the appropriate claim form is received by Principal Life. If it is not reasonably possible to give written proof in the time required, Principal Life shall not reduce or deny a claim for this reason if the proof is filed as soon as reasonably possible.

Payment, Denial, and Review

Georgia law requires that benefits payable under the Group Policy will be payable immediately after receipt of proof and subject to the proof of loss. Should Principal Life fail to pay the benefits payable under this Group Policy upon receipt of due written proof, Principal Life will have 15 working days for electronic claims or 30 calendar days for paper claims thereafter within which to mail, or send electronically, the claimant a letter or notice which states the reasons Principal Life may have for failing to pay the claim, either in whole or in part, and which also gives the claimant a written itemization of any documents or other information needed to process the claim. When all of the listed documents or other information needed to process the claim have been received, Principal Life will then have 15 working days for electronic claims or 30 calendar days for paper claims within which to process and either pay the claim or deny it, in whole or in part, giving the claimant the reasons for the claim denial. Principal Life will pay interest to the claimant equal to 12 percent per annum on the proceeds or benefits due under the terms of this Group Policy for failure to comply with the state's requirements for timely payment of claims.

If proof of loss has not been established from the claimant to process a claim, ERISA further allows a claimant up to 30 calendar days from the request to provide all information.

In actual practice, benefits under the Group Policy will be payable sooner, provided Principal Life receives complete and proper proof of the Critical Illness. Further, if a claim is not payable or cannot be processed, Principal Life will submit a detailed explanation of the basis for the denial.

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

For purposes of this section, "claimant" means the Member or Dependent.

Facility of Payment

Principal Life will normally pay benefits directly to the Member. However, in the special instances listed below, payment will be as indicated. All payments so made will discharge Principal Life to the full extent of those payments.

- If payment amounts remain due upon the Member's death, those amounts may, at the option of Principal Life, be paid to the Member's spouse or Domestic Partner, child, parent, or estate.
- If Principal Life believes a person is not legally able to give a valid receipt for a benefit payment, and no guardian has been appointed, Principal Life may pay whoever has assumed the care and support of the person.

Medical Examinations

Principal Life may have the claimant examined, as may be reasonably required, by a Physician during the course of a claim. Principal Life will pay for these examinations and will choose the Physician to perform them.

Legal Action

Legal action to recover benefits under the Group Policy may not be started earlier than 60 calendar days after proof of the Critical Illness is 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.

Time Limits

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

Notice of Privacy Practices for 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 health information. The terms of this Notice apply to members, their spouses and dependents for their group medical expense, group dental expense and/or group vision care expense insurance with us ("insurance"). As used in this Notice, the term "health information" means information about you that we create, receive or maintain in connection with your insurance; that relates to your physical or mental condition or payment for health care provided to you; and that can reasonably be used to identify you. This Notice was effective April 14, 2003 and revisions to this Notice are effective November 1, 2017.

We are required by law to maintain the privacy of our members' and dependents' health information and to provide notice of our legal duties and privacy practices with respect to their 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 health information maintained by us. Copies of revised Notices will be mailed to plan sponsors for distribution to the members then covered by our insurance. 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 Health Information

Authorization. Except as explained below, we will not use or disclose your 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 50392-0002. A form to revoke an authorization can be obtained from the Health Information Protection Analyst.

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

Uses and Disclosures for Payment. We will use and disclose your health information as necessary for payment purposes. For instance, we may use your 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. Unless we agree in writing to do otherwise, we will send all mail regarding a member's spouse or dependents to the member, including information about the payment or denial of insurance claims.

Uses and Disclosures for Health Care Operations. We will use and disclose your health information as necessary for health care operations. For instance, we may use or disclose your 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 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 the health plan of a member's employer. We may disclose your health information to your health plan for certain functions of its health care operations. This Privacy Notice does not cover the privacy practices of that plan. 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 health information prior to your enrollment under the insurance. We will use this information to determine whether you are eligible to enroll under the insurance and to determine the rates. We will not use or disclose any genetic information we obtain about you or provided from your family history. 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 health information to these outside people or organizations that perform services on our behalf. We require them to appropriately safeguard the privacy of your health information. Principal Life Insurance Company may itself be a business associate of your health plan or health insurance company. We may disclose your health information to your health plan or insurance company and its business associates as needed to fulfill our contractual obligations to them. Please see the notice of privacy practices issued by your plan or insurance company for information about how it uses and discloses your health information.

Plan Sponsor. We may disclose your health information to the plan sponsor the minimum necessary amount of your health information that it needs to perform administrative functions on behalf of the plan (if any), 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 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 health information without your approval. We may also disclose your 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 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 are prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of determining eligibility for coverage, the amount of benefits or premiums or discounts, including rebates, payments in kind, or other premium or benefit differential mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program. We will not request, use or disclose psychotherapy notes without your authorization (except to defend ourselves in a legal action brought by you.) We will not sell your protected health information or use or disclose it for marketing purposes without your authorization, except as permitted by law. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information.

Your Rights

Restrictions on Use and Disclosure of Your Health Information. You have the right to request restrictions on how we use or disclose your 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 50392-0002. 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 Health Information. You have the right to request communications regarding your 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 50392-0002. A form to request a confidential communication can be obtained from the Health Information Protection Analyst.

Access to Your Health Information. You have the right to inspect and/or obtain a copy of your 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 50392-0002. A form to request access to your health information can be obtained from the Health Information Protection Analyst. A fee will be charged for copying and postage.

Amendment of Your Health Information. You have the right to request an amendment to your 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 50392-0002. A form to request an amendment to your 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 Health Information. You have the right to receive an accounting of certain disclosures of your health information made by us during the 6 year period before your request. 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 50392-0002. A form to request an accounting of your 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 50392-0002 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) 843-1371.

STATEMENT OF RIGHTS

Federal law requires that this section be included in the Certificate of Coverage:

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.

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.

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Plan Arranged By

TURNER WOOD & SMITH AGENCY INC
100 BRENAU AV
GAINSVILLE GA
30501



Principal Life Insurance Company
Des Moines, Iowa 50392-0002