ZACHARY EGGERS
11:59
5930 S LAND PARK DRIVE #22069
SACRAMENTO CA 95822

1182575

01/01/2025

GROUP POLICY FOR:

M CORP DBA 11:59

ALL MEMBERS
GROUP VOLUNTARY CRITICAL ILLNESS INSURANCE

Print Date: 02/18/2025

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PRINCIPAL LIFE INSURANCE COMPANY
(called Principal Life in this Group Policy)
711 High Street,
Des Moines, Iowa 50392-0002

This group insurance policy is issued to:

M CORP DBA 11:59

(called the Policyholder in this Group Policy)

The Date of Issue is January 1, 2025.

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

GROUP CRITICAL ILLNESS INSURANCE

subject to the terms, conditions, limitations and exclusions described in this Group Policy, to pay benefits as described in the Certificate of Coverage with respect to each Covered Person under the Group Policy. Principal Life and the Policyholder have agreed to all terms of the Group Policy.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS OR MINIMUM ESSENTIAL COVERAGE AS DEFINED IN FEDERAL LAW.

This Group Policy pays a reduced amount for Carcinoma In Situ and Specified Skin Cancers.

Executive Vice President,
General Counsel and Secretary

Chairman, President and
Chief Executive Officer

GROUP POLICY NO. GCI 1182575
RENEWABLE TERM
CONTRACT STATE OF ISSUE: CALIFORNIA

INTRODUCTION

The Entire Contract is provided in two sections:

(1) the Group Policy provisions for the Policyholder; and
(2) the Certificate of Coverage provisions for Covered Persons.

Both sections together form the Entire Contract and include all of the benefits available under the Group Policy.

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PART I - POLICY ADMINISTRATION

Section A - Contract

Article 1 - Entire Contract

This Group Policy, the current Certificate of Coverage, the attached employer application, and any Employee applications make up the entire contract. Principal Life is obligated only as provided in this Group Policy and is not bound by any trust or any 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 Principal Life has authority to change this Group Policy, and, to be effective, all such changes must be in writing and signed by an executive officer of Principal Life.

Principal Life 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, upon approval by the state's insurance regulator, when such amendment is required for consistent application of policy provisions.

c. By written agreement between Principal Life 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 Covered Person.

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. maintain the greater of 10% participation or 2 Members.

Article 4 – Policy Incontestability

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

Article 5 - Individual Incontestability

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

a. insurance has been in force for less than three years during the Covered Person's lifetime; and

b. the statement is in written form signed by the Covered Person; and

c. a copy of the form, which contains the statement, is given to the Covered Person or their beneficiary at the time insurance is contested.

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

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

Article 6 - Certificate of Coverage

Principal Life will give the Policyholder Certificates of Coverage for delivery to Members. The delivery of such Certificate of Coverage will be in either paper or electronic format. The Certificate of Coverage will be evidence of insurance and will describe the basic features of the coverage.

Article 7 - Dependent Rights

A Dependent will have no rights under this Group Policy except as set forth in Developmentally, Physically or Mentally Disabled Children.

Article 8 - State Required Notice - California

If Principal Life increases a premium, reduces or eliminates benefits, or restricts eligibility, Principal Life must mail advance notice to:

a. the insurance producer and administrator, if any 45 days before the effective date of termination; and
b. the Policyholder 30 days before the effective date of termination.

Article 9 - Waiver of Breach

Waiver of a breach of any Group Policy provision at one time shall not be deemed to be a waiver of any other breach or of the same breach at a later time.

Article 1 - Payment Responsibility; Due Dates; Grace Period

The Policyholder is responsible for collection and payment of all premium due while this Group Policy is in force. Payments must be sent to the home office of Principal Life 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 60 days will be allowed for payment of premium. The Group Policy will remain in force until the end of the Grace Period, unless the Group Policy has been terminated by notice. 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 are stated in the final rate schedule. A new rate schedule will be provided when the premium rates change.

Article 3 - Premium Rate Changes

Principal Life may change a premium rate:

a. on any premium due date, if the initial premium 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; and

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

c. on any date the Policyholder's business, as specified on the employer application, is changed; and

d. on any date that a schedule of insurance or class of Employees is changed.

If the Policyholder has other group insurance with Principal Life, and if coverage is initially added on a date other than the Policy Anniversary and it is more than six months before the next Policy Anniversary, Principal Life reserves the right to change the premium rate on the next Policy Anniversary. Written notice will be given to the Policyholder at least 31 days before the date of change.

The premium rate charged for a Covered Person may change on any Policy Anniversary, if the age of the Covered Person has changed since the last Policy Anniversary.

Article 4 - Premium Amount

The amount of premium to be paid on each due date will be determined in these ways:

a. Member Critical Illness Insurance

   The total volume of insurance in force for Members in each age bracket will be divided by 1,000. Each result will be then multiplied by the premium rate then in effect for that age bracket.

b. Dependent Critical Illness Insurance

   The total volume of insurance in force for the Member's Dependent spouse or Domestic Partner in each age bracket will be divided by 1,000. Each result will be then multiplied by the premium rate then in effect for that age bracket.

Article 5 - Policyholder Responsibility to Principal Life

To ensure accurate premium calculations, the Policyholder is responsible for reporting to Principal Life, the following information during the stated time periods:

a. New Covered Persons are to be reported during the month prior to or during the month that coverage becomes effective.

b. Covered Persons whose coverage has terminated are to be reported within a month of the date coverage terminated.

c. Changes in insurance class are to be reported within a month of the date that the change in insurance class took place.

If a Covered Person is added or a present Covered Person's insurance is increased or terminated on other than the first 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 6 - Policyholder Responsibility to Members

The Policyholder must notify each Member of the applicable premium rate for Covered Persons.

Article 7 - Contributions from Members

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

Article 1 - Failure to Pay Premium

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

Article 2 - Termination Rights of Principal Life

Principal Life may nonrenew or terminate this Group Policy by giving the Policyholder 31 days advance notice in writing, if the Policyholder:

a. ceases to 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; or

b. fails to maintain the participation requirements; or

c. has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact under the terms of this Group Policy; or

d. does not promptly provide Principal Life with information that is reasonably required; or

e. fails to perform any of its obligations that relate to this Group Policy.

Principal Life 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 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 Principal Life 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.

Principal Life may terminate this Group Policy without regard to cause 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. mail promptly to each Member covered under this Group Policy a legible true copy of notice of cancellation of the Group Policy received from Principal Life; and

b. provide promptly to Principal Life proof of that mailing and the date thereof; and

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

Article 5 - Responsibility of Principal Life

If Principal Life terminates this Group Policy for any reason, Principal Life must mail advance notice to:

a. the insurance producer and administrator, if any, 45 days before the effective date of termination; and

b. the Policyholder 30 days before the effective date of termination.

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 Policy Termination provisions, the Policyholder may renew at the applicable premium rates in effect on the Policy Anniversary.

POLICY NOTICE

California insurance law requires that each group policy include the telephone number of the insurance company issuing the policy in order for the persons to present inquiries, to obtain information about coverage, and to provide assistance in resolving complaints. Persons may call or write to:

Principal Life Insurance Company
711 High Street
Des Moines, Iowa 50392-0002

For administration-related inquiries:
Attn: Group Call Center
Phone: 1-800-843-1371

Consumers should contact Principal Life Insurance Company, their agent or other representative regarding complaints. If the policy or certificate was issued or delivered by an agent or broker, the insured must contact his or her agent or broker for assistance.

The California Department of Insurance should be contacted only after discussions with the insurer, or its agent or other representative, or both have failed to produce a satisfactory resolution to the problem.

Persons may contact:

California Insurance Department
Health Claims Bureau
11th Floor
300 South Spring Street, South Tower
Los Angeles, CA 90013
Phone: 1-800-927-4357 (HELP)
TDD: 1-800-482-4833
Website: www.insurance.ca.gov

This Notice is for the Policyholder's information only and does not become a part or condition of this Group Policy.

The Policyholder application may be found on the employer website via eService under the Resources tab or a paper copy can be requested by calling 1-800-843-1371.

Principal Life Insurance Company
Des Moines, Iowa 50392-0002

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Principal®

1182575

01/01/2025

GROUP BOOKLET-CERTIFICATE FOR MEMBERS OF:

M CORP DBA 11:59

ALL MEMBERS
Group Voluntary Critical Illness Insurance

Print Date: 02/18/2025

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CERTIFICATE OF COVERAGE RIDER
HEALTH SCREENING BENEFIT

Insurance under the Group Policy is amended to include a Health Screening Benefit.

Effective as of January 1, 2025, the booklet-certificate to which this Rider is attached is hereby amended with respect to and to the extent provided below.

This Rider will pay one $50 health screening benefit(s) per calendar year for each Covered Person who has one or more of the following tests or procedures performed in the United States while insured under this Rider. The Rider will pay a benefit regardless of the results or cost of the test or procedure.

Health screening tests or procedures covered are limited to:

- Adult and child immunization;
- Annual physical;
- Bone density screening;
- Cancer screening:
  - Bone marrow cancer screening (serum protein electrophoresis)
  - Breast cancer screening (CA 15-3, clinical breast exam, mammogram, MRI, thermography, ultrasound)
  - Cervical cancer screening (pap smear)
  - Colorectal cancer screening (CEA, colonoscopy, double contrast barium enema, fecal occult blood test, sigmoidoscopy)
  - Ovarian cancer screening (CA 125)
  - Prostate cancer screening (digital rectal exam, PSA blood test)
  - Skin cancer screening
  - Human Papillomavirus screening test
  - any other cancer screening test approved by the Federal Food and Drug Administration
- Cardiac stress test or electrocardiogram (EKG/ECG) – resting or stress;
- Chest x-ray;
- Completion of a smoking cessation program;
- Completion of a weight reduction program;
- COVID testing;
- Doppler screening for peripheral vascular disease (arteriosclerosis) or carotid doppler ultrasound;
- Genetic Screening testing;
- Human Papillomavirus (HPV) vaccine;
- Mental Health assessment;
- Sampling of blood or tissue to test for genetic susceptibility for the risk of cancer;
- Standard blood chemistry profile or lipid panel (cholesterol, triglycerides, HDL, LDL, fasting blood glucose, hemoglobin A1c);
- Ultrasound screening of the abdominal aorta for abdominal aortic aneurysm;
- Vision testing.

The Covered Person must submit proof of the test or procedure within one year of the date the test or procedure was performed.

All other benefits and provisions of the Group Policy remain in effect.

See your employer if you have questions concerning this Rider.

Nothing contained in this Rider may vary, alter or extend any provision or condition of the Group Policy other than as stated in this Rider.

PRINCIPAL LIFE INSURANCE COMPANY
711 High Street
Des Moines, Iowa 50392-0002

Executive Vice President,
General Counsel and Secretary

Chairman, President and
Chief Executive Officer

PRINCIPAL LIFE INSURANCE COMPANY
711 High Street
Des Moines, Iowa 50392-0002

CERTIFICATE OF COVERAGE RIDER
INFECTIOUS DISEASE (REQUIRING HOSPITALIZATION) BENEFIT

Insurance under the Group Policy is amended to include an Infectious Disease Benefit.

Effective as of January 1, 2025, the certificate of coverage to which this Rider is attached is hereby amended with respect to and to the extent provided below.

Infectious Disease means one of the covered infectious or contagious diseases shown in the Benefits Payable table that is Diagnosed by a Physician and, as a direct result of such diagnosis, a Covered Person is confined to a Hospital.

Benefit Qualification

To qualify for benefit payment, all of the following must occur while insured under this Rider:

- the Covered Person Incurs an Infectious Disease; and
- the Covered Person is confined to a Hospital for at least 3 consecutive days for the treatment of the Infectious Disease or dies after being confined but before meeting the confinement requirement.

Benefits Payable

Covered infectious diseases include:

Critical Illness	% of Scheduled Benefit for First Occurrence	% of Scheduled Benefit for Additional Occurrences
COVID-19	25%	25%
Diphtheria	25%	25%
Encephalitis	25%	25%
Legionnaire's Disease	25%	25%
Lyme Disease	25%	25%
Malaria	25%	25%
Meningitis	25%	25%
Methicillin-resistant staphylococcus aureus (MRSA)	25%	25%
Necrotizing Fasciitis	25%	25%
Osteomyelitis	25%	25%
Poliomyelitis	25%	25%
Rabies	25%	25%
Sepsis	25%	25%
Tetanus	25%	25%
Tuberculosis	25%	25%

The Infectious Disease will be deemed to be Incurred on the date it is Diagnosed.

We will only pay for infectious diseases specifically listed in this Rider.

All other benefits and provisions of the Group Policy remain in effect.

See your employer if you have questions concerning this Rider.

Nothing contained in this Rider may vary, alter or extend any provision or condition of the Group Policy other than as stated in this Rider.

Executive Vice President,
General Counsel and Secretary

Chairman, President and
Chief Executive Officer

Summary Plan Description for Purposes of Employee Retirement Income Security Act (ERISA):

This booklet-certificate (including any supplement) may be utilized in part in meeting the Summary Plan Description requirements under ERISA for insured employees (or those listed on the front cover) of the Policyholder who are eligible for Group Voluntary Critical Illness insurance.

A separate booklet-certificate will be issued if necessary to cover one or more separate classes of the Policyholder who are eligible for group coverage. For further information, contact your plan administrator.

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

Certificate of Coverage

Important Notice: **This is Critical Illness insurance. It provides a limited specified benefit. This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law. 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 pays a reduced amount for Carcinoma In Situ and Specified Skin Cancers.

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 Covered Persons, 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 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.

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 Policy and any Covered Person's insurance under this policy may be discontinued or altered by the Policyholder or Principal Life at any time without the Covered Person's consent.

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

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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

Employees are considered Actively at Work if they are able and available for active performance of all regular duties with the intent of continuing the active performance of all said duties on an ongoing basis. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, personal/paid time off, an approved State Family and Medical Leave for the care of a qualified family member or an approved FMLA leave of absence for the care of a qualified family member is considered Active Work provided an Employee is able and available for active performance of all regular duties on the effective date of coverage and was working the day immediately prior to the date of absence.

Alzheimer's Disease

A progressive degenerative disease of the brain resulting in loss of intellectual capacity involving impairment of memory and judgment which has progressed to a classification of Stage 6 or greater on the Functional Assessment Staging Test (FAST). Alzheimer's Disease does not include other types of dementing organic brain disorders or psychiatric illnesses.

Diagnosis must be made by a Physician and supported by:

- formal neuropsychological testing; or
- laboratory tests and magnetic resonance imaging, computerized tomography or other reliable imaging techniques that have been completed as part of the evaluation to rule out etiologies other than Alzheimer's Disease.

The initial Diagnosis of any stage of Alzheimer's Disease must occur while insured under this Policy.

Alzheimer's Disease will be deemed to be Incurred on the date it has progressed to a Stage 6 or greater classification on the Functional Assessment Staging Test (FAST).

Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)

A progressive degenerative motor neuron disease marked by muscular weakness and atrophy with spasticity and hyperreflexia. Amyotrophic Lateral Sclerosis does not include other motor neuron diseases.

Diagnosis must be made by a Physician and certified by a Physician as requiring substantial physical assistance from another adult for at least 90 consecutive days

The initial Diagnosis of any stage of Amyotrophic Lateral Sclerosis must occur while insured under this Policy.

Amyotrophic Lateral Sclerosis will be deemed to be Incurred on the date it is Diagnosed and all other etiologies have been ruled out.

Benign Brain Tumor

A non-malignant/non-cancerous tumor or cyst in the brain, cranial nerves or meninges within the skull that results in surgery, radiation treatment or permanent neurological deficit with persisting clinical symptoms, including but not limited to loss of vision, loss of hearing or balance disruption. Benign Brain Tumor does not include tumors of the skull, pituitary adenomas, angiomas or germinomas.

Diagnosis must be made by a Physician and confirmed by imaging and examination findings.

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 Covered Person for Benign Brain Tumor.

Benign Brain Tumor will be deemed to be Incurred on the date of the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

Cancer

This policy pays a benefit for all forms of cancer. Benefits for Cancer will be determined based on severity as follows:

Invasive Cancer

A malignant tumor which has uncontrolled growth of malignant cells and has spread beyond the layer of tissue in which it developed into neighboring tissue.

Invasive Cancer is classified as Stage I, II, III or IV on the AJCC classification system (AJC Cancer Staging Manual, 8th edition). Invasive Cancer also covers the following blood cancers: lymphoma, leukemia and multiple myeloma.

Invasive Cancer also covers the following skin cancers: AJCC Stage IV non-melanoma skin cancer and AJCC Stage I (and higher) melanoma skin cancer.

Diagnosis of Invasive Cancer must be based on microscopic (histologic) examination of fixed tissues or preparations of blood or bone marrow. Such examination must be made by and documented in a written report from a Physician. A Clinical Diagnosis will be accepted only if such Diagnosis is consistent with professional medical standards.

Proof of Invasive Cancer requires submission of medical records.

Invasive Cancer will be deemed to be Incurred on the date it is Diagnosed.

Carcinoma In Situ

A malignant growth that is confined only to the layer of cells where it began (the epithelium) and has not invaded other tissues or spread to lymph nodes or other organs.

Carcinoma in Situ is classified as Stage 0 on the AJCC classification system. Carcinoma in Situ can occur in most organs, including common sites of malignancy such as the breast, prostate and bladder.

CARCINOMA IN SITU EXCLUDES ALL SKIN CANCERS

Diagnosis of Carcinoma in Situ must be based on microscopic (histologic) examination of fixed tissues or preparations of blood or bone marrow. Such examination must be made by and documented in a written report from a Physician. A Clinical Diagnosis will be accepted only if such Diagnosis is consistent with professional medical standards.

Proof of Carcinoma in Situ requires submission of medical records.

Carcinoma in Situ will be deemed to be Incurred on the date it is Diagnosed.

Specified Skin Cancers

Cancer that forms in the tissues of the skin and includes:

- AJCC Stage 0, I, II or III non-melanoma skin cancer including basal cell carcinoma and squamous cell carcinoma of the skin;
- AJCC Stage 0 melanoma skin cancer; and
- Melanoma in situ.

Diagnosis of Skin Cancer must be made by a Physician and based on the date of microscopic examination of skin biopsy samples.

Skin Cancer will be deemed to be Incurred on the date it is Diagnosed.

Childhood Conditions

The following covered childhood conditions apply only to children who meet the definition of Dependent Children.

Cerebral Palsy

A group of non-progressive disorders affecting movement, muscle tone and posture caused by the abnormal development of or damage to the motor control centers of the brain. The motor disorders are often accompanied by disturbances of sensation, cognition, communication, perception and/or behavior, as well as seizures and secondary musculoskeletal problems. Cerebral Palsy does not include other similar conditions such as degenerative nerve disorders, genetic diseases, muscle diseases, metabolic disorders, nervous system tumors, coagulation disorders, or other injuries or disorders which may delay early development but can be outgrown.

Diagnosis must be made by a Physician and confirmed by diagnostic testing.

Cerebral Palsy will be deemed to be Incurred on the first date after live birth it is Diagnosed.

Cleft Lip / Palate

Cleft Lip is a congenital failure of the upper lip to close resulting in a narrow opening or gap in the skin of the upper lip that extends to the nostril on one or both sides of the mouth. Cleft Palate is a congenital failure to close an opening in the roof of the mouth that extends to the nasal cavity.

Diagnosis must be made by a Physician and confirmed by diagnostic testing if applicable.

Cleft Lip or Cleft Palate will be deemed to be Incurred on the first date after live birth it is Diagnosed.

If Cleft Lip and Cleft Palate are both present, only one benefit is payable.

Cystic Fibrosis

A progressive genetic disease characterized by the production of abnormally viscous mucus, leading to the blockage of the pancreatic ducts, intestines and bronchi and often resulting in severe damage to the lungs and digestive system and nutritional deficiencies.

Diagnosis must be made by a Physician and confirmed by a positive sweat test with results of chloride concentrations greater than 60 mmol/L or genetic testing.

Cystic Fibrosis will be deemed to be Incurred on the first date after live birth it is Diagnosed.

Down Syndrome

A congenital disorder arising from a chromosome defect involving chromosome 21, causing intellectual impairment, physical abnormalities and developmental delays.

Down Syndrome includes:

- Trisomy 21: The child has three instead of two chromosome 21's.
- Translocation: An extra part of chromosome 21 is attached to another chromosome.
- Mosaicism: The child has an extra chromosome 21 in only some of the cells but not all of them. The other cells have the usual pair of chromosome 21's.

Diagnosis must be made by a Physician and must include a chromosome test that positively reveals Down Syndrome.

Down Syndrome will be deemed to be Incurred on the first date after live birth it is Diagnosed.

Muscular Dystrophy

A group of genetic diseases characterized by progressive weakness and degeneration of the skeletal or voluntary muscles that control movement.

Diagnosis must be made by a Physician and be based on testing methods, including but not limited to electromyography, muscle biopsy, nerve conduction tests or blood enzyme tests.

Muscular Dystrophy will be deemed to be Incurred on the first date after live birth it is Diagnosed.

Spina Bifida

A congenital defect of the spine in which part of the spinal cord and its meninges are exposed through a gap in the backbone. Spina Bifida includes the conditions of meningocele and myelomeningocele. Spina Bifida does not include spina bifida occulta.

Diagnosis must be made by a Physician and confirmed by diagnostic testing.

Spina Bifida will be deemed to be Incurred on the first date after live birth it is Diagnosed.

Clinical Diagnosis

An identification of Invasive Cancer, Carcinoma In Situ or Specified Skin Cancers based on observation and history, diagnostic and laboratory studies and symptoms.

Coma

A continuous state of profound unconsciousness due to disease lasting at least 7 consecutive days characterized by the absence of eye opening, motor response, and verbal response, and requiring intubation for respiratory assistance. Coma does not include a medically-induced coma or a coma directly resulting from alcohol or drug use.

Diagnosis must be made by a Physician and supported by medical evidence.

Coma will be deemed to be Incurred on the date the Covered Person has been in a Coma for at least 7 consecutive days.

Coronary Artery Disease Requiring Coronary Artery Bypass Graft (CAD)

Narrowing or blockage of one or more coronary arteries leading to a recommendation for Coronary Artery Bypass Graft.

Diagnosis must be made by a Physician and supported by pre-operative angiographic evidence.

Coronary Artery Disease Requiring Coronary Artery Bypass Graft will be deemed to be Incurred on the date the Covered Person's coronary artery disease has been Diagnosed by a Physician.

Covered Person

An Employee or Dependent who is insured under the Group Policy.

Critical Illness

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

Date of Issue

The date the Group Policy is placed in force: January 1, 2025.

Dependent

- An Employee's spouse, if that spouse:

  - is legally married to the Employee; and
  - is not in the Armed Forces of any country; and
  - is not insured under the Group Policy as a Member.

  Wherever the term spouse is used, this provision also includes a state registered domestic partner.

- An Employee's Dependent Child(ren) as defined below.

- An Employee's Domestic Partner, if the Employee and the Domestic Partner complete and submit a Declaration of Domestic Partnership which is approved by Principal Life.

Dependent Child(ren)

- An Employee's natural child, if that child:

  - is not insured under the Group Policy as a Member; and
  - is less than 26 years of age.

- An Employee's stepchild, if that child:

  - meets the requirements above; and
  - receives principal support from the Employee.

- An Employee's foster child, if that child:

  - meets the requirements above; and
  - lives with the Employee; and
  - receives principal support from the Employee; and
  - is under legal guardianship of the Employee or the Employee's spouse or Domestic Partner; and
  - is approved in writing by Principal Life as a Dependent Child.

- An Employee's adopted child, if that child meets the requirements above and the Employee:

  - is a party in a lawsuit in which the Employee 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 Employee.

  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.

- An Employee's state registered domestic partner's child who otherwise qualifies above or if the Employee or state registered domestic partner are the child's guardian by court order.

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

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 disability 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:

- 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 (other than state registered domestic partners)

An Employee'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 Employee are married; and
- neither the partner nor the Employee 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 Employee's blood relative; and
- the partner and the Employee have shared the same residence for at least six consecutive months and continue to do so; and
- the partner and the Employee are each other's sole life partner and intend to remain so indefinitely; and
- the partner and the Employee are jointly responsible for each other's financial welfare; and
- the partner and the Employee 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 is regularly scheduled to work for the Policyholder for at least 30 hours per week. The Employee must be compensated by the Policyholder and either 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 their 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 their 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 Covered Person meets the definition of a Critical Illness after being insured under the Group Policy.

Grace Period

The first 60 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 Covered Persons. The Entire Contract is divided into two sections:

- the Group Policy provisions for the Policyholder; and
- the Certificate of Coverage provisions for Covered Persons.

Heart Attack

Death of heart muscle due to inadequate blood supply.

Diagnosis must be made by and documented in a written report from a Physician and include all of the following criteria:

- typical clinical symptoms, for example central chest pain; and
- diagnostic increase of cardiac Troponin (cTn) in the blood, which would indicate damage to the heart muscle; and
- new electrocardiographic changes of infarction.

Proof of Heart Attack requires submission of medical records. In the event of death, an autopsy confirmation and/or death certificate identifying Heart Attack as the cause of death will be accepted.

The Heart Attack will be deemed to be Incurred on the date the Diagnosis is made.

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

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 Covered Person, a Covered Person'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.

Loss of Hearing

The total and irrevocable loss of hearing in both ears due to disease that results in the inability to hear sounds at or below 70 decibels which cannot be partially or totally corrected by any procedure, aid or device.

A Dependent Child must be at least 3 years old on the date of Diagnosis to receive a benefit. However, if an insured Dependent Child is Diagnosed prior to age 3, we will pay a benefit if the initial diagnosis occurred while insured by this Group Policy, and the Diagnosis is confirmed on or after the child reaches age 3 and remains insured by this Group Policy.

Diagnosis of the disease and confirmation of the loss of hearing must be made by a Physician and supported by audiometric testing.

Loss of Hearing will be deemed to be Incurred on the date the Covered Person is unable to hear sounds at or below 70 decibels in both ears which cannot be partially or totally corrected by any procedure, aid or device.

Loss of Sight

The total and irrevocable loss of sight in both eyes due to disease which cannot be partially or totally corrected by any procedure, aid or device. Sight must be reduced to a corrected visual acuity of 20/200 or less in both eyes or a visual field of 20 degrees or less in both eyes.

A Dependent Child must be at least 3 years old on the date of Diagnosis to receive a benefit. However, if an insured Dependent Child is Diagnosed prior to age 3, we will pay a benefit if the initial diagnosis occurred while insured by this Group Policy, and the Diagnosis is confirmed on or after the child reaches age 3 and remains insured by this Group Policy.

Diagnosis of the disease and confirmation of the loss of sight must be made by a Physician. A Clinical Diagnosis will be accepted only if such Diagnosis is consistent with professional medical standards.

Loss of Sight will be deemed to be Incurred on the date the Covered Person's sight is reduced to a corrected visual acuity of 20/200 or less in both eyes or a visual field of 20 degrees or less in both eyes which cannot be partially or totally corrected by any procedure, aid or device.

Loss of Speech

The total and irrevocable loss of the ability to speak due to disease which cannot be partially or totally restored by any procedure, aid or device. Loss of Speech does not include congenital birth defects or developmental delays.

A Dependent Child must be at least 3 years old on the date of Diagnosis to receive a benefit. However, if an insured Dependent Child is Diagnosed prior to age 3, we will pay a benefit if the initial Diagnosis occurred while insured by this Group Policy, and the Diagnosis is confirmed on or after the child reaches age 3 and remains insured by this Group Policy.

Diagnosis of the disease and confirmation of the loss of speech must be made by a Physician. A Clinical Diagnosis will be accepted only if such Diagnosis is consistent with professional medical standards.

Loss of Speech will be deemed to be Incurred on the date it is Diagnosed.

Major Organ Failure

Irreversible end-stage failure of the 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 Covered Person is either listed with the United Network of Organ Sharing (UNOS) or a suitable donor is found without a UNOS listing.

Failure of any other organ not listed above is excluded.

Diagnosis must be made by and documented in a written report from a Physician.

Proof of Major Organ Failure requires submission of medical records. These records must include (except for kidney failure on dialysis) documentation of either listing with the UNOS or 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 Covered Person 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.

Multiple Sclerosis

A chronic disease involving damage to the sheaths of nerve cells in the brain and spinal cord. Symptoms may include numbness, impairment of speech and of muscular coordination, blurred vision, and severe fatigue. Such neurological deficits must be present for at least six months.

Diagnosis must be made by a Physician and supported by:

- neurological examination demonstrating functional impairments; and
- imaging studies of the brain or spine demonstrating lesions consistent with Multiple Sclerosis; or
- analysis of cerebrospinal fluid consistent with the diagnosis.

Multiple Sclerosis will be deemed to be Incurred on the date the Covered Person has had neurological deficits present for at least six months due to Multiple Sclerosis.

Paralysis

A total and irrevocable loss of use of two or more arms or legs due to disease which has continued for 90 consecutive days. Paralysis must be determined by a Physician to be permanent, complete and irreversible.

Diagnosis must be confirmed by a board-certified neurologist and supported by neurological evidence.

Paralysis will be deemed to be Incurred on the date it is Diagnosed.

Parkinson's Disease

A progressive disease of the nervous system marked by muscle rigidity, tremors, and changes in speech and gait which has progressed to a classification of Stage 4 or greater on the Hoehn and Yahr scale. Parkinson's Disease does not include other Parkinsonian syndromes or substance-induced diseases.

Diagnosis must be made by a Physician based on abnormal findings from neurological examination and cognitive testing, or results of imaging studies.

The initial Diagnosis of any stage of Parkinson's Disease must occur while insured under this Group Policy.

Parkinson's Disease will be deemed to be Incurred on the date the Covered Person has progressed to a Stage 4 or greater classification on the Hoehn and Yahr scale due to Parkinson's Disease.

Period of Limited Activity

Any period of time during which a Dependent due to sickness or injury is:

- confined in a Hospital for any cause or confined in a Skilled Nursing Facility; or
- unable to leave their home except to receive medical treatment.

Physical or Mental Disability

A Dependent Child's substantial Physical or Mental Disability 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; or

- any qualified medical professional expressly authorized by law to diagnose and treat the illness, acting within the scope of their license.

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

January 1, 2026 and the same day of each following year.

Policyholder

M CORP DBA 11:59.

Proof of Good Health

Written evidence that a Covered Person is insurable under Principal Life underwriting standards.

Scheduled Benefits Summary

The page, to be attached to the 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.

State Family and Medical Leave

A state mandated law that provides employees with paid family and/or medical leave.

Stroke

Death of brain tissue due to an acute cerebrovascular event.

Stroke does not include symptoms due to transient ischemic attack (TIA/mini-stroke), migraine, hypoxia, traumatic injury to brain tissue or blood vessels, and vascular disease affecting the eye, optic nerve or vestibular functions. A transient ischemic attack is an episode in which a person has stroke-like symptoms which disappear completely within a few minutes to an hour with no evidence of acute stroke on CT or MRI scans and no permanent neurological deficit.

Diagnosis must be made by and documented in a written report from a Physician, and include all of the following criteria:

- 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.

Proof of Stroke requires submission of medical records.

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

HOW TO BE INSURED - EMPLOYEES

Eligibility

Only Employees will be eligible for insurance.

For ALL MEMBERS:

Anyone meeting the definition of Employee will be eligible on the first of the Insurance Month next following the date they become an Employee.

Effective Date - Actively at Work

If an 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.

Individual Incontestability

All statements made by any Covered Person will be representations and not warranties. In the absence of fraud, these statements may not be used to contest a Covered Person's insurance unless:

- the insurance has been in force for less than three years during the Covered Person's lifetime; and
- the statement is in written form signed by the Covered Person; and
- a copy of the form, which contains the statement, is given to the Covered Person 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 Covered Person not being eligible for insurance under the Group Policy or upon other provisions of the Group Policy.

In addition, if a Covered Person'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. 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 $30,000.
- If less than 10% participation or five Members, to make effective any Scheduled Benefit for Covered Persons.
- 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 of the request, 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, establishment of a state registered domestic partnership or declaration of a Domestic Partner relationship or divorce or termination of a state registered domestic partnership 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 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 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; 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 Covered Person is temporarily outside the United States, the Covered Person may choose to continue insurance, subject to premium payment for a period of six months or less for one of the following reasons:

- travel; or
- a business assignment; or
- full-time student status, provided the Covered Person is either:
    - enrolled and attending an accredited school in a foreign country; or
    - participating in an academic program in a foreign country, for which the institution of higher learning at which the Covered Person is enrolled in the U.S. grants academic credit.

If the Covered Person is outside the United States for any other reason than those listed above, their coverage will automatically terminate.

HOW TO BE INSURED - DEPENDENTS

Eligibility

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

- the date the Employee 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 spouse 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 spouse 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 spouse under the terms of the Group Policy; or
    - the date Principal Life approves the Domestic Partner's status as a Dependent.
- A newly born child will be insured from the moment of live birth and a newly adopted child will be insured on the date of adoption or placement for adoption (whichever is earlier), provided the Employee is a Member and the child meets the definition of a Dependent Child.
- A new Dependent Child (other than a newborn child or newly adopted child) will be insured on the date acquired.

Proof of Good Health

In some instances, Proof of Good Health will be required to place Dependent insurance in force. 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 $15,000.
- If less than 10% participation or five Members, to make effective any Scheduled Benefit for the Dependent.
- To make effective any request for a Scheduled Benefit increase.

Individual Incontestability

Dependents will be subject to the Individual 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
- 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, State Family and Medical Leave and Other Continuation Provisions

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

If the continuation portion of the State Family and Medical Leave or FMLA applies to the Member's insurance, these 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 federal continuation, the continuation period will be counted concurrently toward satisfaction of the continuation period under both 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 described in Termination, except for Active Work; 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 described in Termination, except for Active Work; 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 Child 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, 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; 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 but no more often than once each calendar year; and

- the child undergoes examination by a Physician when Principal Life requests but not more often than once per calendar year. 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 Employee 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 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 Employee remained continuously insured.

Only the period of time during which the Employee 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.

State Family and Medical Leave and Federal Family and Medical Leave Act (FMLA)

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

In addition, a longer reinstatement period will be allowed for an approved leave of absence taken in accordance with the provisions of the state law regarding family leave.

Reinstatement of Insurance When Insurance Ends due to Living Outside of the United States

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

- the Employee or Dependent returns 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 Employee, the Employee returns to Active Work in the United States for the Policyholder for a period of at least 30 consecutive days. The Employee will be eligible for insurance on the day immediately following completion of the 30 consecutive days of Active Work; and
- for the Dependent, they remain in the United States for 30 consecutive days. If the Dependent does so, they 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 Employee or Dependent does not complete the 30 consecutive days of residence, their insurance will not be reinstated.

CRITICAL ILLNESS INSURANCE

Benefit Qualification

To qualify for benefit payment, all of the following must occur:

- the Covered Person must Incur the Critical Illness and the initial diagnosis of any stage of the illness must be made while insured for that Critical Illness under this Group Policy; and
- for Childhood Conditions, the Critical Illness must be Diagnosed before the age of 18; and
- for Childhood Conditions, a Diagnosis made prior to birth is covered if the Member was insured under this Group Policy at the time of Diagnosis and the Dependent Child became insured at live birth; and
- the Covered Person must meet the terms and conditions for an applicable Critical Illness listed below; and
- the Covered Person must submit proof of Diagnosis which requires submission of medical records; and
- Limitations and Exclusions must not apply; and
- Claim Procedures must be satisfied.

Schedule of Insurance

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

The specific Scheduled Benefit for each Covered Person is 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 $30,000, subject to the provisions below.
Dependent 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 $15,000, subject to the provisions below.
Dependent Child(ren)	25% of the Member Scheduled Benefit

*The Scheduled Benefit is subject to the Proof of Good Health requirements. 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 spouse’s or Domestic Partner's Scheduled Benefit be more than 50% of the Member's Scheduled Benefit. If the Member elects a Dependent spouse’s or Domestic Partner's Critical Illness benefit in excess of 50% of the Member's Scheduled Benefit amount, the Dependent spouse or Domestic Partner 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
Alzheimer's Disease	100%	0%
Amyotrophic Lateral Sclerosis	100%	0%
Benign Brain Tumor	100%	0%
Carcinoma In Situ	25%	25%
Coma	100%	0%
Coronary Artery Disease	25%	25%
Heart Attack	100%	100%
Invasive Cancer	100%	100%
Loss Of Hearing	100%	0%
Loss Of Sight	100%	0%
Loss Of Speech	100%	0%
Major Organ Failure	100%	100%
Multiple Sclerosis	100%	0%
Paralysis	100%	0%
Parkinson's Disease	100%	0%
Specified Skin Cancers	$250	$0
Stroke	100%	100%
Childhood Conditions		
Cerebral Palsy	100%	0%
Cleft Lip / Palate	100%	0%
Cystic Fibrosis	100%	0%
Down Syndrome	100%	0%
Muscular Dystrophy	100%	0%
Spina Bifida	100%	0%

Benefits for a First Occurrence of a different Critical Illness will be payable if the Critical Illness is Incurred more than 12 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 12 months from the date the preceding Critical Illness was Incurred and the Covered Person 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.

Total payment for all Critical Illnesses that result from the same illness or disease will not exceed the Scheduled Benefit.

DESCRIPTION OF BENEFITS

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; 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
- any loss sustained or contracted in consequence of the Covered Person being intoxicated or under the influence of any controlled substance unless administered on the advice of a Physician; or
- a Preexisting Condition as described below.

Exclusions

No benefits will be paid for any Critical Illness:

- Incurred while residing outside the United States for more than 6 months; or
- Incurred while incarcerated in any type of penal or detention facility; or
- for which proof is submitted by a Physician who is part of the Covered Person's Immediate Family.

Preexisting Conditions Exclusion for Initial Coverage

A Preexisting Condition is any sickness or injury, for which a Covered Person:

- received medical treatment, diagnosis, care, or services; or
- was prescribed or took prescription medications;

in the six month period before the Covered Person became insured under the Group Policy.

No benefits will be paid for a Critical Illness that results from a Preexisting Condition unless, on the date the Covered Person Incurs the Critical Illness, the Member has been Actively At Work for one full day for the Member's Critical Illness or the Dependent has been insured for one full day for a Dependent's Critical Illness, after completing 12 consecutive months during which the Covered Person was insured under the Group Policy.

Preexisting Conditions Exclusion for Benefit Increases

A Preexisting Condition is any sickness or injury, for which a Covered Person:

- received medical treatment, diagnosis, care, or services; or
- was prescribed or took prescription medications;

in the six month period prior to a 25% or greater increase in the Scheduled Benefit or change in the Group Policy.

The benefits and the Group Policy provisions in force immediately prior to the increase or change will be payable for a Critical Illness that:

- results from a Preexisting Condition; and

- begins within six consecutive months after the effective date of the increase in benefits or change in the Group Policy provisions.

The increase in benefits or change in the Group Policy provisions will be payable if the Covered Person has received no treatment, diagnosis, care, or service, and no prescription medication was prescribed or taken for the Preexisting Condition in the 12 consecutive months following the effective date of the increase in benefits or change in the Group Policy provisions. Following this 12 month period, the Member must be Actively at Work for one full day for the Member's Critical Illness or the Dependent must be insured for one full day for a Dependent's Critical Illness.

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.

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 Member Critical Illness Portability Insurance, the Member must be less than age 70; and
- for Dependent Critical Illness Portability Insurance, the Dependent spouse or Domestic Partner must be less than age 70; and
- for any Dependent, Member Critical Illness must be continued.

Insurance may not be continued for the Covered Person 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 critical illness insurance policy; or
- a Critical Illness was Incurred, regardless of whether a benefit was payable, other than the Health Screening Benefit; or
- for Dependent Critical Illness Portability Insurance, the Dependent ceases to be a Dependent; or
- the Member dies.

Ported Coverage

The insurance that is available for continuation will be the benefits as shown on the Scheduled Benefits Summary and on the Description of Benefits Benefit Provisions section that are in force on the date insurance terminates under the Group Policy. The Health Screening Benefit is 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 Member insurance, the May 1 next following the Member's 70th birthday; or
- for Dependent insurance for the Dependent spouse or Domestic Partner, the May 1 next following the Dependent spouse's or Domestic Partner's 70th birthday; or

- for Dependent insurance, the date the Dependent no longer qualifies as a Dependent, due to divorce, termination of a state registered domestic partner relationship 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

- for Dependent insurance, the date Member Critical Illness Insurance ceases.

Request for Insurance/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 request 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. Principal Life will provide forms to assist the Member in filing claims. If notice is given and the completed forms are not provided within 15 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 90 days after the date the Critical Illness was Incurred. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the date proof is otherwise required. 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. Receipt of claim will be considered to be met when the appropriate claim form is received by Principal Life.

Payment, Denial, and Review

State law requires payment of benefits within 30 calendar days after Principal Life receives all information needed to make a claim determination. The 30-calendar day period does not include any time during which Principal Life is awaiting receipt of complete and proper proof of the Critical Illness. If Principal Life has not received all information needed to make a claim determination within 30 calendar days after receipt of the claim, Principal Life will notify the claimant in writing and include a written list of all information reasonably needed to make the claim determination. A claimant is then allowed up to 45 days to provide all additional information requested. Principal Life is permitted two 30-day extensions for processing an incomplete claim. Written notification will be sent to a claimant regarding the extension.

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 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 45 days after receipt of the appeal request. If the appeal cannot be processed within the 45-day period because Principal Life did not receive the requested additional information, Principal Life will send a written explanation prior to the expiration of the 45 days. The claimant is then allowed 45 days to provide all additional information requested. Principal Life is permitted a 45-day extension for the review. Written notification will be sent to the claimant regarding the extension.

For purposes of this section, "claimant" means the Covered Person.

Right to Recover Overpayments

If an overpayment of benefits occurs under the Group Policy, Principal Life will have the option to:

- reduce or withhold future benefits Principal Life determines to be due; or
- recover the overpayment directly from the Member; or
- take legal action.

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 be paid to the Member's spouse or Domestic Partner, child or parent.

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.

If the Member has no eligible survivors, payment will be made to the Member's estate, unless there is none. In this case, no benefit will be payable.

Medical Examinations

Principal Life may have the claimant examined 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 days after required proof of the Critical Illness has been filed. Further, no legal action may be started later than three years after that proof is required to be filed.

If the claim is subject to ERISA (Employee Retirement Income Security Act of 1974), before bringing a civil legal action under the federal labor law known as ERISA, the Member must exhaust available administrative remedies. Under this Group Policy, the Member must first exhaust the appeal procedures listed above. After the required reviews:

- the Member or the Member's beneficiary may bring legal action under Section 502(a) of ERISA; and
- Principal Life will waive any right to assert that the Member failed to exhaust administrative remedies.

Time Limits

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

BOOKLET-CERTIFICATE NOTICE

California insurance law requires that a group policy include the telephone number of the insurance company issuing the policy in order for the persons to present inquiries, to obtain information about coverage, and to provide assistance in resolving complaints. Persons may call or write to:

Principal Life Insurance Company
711 High Street
Des Moines, Iowa 50392-0002

For administration-related inquiries:
Attn: Group Call Center
Phone: 1-800-843-1371

Consumers should contact Principal Life Insurance Company, their agent or other representative regarding complaints. If the policy or certificate was issued or delivered by an agent or broker, the insured must contact his or her agent or broker for assistance.

The California Department of Insurance should be contacted only after discussions with the insurer, or its agent or other representative, or both have failed to produce a satisfactory resolution to the problem.

Persons may contact:

California Insurance Department
Health Claims Bureau
11th Floor
300 South Spring Street, South Tower
Los Angeles, CA 90013
Phone: 1-800-927-4357 (HELP)
TDD: 1-800-482-4833
Website: www.insurance.ca.gov

This Notice is for your information only and does not become a part or condition of this booklet-certificate.

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 dental expense, group vision care expense, group hospital indemnity, and/or group critical illness 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 May 15, 2024.

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: HIPAA Privacy Officer, Enterprise Privacy Office, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002. Once we receive your request, a form to revoke an authorization will be sent to your attention for completion.

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 provide a pre-determination of benefits 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. 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.

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. 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. 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. 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.

Exercising your rights. To exercise any of the above rights, you must submit a written request indicating which rights you are requesting to: HIPAA Privacy Officer, Enterprise Privacy Office, Principal Life Insurance Company, 711 High Street, Des Moines IA 50392-0002. Once we receive your request, a form(s) will be sent to your attention for completion.

Complaints. If you believe your privacy rights have been violated, you can send a written complaint to us at Complaint Handler, Workplace Benefits, 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.

A scheduled benefit summary individualized to the benefits you have chosen may be found on your employee website via eService.

Principal Life Insurance Company
Des Moines, Iowa 50392-0002

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.

SUPPLEMENT TO YOUR CERTIFICATE OF COVERAGE

The Employee Retirement Income Security Act (ERISA) requires that certain information be furnished to each participant in an employee benefit plan. Policyholders may use this Certificate of Coverage in part in meeting Summary Plan Description requirements under ERISA.

1. **Employer Plan Identification Number:**

   EIN: 20-0810267

2. **Type of Administration:**

   Critical Illness: Insurance Contract.

3. **Plan Administrator:**

   M CORP DBA 11:59
   5930 S LAND PARK DRIVE #22069
   SACRAMENTO CA 95822

   See your employer for the business telephone number of the Plan Administrator.

4. **Plan Sponsor:**

   M CORP DBA 11:59
   5930 S LAND PARK DRIVE #22069
   SACRAMENTO CA 95822

5. **Agent for Service of Legal Process:**

   M CORP DBA 11:59
   5930 S LAND PARK DRIVE #22069
   SACRAMENTO CA 95822
   Telephone: (916)254-0355

   Legal process may also be served upon the plan administrator.

6. **Type of Participants Covered Under the Plan:**

   All active full-time employees of M CORP DBA 11:59, and provided you are a Member as defined in the DEFINITIONS Section of this booklet (page GH 5712 (CI)).

7. **Sources and Methods of Contributions to the Plan:**

   Employee pays all of employee's contribution.

   Employee pays all of Dependent's contributions.

8. **Ending Date of Plan's Fiscal Year:**

   January 31

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Principal Life Insurance Company
Des Moines, Iowa 50392-0002