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12/01/2019

GROUP BOOKLET-CERTIFICATE FOR MEMBERS OF:

MOTIVE POWER, INC.

ALL MEMBERS
Group Vision Care Expense Insurance

Print Date: 12/25/2019

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

Certificate of Coverage

Important Notice: This is Vision Care Expense Insurance. Please read this Certificate of Coverage carefully to fully understand what it covers, limits, and excludes. Principal Life suggests starting with a review of the terms listed in the DEFINITIONS section. Knowing the meaning of these terms will help with understanding the insurance.

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

This insurance has been designed to provide a benefit payment when a covered loss occurs. The benefits are provided by a Group Policy issued by Principal Life. The Group Policy is administered and underwritten by Principal Life as an insurer and payment of claims will be handled by the Claims Administrator.

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 Certificate of Coverage or a Certificate of Coverage rider.

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

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

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

No Cost Language Services. You can get an interpreter and get documents read to you in your language. For help, call us at 1-800-247-4695. For more help call the CA Dept. of Insurance at 1-800-927-4357.

Note: This Group Policy is not designed to meet the requirements of pediatric vision essential health benefits as defined by the Affordable Care Act (ACA).

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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

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

Benefit-Waiting Period

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

Calendar Year

January 1 through December 31 of each year.

Claims Administrator

Vision Service Plan Insurance Company (VSP)
3333 Quality Drive
Rancho Cordova, California 95670
(800) 877-7195

Copayment

A specified dollar amount that must be paid by a Member or Dependent each time certain or specified covered services are rendered.

Date of Issue

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

Dependent

- A Member's spouse or state registered domestic partner, if that spouse or state registered domestic partner is not in the Armed Forces of any country.

- A Member's Dependent Child(ren) as defined below.

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

Dependent Child(ren)

- A Member's natural child, if that child:

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

- A Member's stepchild or an existing child of a state registered domestic partner or Domestic Partner, if that child:

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

- A Member's foster child, if that child:

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

- A Member's adopted child, if that child meets the requirements above and the Member:

  - is a party in a lawsuit in which the Member is seeking the adoption of the child; or
  - has custody of the child under a court order that grants custody of the child to the Member.

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

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

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.

Domestic Partner (other than state registered domestic partners)

A Member's opposite sex or same sex (other than state registered domestic partners) life partner, provided:

- the partner is not in the Armed Forces of any country; and

- the partner is at least 18 years of age; and

- neither the partner nor the Member are married; and

- neither the partner nor the Member have had another Domestic Partner in the six-month period preceding the date of the signed Declaration of Domestic Partnership; and

- the partner is not the Member's blood relative; and

- the partner and the Member have shared the same residence for at least six consecutive months and continue to do so; and

- the partner and the Member are each other's sole life partner and intend to remain so indefinitely; and

- the partner and the Member are jointly responsible for each other's financial welfare; and

- the partner and the Member are not in the relationship solely for the purpose of obtaining insurance coverage.

Employee

Any PERSON, residing in the United States, who is a U.S. citizen or is legally working in the United States, who is regularly scheduled to work for the Policyholder for at least 30 hours a week. The person must be compensated by the Policyholder and either the employer 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 or at another place to which an employee must travel to perform his or her regular duties. A person is considered to be residing in the United States if his or her main home or permanent address is in the United States or if the person is in the United States for six months or more during any 12-month period.

An owner, proprietor, or partner of the Policyholder's business will be deemed to be an eligible employee for purposes of the Group Policy, provided he or she is regularly scheduled to work for the Policyholder for at least 30 hours a week and otherwise meets the definition of Employee.

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 Members and Dependents. The Entire Contract is provided in two sections:

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

Immediate Family

A Member's spouse, state registered domestic partner, 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.

Insurance Month

Calendar month.

Member

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

Necessary Contact Lenses

Necessary contact lenses are prescribed by your provider when a specific criterion is met, including but not limited to the following:

- to correct extreme visual acuity problems that cannot be corrected with regular lenses;
- for certain conditions of anisometropia; or
- for keratoconus.

Non-Preferred Provider/Non-PPO Provider

Any optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted with the Preferred Provider Organization (PPO).

Participating Retail Chain Provider

Any optometrist or ophthalmologist or providers of covered services who are licensed or otherwise qualified to practice vision care and/or provide vision care materials who are not contracted with the Preferred Provider Organization (PPO) but who have agreed to bill directly for benefits payable.

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.

Placement for Adoption; Placement

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

Policy Anniversary

January 1, 2021 and the same day of each following year.

Policyholder

MOTIVE POWER, INC..

Preferred Provider/PPO Provider

Any optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with the Preferred Provider Organization (PPO).

Preferred Provider Organization (PPO)

Vision Service Plan Insurance Company (VSP)
3333 Quality Drive
Rancho Cordova, California 95670
(800) 877-7195

Premium Period

A monthly basis on which the premium is due.

Prior Policy

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

Vision Examinations

Comprehensive examination of visual function and prescription of corrective eyewear.

HOW TO BE INSURED - MEMBERS

VISION CARE EXPENSE INSURANCE

Eligibility

Only Employees will be eligible for insurance.

Anyone meeting the definition of Employee on December 1, 2019, will be eligible on that date.

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

Effective Dates - Actively at Work

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

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

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

This Actively at Work requirement may also be waived as described under Replacement of a Prior Policy on GH 9022.

Individual Incontestability

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

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

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

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

Effective Date for Non-Contributory Insurance

Insurance for which the Employee contributes no part of the premium will become effective on the date the Employee is eligible. The Employee must request insurance in a form approved by Principal Life.

In addition, insurance will be subject to the Benefit-Waiting Period provisions described below.

Effective Date for Contributory Insurance

If the Employee is required to contribute towards the cost of insurance, the Employee must request insurance in a form approved by Principal Life. The requested insurance will become effective on:

- the first of the Insurance Month coinciding with or next following 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 Employee's request, if the Employee makes the request within 31 days after the date the Employee is eligible; or

- the first of the Insurance Month coinciding with or next following the date of the Employee's request, if the Employee makes the request more than 31 days after the date the Employee is eligible.

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

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

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

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

However, if the Member is not Actively at Work on the date insurance would otherwise be effective, the Employee's insurance will not be in force until the date the Employee returns to Active Work.

In addition, insurance will be subject to the Benefit-Waiting Period provisions described below.

Annual Enrollment Period

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

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

- during any previous Annual Enrollment Period; or

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

For any Member or Dependent not previously insured under the Group Policy, the Benefit-Waiting Period provisions described below do not apply during the Annual Enrollment Period.

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

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

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

The Annual Enrollment Period is generally the one-month period immediately prior to the Policy Anniversary date or another period of time requested by the Policyholder and accepted by Principal Life.

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

Court-Ordered Coverage Under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN): Benefit-Waiting Period provisions as described below will not apply to the Member or the Member's Dependent Child if:

- the Member is enrolled (or eligible to be enrolled but failed to enroll during a previous enrollment period); and
- the Member failed to enroll a Dependent Child during a previous enrollment period; and
- the Member is required by a QMCSO or NMSN as defined by applicable federal law and state insurance laws to provide vision coverage for a Dependent Child.

The request for enrollment:

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

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

- will be the first of the Insurance Month coinciding with or next following the date of the request for enrollment; and
- will not be subject to the Actively at Work provisions described in this section.

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

Special Enrollment Period

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

The Special Enrollment Periods are:

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

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

  The effective date of insurance will be the first of the Insurance Month coinciding with or next following the date of the request for enrollment provided contribution has been received for the requested insurance.

  NOTE: For the purpose of (ii) above:

  "Loss of eligibility" does not include:

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

- Newly Acquired Dependents: A Special Enrollment Period will apply to the Member or Dependent if:

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

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

(i) in the event of marriage, or establishment of a state registered domestic partnership, or declaration of a Domestic Partner relationship, the date of such marriage, or establishment of a state registered domestic partnership, or declaration of a Domestic Partner relationship; or
(ii) in the event of a Dependent Child's birth, the date of such birth; or
(iii) in the event of a Dependent Child's adoption or Placement for Adoption, the date of such adoption or Placement for Adoption, whichever is earlier.

During a Special Enrollment Period, insurance will not be subject to the Benefit-Waiting Period provisions described below.

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

Other than during an Annual Enrollment Period or Special Enrollment Period or coverage required under a QMCSO or NMSN as described above, if the Member requests insurance for themselves or a Dependent more than 31 days after the date the Member or Dependent is eligible, or the Member elects to terminate insurance and more than 31 days later request to be insured again, benefits will be limited as follows:

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

After insurance has been in force for 12 consecutive months, benefits will be payable for charges incurred for frames, lenses, and contact lenses (subject to Maximum Payment Limits shown under Payment Conditions on GH 9018).

Effective Date for Benefit Changes

A change in the Member's Scheduled Benefit amount because of a change in status (insurance class) will normally be effective on the first of the Insurance Month coinciding with or next following the date of the change in status.

Any termination in the Member's Scheduled Benefit amount due to a change in status (insurance class) will be effective on the date of the change in status, whether or not the Member is Actively at Work.

A change in the Member's Scheduled Benefit amount because of a change in benefits provided under the Group Policy will normally be effective on the first of the Insurance Month coinciding with or next following the date of change.

However, if the Member is not Actively at Work on the date the change would otherwise be effective, the change will not be in force until the day the Member returns to Active Work.

Termination

Unless continued as provided on GH 9016, 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 contribution is made for the Member's insurance; or
- for contributory insurance 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 belong to a class for which insurance is provided; or
- the end of the Insurance Month in which the Employee ceases to be a Member; or
- the end of the Insurance Month in which the Member ceases Active Work.

HOW TO BE INSURED - DEPENDENTS

VISION CARE EXPENSE INSURANCE

Eligibility

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

- the date the Member is eligible for Member insurance; or
- the date the Member first acquires a Dependent; or
- the date the Member enters a class for which Dependent insurance is provided.

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

A Member may elect to insure his or her spouse or state registered domestic partner or Domestic Partner as a Dependent even though such spouse or state registered domestic partner or Domestic Partner is also insured under this Group Policy as a Member, provided the spouse or state registered domestic partner or Domestic Partner otherwise qualifies as a Dependent and the Member remains insured for Member Vision Care Expense Insurance. With respect to such spouse or state registered domestic partner or Domestic Partner, benefits payable shall be subject to the terms and conditions described in Coordination with Other Benefits in GH 9023 and in no event shall exceed 100% of the charge for the treatment or service.

Effective Date

Dependent insurance is available only with respect to Dependents of Members currently insured for Member insurance. If a Member is eligible for Dependent insurance, such insurance for the Member's Dependents will become effective under the same terms as described earlier for Member insurance, except:

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

In addition, Dependent Vision Care Expense Insurance will be subject to the Benefit-Waiting Period provisions described on GH 9014.

Insurance for a Domestic Partner

If the Member requests insurance for a Domestic Partner, insurance for a Domestic Partner will be in force on the later of:

- the date insurance would otherwise become effective for a Dependent under the terms of the Group Policy; or
- the date Principal Life approves the Domestic Partner's status as a Dependent.

Individual Incontestability

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

Termination

Unless continued as provided on GH 9016, insurance for Dependents will terminate on the earliest of:

- the end of the Insurance Month in which the Member ceases to belong to a class for which Dependent insurance is provided; or

- the date Dependent Vision Care Expense Insurance is removed from the Group Policy; or

- the date Member insurance ceases; or

- the end of the Insurance Month for which the last contribution is made for Dependent insurance; or

- for contributory insurance the end of any Insurance Month, if requested by the Member before that date.

Insurance for any one Dependent will terminate on the earlier of:

- the last day of the Insurance Month in which he or she ceases to be the Member's Dependent. However, a spouse or state registered domestic partner who no longer resides with the Member will not cease to be a Dependent until legally separated or divorced, or termination of state registered domestic partnership, provided the spouse or state registered domestic partner otherwise continues to be a Dependent; or

- for a Domestic Partner or each Domestic Partner's Dependent Child, on the last day of the Insurance Month in which that Domestic Partner or Domestic Partner's Dependent Child ceases to be a Dependent. However, a Domestic Partner who no longer resides with the Member will not cease to be a Dependent until the Declaration of Termination of Domestic Partnership has been received by Principal Life, provided the Domestic Partner otherwise continues 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.

CONTINUATION OF COVERAGE

FEDERAL REQUIRED CONTINUATION - CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) applies to any employer (except the federal government and religious organizations) that: (a) maintains group health coverage; and (b) normally employed 20 or more employees on a typical business day during the preceding Calendar Year. For this purpose, "employee" means full-time employees and full-time equivalent for part-time employees.

Where applicable, COBRA requires that your group health insurance allow qualified persons (described below) to continue group health coverage after it would normally end. The term "group health coverage" includes any medical, dental, vision care, and prescription drug coverages that are part of your insurance.

A full description of the COBRA continuation provisions is included in the administration material provided to the Policyholder. Members should refer questions to the Policyholder regarding COBRA.

Note: COBRA Continuation is not available to state registered domestic partners or Domestic Partners or to a state registered domestic partner's or a Domestic Partner's Dependent Child.

FEDERAL FAMILY AND MEDICAL LEAVE ACT (FMLA) AND OTHER CONTINUATION PROVISIONS

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

If the continuation portion of the FMLA applies to the Member's insurance, these FMLA continuation provisions:

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

A full description of the FMLA continuation provisions is included in the administration material provided to the Policyholder. Members should refer questions to the Policyholder regarding FMLA.

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

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

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

- for the Member and the Member's Dependents:
  - the date the Group Policy is terminated; or
  - the end of the premium period for which premium is paid if the Member fails to make timely payment of a required premium; or
  - the date 24 months after the date the Member enters active military duty; or
  - the date after the day in which the Member fails to return to Active Work or apply for reemployment with the Policyholder.
- for the Member's Dependents:

- the date Dependent insurance would otherwise cease as provided on GH 9015; or

- the end of any Insurance Month, if requested by the Member before that date.

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

A full description of the USERRA continuation provisions is included in the administration material provided to the Policyholder. Members should refer questions to the Policyholder regarding USERRA.

Note: USERRA Continuation is not available to state registered domestic partners or Domestic Partners or to a state registered domestic partner's or Domestic Partner's Dependent Child.

MEMBER INSURANCE - SICKNESS OR INJURY

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

- the date insurance would otherwise cease as provided in GH 9014; or

- the end of the Insurance Month in which the Member recovers; or

- the end of the Insurance Month in which the Member is covered under the USERRA continuation provision.

- the end of the Insurance Month after coverage has been continued under this section for 12 consecutive month(s).

If insurance under the Group Policy is subject to either COBRA or a state continuation mandate, this continuation period will run concurrent with the COBRA or state continuation period.

MEMBER INSURANCE - LAYOFF OR APPROVED LEAVE OF ABSENCE

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

- the date insurance would otherwise cease as provided in GH 9014; 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 group vision care coverage; or

- the date one month after the end of the Insurance Month in which Active Work ends.

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

If insurance under the Group Policy is subject to either COBRA or a state continuation mandate, this continuation period will run concurrent with the COBRA or state continuation period.

STATE REQUIRED CONTINUATION - CALIFORNIA: MEMBER

State Required Notice:

A Member should examine his or her options carefully before declining this coverage. A Member should be aware that companies selling individual health insurance typically require a review of medical history that could result in a higher premium or a declination of coverage entirely.

Cal-COBRA - (Applicable only to small employer groups who have at least two but not more than 19 employees and are not subject to COBRA)

- **Definitions**

  Qualified Person means a Member or any covered Dependent who, on the day before a Qualifying Event, is insured under the Group Policy and any child born to or placed for adoption with the Member who is on continuation.

  Qualifying Event means, except for the election to continue insurance, insurance would cease due to the Member's termination of employment or reduction in work hours for reasons other than gross misconduct.

- **Qualification for Continuation**

  Qualified Persons, who would lose insurance under the Group Policy because of a Qualifying Event, may elect to continue insurance on the date insurance would otherwise cease if:

  - the Group Policy is in force; and
  - the Qualified Person timely elects to continue insurance and agrees to pay the required premium; and
  - the Qualified Person is not entitled to Medicare; and
  - the Qualified Person is not covered under any other vision care expense plan in which the preexisting exclusion provisions have been satisfied; and
  - the Qualified Person is not covered or eligible for COBRA.

- **Period of Continuation**

  Insurance for the Qualified Person may be continued until the earliest of:

  - the date the Group Policy is terminated; or
  - the date insurance would otherwise ceases as provided in the Group Policy; or
  - the end of the period for which premium is paid, if payment of the required premium is not made within the Grace Period; or
  - the date the Qualified Person becomes entitled to Medicare; or
  - the date the Qualified Person becomes covered under any other vision care expense plan and has satisfied the preexisting exclusion provision (if any); or
  - the date the Qualified Person becomes covered or eligible for COBRA; or
  - the date insurance has been continued for 36 months.

  For a Member's child who is born to or placed for adoption with the Member while on continuation, the maximum continuation period for that child will be the Member's maximum continuation period.

- **Notice, Election, and Premium Requirements**

  - **Policyholder Notice Requirements**

    The Policyholder must notify Principal Life within 30 days of a Qualifying Event or when the Policyholder becomes subject to the federal continuation law (COBRA).

    If this Group Policy terminates, the Policyholder must notify Qualified Persons of the termination and of the ability to remain covered under a replacing plan, if any. The notice to Qualified Persons must be provided the later of: 30 days prior to the date of termination of this Group Policy or when active Members are notified. The Policyholder must notify the replacing carrier in writing of the names of all Qualified Persons. Within 15 days of a written request, Principal Life will provide the Policyholder or the agent or broker representative information necessary to fulfill the Policyholder and replacing carrier notice obligations.

  - **Qualified Person Notice Requirements**

    Qualified Persons must notify Principal Life within 30 days of the date a child is born to or placed for adoption with the Member.

If this Group Policy terminates, the Qualified Person may elect to complete the remaining continuation period under the Policyholder's replacing plan, if any. The Qualified Person must elect continuation and pay the required payment within 30 days after receiving the replacing carrier's notice.

- **Election Requirements**

  Principal Life must notify a Qualified Person of the availability of continuation within 14 days after receiving notice of a Qualifying Event. The notification to the Qualified Person must include premium information and an election form and be mailed to the Qualified Person's last known address.

  The Qualified Person must make written election and deliver the election notice by first class mail (or other reliable means) to Principal Life. The election must be made within 60 days following the date insurance would otherwise cease due to the Qualifying Event, or the date of the notice from Principal Life, whichever is later. Failure to elect continuation within the 60-day period will disqualify the Qualified Person from continuation.

- **Premium Requirements**

  Premium charged for the continuation will be 110% of the applicable group rate.

  The first premium payment must be delivered to Principal Life by first class or certified mail (or other reliable means) within 45 days after the date the Qualified Person elects continuation. The first premium payment must be sufficient to pay all required payments. Failure to make the first payment as required will disqualify the Qualified Person from continuation.

  All subsequent payments are due monthly on or before the due date. Failure to make the required premium within the Grace Period will disqualify the Qualified Person from continuation.

STATE REQUIRED CONTINUATION - CALIFORNIA: DEPENDENT

Cal-COBRA (Applicable only to small employer groups who have at least two but not more than 19 employees and are not subject to COBRA)

- **Definitions**

  Qualified Person means a Dependent who, on the day before a Qualifying Event, is covered under the Group Policy as a Dependent spouse, state registered domestic partner or Domestic Partner, or Dependent Child of a Member.

  Qualifying Event means any of the following events which, except for the election to continue coverage, would result in a loss of coverage to a Qualified Person:

  - the Member's death; or
  - the Member's divorce or legal separation from his or her spouse; or
  - the Member's termination from his or her state registered domestic partnership or Domestic Partnership; or
  - the Member's option to terminate coverage under the Group Policy when he or she becomes entitled to Medicare; or
  - a Member's child ceasing to be a Dependent Child as defined in the Group Policy.

- **Qualification for Continuation**

  A Qualified Person who would lose insurance under the Group Policy because of a Qualifying Event may elect to continue insurance on the date insurance would otherwise cease if:

  - the Group Policy is in force; and

- the Qualified Person timely elects to continue insurance and agrees to pay the required premium; and
- the Qualified Person is not entitled to Medicare; and
- the Qualified Person is not covered under any other dental plan in which the preexisting exclusion provisions have been satisfied; and
- the Qualified Person is not covered or eligible for COBRA.

- **Period of Continuation**

Insurance for the Qualified Person may be continued until the earliest of:

- the date the Group Policy is terminated; or
- the date insurance would otherwise ceases as provided in the Group Policy; or
- the end of the period for which premium is paid, if payment of the required premium is not made within the Grace Period; or
- the date the Qualified Person becomes entitled to Medicare; or
- the date the Qualified Person becomes covered under any other dental plan and has satisfied the preexisting exclusion provision (if any); or
- the date the Qualified Person becomes covered or eligible for COBRA; or
- the date insurance has been continued for 36 months.

- **Notice, Election and Premium Requirements**

  - **Policyholder Notice Requirements**

    The Policyholder must notify Principal Life within 30 days after becoming subject to the federal continuation law (COBRA).

    If this Group Policy terminates, the Policyholder must notify Qualified Persons of the termination and of the ability to remain covered under a replacing plan, if any. The notice to Qualified Persons must be provided the later of, 30 days prior to the date of termination of this Group Policy, or when active Members are notified. The Policyholder must notify the replacing carrier in writing of the names of all Qualified Persons. Within 15 days of a written request, Principal Life will provide the Policyholder or the agent or broker representative information necessary to fulfill the Policyholder and replacing carrier notice obligations.

  - **Qualified Person Notice Requirements**

    Qualified Persons must notify Principal Life within 30 days any Qualifying Event.

    If this Group Policy terminates, the Qualified Person may elect to complete the remaining continuation period under the Policyholder's replacing plan, if any. The Qualified Person must elect continuation and pay the required payment within 30 days after receiving the replacing carrier's notice.

  - **Election Requirements**

    Principal Life must notify a Qualified Person of the availability of continuation within 14 days after receiving notice of a Qualifying Event. The notification to the Qualified Person must include premium information and an election form and be mailed to the Qualified Person's last known address.

    The Qualified Person must make written election and deliver the election notice by first class mail (or other reliable means) to Principal Life. The election must be made within 60 days following the date insurance would otherwise cease due to the Qualifying Event, or the date of the notice from Principal Life, whichever is later. Failure to elect continuation within the 60-day period will disqualify the Qualified Person from continuation.

  - **Premium Requirements**

Premium charged for the continuation will be 110% of the applicable group rate.

The first premium payment must be delivered to the Principal Life by first class or certified mail (or other reliable means) within 45 days after the date the Qualified Person elects continuation. The first premium payment must be sufficient to pay all required payments. Failure to make the first payment as required will disqualify the Qualified Person from continuation.

All subsequent payments are due monthly on or before the due date. Failure to make the required premium within the Grace Period will disqualify the Qualified Person from continuation.

If the Group Policy is subject to another state-required continuation law this continuation period will be concurrent with any other state-required continuation period.

DEPENDENT INSURANCE - DEVELOPMENTALLY, PHYSICALLY OR MENTALLY DISABLED CHILDREN

Qualification

Dependent Vision Expense Insurance for a child may be continued after the child reaches the maximum age for Dependent Children as defined in GH 9012 of this Certificate of Coverage, provided that:

- the child is incapable of self-support as the result of a Developmental, Physical or Mental Disability and they became so before reaching the maximum age and is dependent on the Member for primary support; and

- except for age, the child continues to be a Dependent Child as defined in GH 9012; and

- proof of the child's incapacity is sent to Principal Life within 31 days after the date the child reaches the maximum age; and

- further proof that the child remains incapable of self-support is provided when Principal Life requests; and

- the child undergoes examination by a physician when Principal Life requests. Principal Life will pay for these examinations and will choose the physician to perform them.

Period of Continuation

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

- the date insurance would cease for any reason other than the child's attainment of the maximum age; or

- the date the child becomes capable of self-support or otherwise fails to qualify as set forth above.

CONTINUATION FOR STATE REGISTERED DOMESTIC PARTNERS OR DOMESTIC PARTNERS AND/OR A STATE REGISTERED DOMESTIC PARTNER'S OR DOMESTIC PARTNER'S DEPENDENT CHILD

A. Qualified Persons/Qualifying Events

Continuation of group vision coverage will be offered to the following persons if the person is not covered or eligible for federal continuation (COBRA), the Group Policy is in force, the person was insured under the Group Policy on the day before a qualifying event and the person would otherwise lose that coverage as a result of the following qualifying events:

(1) an insured state registered domestic partner or Domestic Partner (and any Dependent Children) following the Member's:

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

(b) a reduction in work hours.

Reduction in work hours includes, but is not limited to, leave of absence, layoff, continuation due to sickness or injury, or when applicable, retirement.

(Note: In this instance, the Member must elect and become covered under COBRA in order for an insured state registered domestic partner or Domestic Partner to qualify for this group vision continuation); and

(2) a Member's former state registered domestic partner or Domestic Partner (and any Dependent Children) following the Member's termination from his or her state registered domestic partnership or Domestic Partnership; and

(3) a Member's surviving state registered domestic partner or Domestic Partner (and any Dependent Children), following the Member's death; and

(4) a Member's state registered domestic partner or Domestic Partner (and any Dependent Children) following the Member's entitlement to Medicare.

B. Maximum Continuation Period

Following a qualifying event, vision coverage can continue up to the maximum continuation period. The maximum continuation period for an insured state registered domestic partner or Domestic Partner following the Member's termination of employment or reduction in work hours is 18 months from the date of the qualifying event or the date the Member is no longer covered under COBRA, whichever occurs first.

Following the Member's termination of employment or reduction in work hours, a qualified person may request an 11-month extension of this group vision continuation. The maximum group vision continuation will be 29 months from the date of the qualifying event (see Disabled Extension, Section D).

When a Member becomes entitled to Medicare before his or her employment terminates or work hours are reduced, the maximum continuation period for the insured state registered domestic partner or Domestic Partner will be the longer of:

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

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

The maximum continuation period for a qualified person following a qualifying event described in A (2) through A (4) is 36 months from the date of the qualifying event.

C. Second Qualifying Events

If during an 18-month continuation period (or, 29 months for a qualified person on the disabled extension), a second qualifying event described in A (2) through A (4) occurs, the maximum continuation period may be extended for the qualified person up to 36 months. That is, following a second qualifying event, a qualified person may continue for up to a maximum of 36 months dating from the Member's termination of employment or reduction in work hours. The extension is only available if the second qualifying event described in A (2) through A (4), absent the first qualifying event, would result in a loss of coverage for the covered state registered domestic partner or Domestic Partner under the Group Policy.

D. Disabled Extension

Following a Member's termination of employment or reduction in work hours, a qualified person who has been determined disabled by the Social Security Administration either before or within 60 days after the qualifying event may request an extension of the continued coverage from 18 months to 29 months.

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

E. Termination of Continued Coverage

Continued coverage ends the earliest of the following:

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

(2) the date the qualified person enrolls in Medicare; however, this does not apply to a person who is already enrolled in Medicare on the date he or she elects this group vision continuation; or

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

(4) the date the Group Policy is terminated; or

(5) the date insurance would otherwise cease under the Group Policy; or

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

(7) the date the Member is no longer covered under COBRA as described in A (1).

Note: Persons who, after the date of this group vision continuation election, become entitled to Medicare or become covered under another group vision plan and have satisfied the preexisting exclusion provision, are not eligible for continued coverage.

F. Employer/Plan Administrator Notification Requirement

When a covered state registered domestic partner or Domestic Partner has a qualifying event due to the Member's termination of employment, the Member's reduction in work hours, death of the Member, the Member's entitlement to Medicare, the employer must notify the plan administrator within 30 days of the date of the qualifying event. The plan administrator must notify the qualified person of the right to this group vision continuation within 14 days after receiving notice of a qualifying event from the employer.

G. Qualified Person Notice and Election Requirement

A qualified person must notify the plan administrator in writing within 60 days after (a) the date of a qualifying event (i.e., Member's termination from his or her state registered domestic partnership or Domestic Partnership under the terms of the Group Policy); (b) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (c) the date the qualified person is first informed of this notice obligation; otherwise the right to this group vision continuation ends. This 60-day notice period applies to initial and second qualifying events.

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

Notification of a qualifying event to the plan administrator must be in writing and must include the following information: (a) name and identification number of the Member and the qualified person; (b) type and date of initial or second qualifying event; (c) if the notice is for an extension due to disability, a copy of

any letters from the Social Security Administration and the Notice of Determination; and (d) the name, address and daytime phone number of the qualified person (or legal representative) that the plan administrator may contact if additional information is needed to determine group vision continuation rights.

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

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

To protect group vision continuation rights, the plan administrator must be informed of any address changes for a covered state registered domestic partner or Domestic Partner. Retain copies of any notices sent to the plan administrator.

H. Monthly Cost

A qualified person electing continued coverage can be required to pay 102% of the cost for the applicable coverage.

I. Grace Period

A qualified person has 45 days after the initial election to remit the first payment. The first payment must include all payments due when sent. All other payments (except for the first payment) will be timely if made within the Grace Period. "Grace Period" means the first 60-day period following a premium due date. Except for the first payment, a Grace Period of 60 days will be allowed for payment of premium. However, benefits for Treatment or Service received while in the Grace Period will be payable only if the past due premium is received before the Grace Period expires, subject to all other terms and conditions of the Group Policy. If payment of past due premium is not made prior to the expiration of the Grace Period, it is in default and the coverage terminates effective as of the premium due date.

J. Policy Changes

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

K. Contact Information

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

Group Vision Plan:	MOTIVE POWER INC Vision Plan
Contact Name/Area:	MOTIVE POWER INC Benefits Department
Address:	353 SACRAMENTO ST FLOOR 8 SAN FRANCISCO CA 94111
Phone Number:	707-477-3466

If coverage under this Group Policy is continued under a state continuation mandate, the continuation coverage provided under this subsection will run concurrently with the state continuation period.

NOTICE OF OCCURRENCE OF A Cal-COBRA QUALIFYING EVENT

In order to continue vision care expense insurance under the Group Policy, Principal Life Insurance Company must be notified of the occurrence of a Qualifying Event. For this purpose, Qualified Persons must complete this form and mail by first class mail (or other reliable means) to the address below within 60 days after the date of the Qualifying Event. Failure to provide notice of a Qualifying Event within the 60-day period will disqualify the Qualified Person from continuation. Within 14 days following receipt of a notice of a Qualifying Event, Principal Life will send the Qualified Person a Notification and Election form.

Name of Member	Member phone number		
Member address (street)	City	State	Zip code

Qualifying Event (reason coverage will terminate): _____

_____

_____

Date of Qualifying Event: _____

List all Qualified Persons (persons who will lose coverage and request continuation):

_____

_____

_____

Address that the Notification and Election form should be mailed to (if different than above).

_____

_____

Qualified Person signature	Date
Name of Group Policyholder	Account number

Mail completed form to:
Principal Life Insurance Company
P. O. Box 4933
Grand Island, NE 68802-4933

REINSTATEMENT

Terminated insurance will be reinstated if:

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

Reinstated insurance will be in force on the date the Member returns to Active Work. However, the Actively at Work provisions defined on GH 9012 will apply.

Only the period of time during which the Member is actually insured will be included in determining the length of continuous coverage under this Certificate of Coverage. For this purpose, the period of time during which a reinstated Member's 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).

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.

Federal Required Family and Medical Leave Act (FMLA)

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

DESCRIPTION OF BENEFITS

VISION CARE EXPENSE INSURANCE
(PAYMENT PROVISIONS)

Benefit Qualification

To qualify for payment of the benefits provided, for an insured class, the Member and the Member's Dependents must:

- be insured in that class on the date vision treatment or service is received; and
- satisfy the requirements listed in the CLAIM PROCEDURES Section.

Benefits Payable

Benefits payable will be as described in this section, subject to all listed Limitations and Exclusions.

Payment Conditions

If the Member or Dependent receives vision treatment or service, Scheduled Benefits then in force will be payable. Scheduled Benefits are based on the Member's class and the status of the Member's Dependents:

Class	**Scheduled Benefits**
All Members and Dependents	As shown below

If the Member or Dependent undergoes a Visual Examination or purchases any of the listed vision aids, Principal Life will pay the provider's charges:

- in excess of the Copayment Amount; and
- to the Maximum Payment Limits

as described below.

Preferred Provider or Participating Retail Chain Provider Benefits

Obtaining Benefits from Preferred Providers

When a Member or Dependent wants to receive benefits from a Preferred Provider they should contact the provider before receiving services and inform them that they are covered by the Preferred Provider Organization. The provider will contact the Preferred Provider Organization to obtain authorization. If the Member received services from a Preferred Provider without authorization, any services or materials received from the provider may be treated as benefits from a Non-Preferred Provider.

Copayment

A Copayment amount of $10 for the examination will be payable by the Member or Dependent at the time of treatment or service. There will be a Copayment of $25 for frames, lenses, and Necessary Contact Lenses.

The Copayment does not apply to elective contact lenses.

Vision Examination

Covered in full (after the Copayment) one per 12 month period.

Lenses (Glass or Plastic)

(Single, Lined Bifocal, Lined Trifocal, or Lenticular)

Covered in full (after the Copayment) (one pair per 12 month period)

Polycarbonate Lenses are covered in full for Dependent children up to age 18.

Frames

Covered up to $130* (after the Copayment) (one set per 24 month period).

*$70 at selected Participating Retail Chain Providers

SOME PARTICIPATING RETAIL CHAIN PROVIDERS MAY BE UNABLE TO PROVIDE ALL COVERED SERVICES AND COVERED PERSONS SHOULD DISCUSS REQUESTED SERVICES WITH THEIR PROVIDER OR CONTACT VSP CUSTOMER CARE FOR DETAILS.

Contact Lenses

Elective contact lens fitting and evaluation services are covered in full (once per 12 month period), after a $60 Copayment. Elective contact lenses (materials only) are covered up to $130 (per 12 month period).

Necessary Contact Lenses are covered in full (after the Copayment) (one pair per 12 month period).

Contact lenses are provided in lieu of the lens and frame benefits.

Low Vision

Professional services for visual problems that cannot be corrected by regular lenses.

Supplemental Testing (Evaluation, diagnosis and prescription of vision aids)

Covered in full (after Copayment)

Supplemental aids

Covered at 75% of Preferred Provider's fee, up to $875 (after the Copayment).

Maximum benefit for all Low Vision services and materials is $1,000 every 24 month period.

Non-Preferred Provider Benefits

Treatment or services received from Non-Preferred Providers is in lieu of treatment or service received from a Preferred Provider.

Maximum Payment Limit

The reimbursement is the lesser of the maximum payment limit or billed amount minus the applicable Preferred Provider copay.

Vision Examinations (one per 12 month period)	$	45.00
Frames (one set per 24 month period)	$	70.00
Single Vision Lenses (one pair per 12 month period)	$	30.00
Lined Bifocal Lenses (one pair per 12 month period)	$	50.00
Lined Trifocal Lenses (one pair per 12 month period)	$	65.00
Lenticular Lenses (one pair per 12 month period)	$	100.00

Elective Contact Lenses (in lieu of lens and frame benefit)	$	105.00
Necessary Contact Lenses (in lieu of lens and frame benefit)	$	210.00

Low Vision

Professional services for severe visual problems that cannot be corrected with regular lenses.

Supplemental Testing (Evaluation, diagnosis and prescription of vision aids)

Covered up to $125

Supplemental aids: 75% of Non-Preferred Provider's fee, up to $875 (after the Copayment).

Maximum benefit for all Low Vision services and materials is $1,000 every 24 month period.

DESCRIPTION OF BENEFITS

VISION CARE EXPENSE LIMITATIONS AND EXCLUSIONS

Limitations

No benefits will be paid for:

- Services and\or materials not specifically included in the benefit schedule on GH 9018; or
- Plano lenses (lenses with refractive correction of less than + .50 diopter); or
- Two pair of glasses instead of bifocals; or
- Replacement of lenses, frames, and\or contact lenses furnished under this plan which are lost or damaged, except at the normal intervals when Group Policy benefits are otherwise available; or
- Orthoptics or vision training and any associated supplement testing; or
- Medical or surgical treatment of the eyes; or
- Contact lens insurance policies or service agreements; or
- Refitting of contact lenses after the initial (90 day) fitting period; or
- Contact lens modification, polishing, or cleaning; or
- Local, state and/or federal taxes, except where Principal Life is required by law to pay.

Exclusions

Benefits will not be paid for any Vision Care Expense for:

- Which proof is submitted by a person who is part of the Member's or Dependent's Immediate Family; or
- a Visual Examination or vision aids provided outside the United States, unless the Member or Dependent is outside the United States for one of the following reasons:
    - travel, provided the travel is for a reason other than securing vision care diagnosis or treatment; or
    - a business assignment, provided the Member or Dependent is temporarily outside the United States; or
    - full-time student status, provided the student is either:
        - enrolled and attending an accredited school in a foreign country; or
        - is participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit.

REPLACEMENT OF A PRIOR POLICY

Applicability

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

- are eligible and enrolled under the Group Policy on its Date of Issue; and
- were covered under the Prior Policy on the date of its termination.

This section will also apply to any child, covered under the Prior Policy, who is not otherwise eligible under this Group Policy because the child does not receive principal support from the Member.

Benefits Payable

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

- benefits would have been paid under the Prior Policy had it remained in force; and
- benefits are not paid under the Prior Policy due to its termination.

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

- the benefits of the Group Policy; or
- the benefits that would have been paid by the Prior Policy had it remained in force.

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

In no event will benefits be paid for any treatment or service:

- received before the Date of Issue of this Group Policy; or
- for which benefits are paid under the Prior Policy; or
- for which benefits would have been paid under the Prior Policy (including that policy's extended benefit provision) in the absence of this section.

COORDINATION WITH OTHER BENEFITS

Applicability

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

Definitions

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

- **Plan**

  *Any vision care expense benefits provided under:

  - any insured or noninsured group, service, prepayment, or other program arranged through an employer, trustee, union, or association; and
  - any program required or established by state or Federal law (including Medicare Parts A and B); and
  - any program sponsored by or arranged through a school or other educational agency.

  The term Plan will not include benefits provided under:

  - a student accident policy; or
  - a state medical assistance program where eligibility is based on financial need; or
  - individual or family policies; or
  - individual or family subscriber contracts; or
  - entitlements to Medi-Cal benefits; or
  - benefits provided under the California Crippled Children Services program; or
  - the medical payment benefits customarily included in the traditional automobile contracts; or
  - any other coverage provided for or required by law when its benefits are excess to any private insurance or other non-governmental program.

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

  *In the event a husband and wife or a Member and his or her state registered domestic partner are both employed by the Policyholder, each Plan will be considered a separate Plan with respect to these coordination of benefits provisions. The amount payable will not be more than 100% of the actual cost charged for treatment or service.

- **Allowable Expense**

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

- **Claim Determination Period**

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

Effect on Benefits

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

- benefits are payable under any other Plan for the same Allowable Expenses; and
- the rules listed below provide that benefits payable under the other Plan are to be determined before the benefits payable under the Group Policy.

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

For this purpose benefits payable under other Plans will include the benefits that would have been paid had claim been made for them. Also, for any person covered by Medicare Part A, benefits payable will include benefits provided by Medicare Part B whether or not the person is covered under that Part B.

Order of Benefit Determination

Except as described below, the benefits payable of a Plan that does not have a coordination of benefits provision substantially similar to the provision described in this section will be determined before the benefits payable of a Plan that does have such a provision. In all other instances, the order of determination will be:

- Non-Dependent/Dependent. The benefits of a Plan which covers the person for whom benefits are claimed as an employee, Member, or subscriber (that is, other than as a Dependent) are determined before the benefits of a Plan which covers the person as a Dependent. Exception: If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
  - secondary to the Plan covering the person as a Dependent; and
  - primary to the Plan covering the person as other than a Dependent (e.g., a retired employee);

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

  However, if another Plan does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits
- Dependent Child--Separated or Divorced Parents. If two or more Plans cover a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - first, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse or state registered domestic partner of the parent with custody of the child; and

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

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

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

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

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

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

  - second, the benefits under the continuation coverage.

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

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

Medicare Exception

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

Exchange of Information

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

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

Facility of Payment

The Claims Administrator may reimburse any other Plan if:

- benefits were paid by that other Plan; but

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

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

Right of Recovery

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

- the person to or for whom the benefits were paid; or
- the other companies or organizations liable for the benefit payments.

Subrogation will not be allowed in any plan as distinguished from the rights to recovery.

CLAIM PROCEDURES

Notice of Claim

The Claims Administrator will acknowledge verbal or written notice of claim within 15 calendar days of receipt unless payment is made within that time period.

Claim Forms

The Claims Administrator, when it receives notice of claim, will provide claim forms, instructions, and reasonable assistance within 15 calendar days of receipt of such notice.

Proof of Loss

Written proof of loss should be sent to the Claims Administrator within 365 calendar days after the date of loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when the Claims Administrator receives proof of loss. Proof of loss includes the patient's name, the Member's name (if different from the patient's name), Member's ID number, provider of services, dates of service, itemized description of Treatment or Service provided and extent of the loss. The Claims Administrator may request additional information to substantiate loss. Failure to comply with such request could result in declination of the claim. For purposes of satisfying the claims processing timing requirements of the Employee Retirement Income Security Act (ERISA), receipt of claim will be considered to be met when the appropriate claim form is received by the Claims Administrator.

Payment, Denial, and Review

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

The Claims Administrator shall pay or deny claims for benefits provided to a Member or Dependent less any applicable Copayment within a reasonable time but not more than 30 calendar days after the Claims Administrator receives the completed claim.

If a claim is denied in whole or in part, under the terms of the Group Policy, a request may be submitted to the Claims Administrator by claimant for full review of the denial. The claimant may designate any person, including their provider, as their authorized representative.

A Claimant may request an appeal of a claim denial by written request to the Claims Administrator within 180 calendar days of receipt of notice of the denial. The Claims Administrator will make a full and fair review of the claim. The Claims Administrator may require additional information to make the review. The Claims Administrator will notify the Claimant in writing of the appeal decision within 30 calendar days of receiving the appeal request. The first level of appeal review must be completed before filing a civil action or pursuing any other legal remedies.

After exhaustion of the formal appeal process, a Claimant may request a secondary appeal. The appeal must be requested in writing. The Claimant may submit written comments, documents, records, and other information relating to the claim for benefits within 60 calendar days after receipt of the Claims Administrator's response to the initial appeal. The Claims Administrator will communicate its final determination within 45 calendar days of request for a secondary appeal. However, if the appeal cannot be processed due to incomplete information, the Claims Administrator will send a written explanation of the additional information that is required or an authorization for the Claimant's Signature so information can be obtained from the provider. This information must be sent to the Claims Administrator within 45 calendar days of the date of the written request for the

information or as required by state law. Failure to comply with the request for additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 30 calendar days of the receipt of all necessary information to properly review the appeal request or as required by state law.

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

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

State law permits up to 30 days after receipt of proof of claim to determine if the claim will be paid or denied. If a determination cannot be made within 30 days, the Claims Administrator will send a written explanation describing the information necessary to establish receipt of claim prior to the end of the original 30 days and every 30 days thereafter, (Exception: If there is a reasonable basis for the Claims Administrator to believe a claim is false or fraudulent, the limit is extended to 80 days.

If it is determined that the claim will be paid, payment must be made within 30 days of (a) determination of coverage, or (b) execution of a settlement agreement.

If the claim is denied, in whole or in part, the Claims Administrator will notify the claimant in writing of the basis for the denial. This denial notice will include an explanation of the policy provisions, condition, or exclusion relevant to the facts of the claim. The notice will also provide the address and telephone number of the unit of the California Department of Insurance the claimant should contact for review if he or she believes the claim has been wrongfully denied.

Complaints and Grievances

Complaints and grievances may be submitted by the Member or Dependent to the Claims Administrator in writing, by telephone, online or through the Member's or Dependent's Preferred Provider. The Claims Administrator will resolve all complaints and grievances within thirty (30) calendar days following receipt unless special circumstances require an extension of time. Where such extension is required, the Claims Administrator will resolve all complaints and grievances as soon as possible, but not later than one hundred twenty (120) calendar days after receipt. If the Claims Administrator determines that a complaint or grievance cannot be resolved within thirty (30) calendar days, it will notify the Member or Dependent of the expected resolution date. The Claims Administrator will notify the Member or Dependent in writing of the final resolution of all complaints and grievances.

The Member or Dependent shall report any complaints and/or grievances either in writing mailed to the Claims Administrator at Vision Services Plan Insurance Company, Complaint and Appeals Team, 3333 Quality Drive, Rancho Cordova, CA 95670-7985, verbally by calling VSP's Customer Care toll-free number (1-800-877-7195), on-line by completing a Member grievance form on www.vsp.com, or through the Preferred Provider.

Facility of Payment

Benefits under this Group Policy will be payable immediately after the Claims Administrator receives complete and proper proof of loss.

The Claims Administrator will normally pay all Non-PPO benefits directly to the Member. Also, in the special instances listed below, payment will be as indicated with proper legal documentation. 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 state registered domestic partner or Domestic Partner, child, parent, or estate.

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

- Benefits payable to a Preferred Provider will be paid directly to the Preferred Provider on behalf of the Member or Dependent.

Legal Action

Legal action to recover benefits under the Group Policy may not be started earlier than 90 calendar days after proof of loss is filed and before the appeal procedures have been exhausted. Further, no legal action may be started later than three years after that proof is required to be filed.

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:

For Vision claim-related inquiries:

Vision Service Plan Insurance Company (VSP)
3333 Quality Drive
Rancho Cordova, California 95670
Phone: 1-800-877-7195

For administration-related inquiries:

Principal Life Insurance Company
Attn: Group Call Center
711 High Street
Des Moines, Iowa 50392-0002
Phone: 1-800-843-1371

Consumers should contact the above entities, 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
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.

BOOKLET-CERTIFICATE NOTICE
TIMELY ACCESS TO CARE

The state of California wants you to know you have the right to expect the following from your Preferred Provider:

- Urgent appointments must be offered within 72 hours of the time of request for an appointment, when consistent with your needs and as required by professionally recognized standards of practice;
- Non-urgent appointments must be offered within 36 business days of the request for an appointment; and
- Preventive appointments must be offered within 40 business days of the request for an appointment.

The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, has determined and noted in the record that a longer waiting time will not have a detrimental impact on your health.

When it is necessary for you or your Preferred Provider to reschedule an appointment, the appointment must be promptly rescheduled in a manner that is appropriate for your health care needs, and ensures continuity of care consistent with good professional practice.

At the time of your appointment, you can get an interpreter. For help, call us at the number listed on your ID card or 1-800-247-4695. For more help, persons may contact:

California Insurance Department
Health Claims Bureau
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 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, 2019.

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: Compliance Privacy Consultant, Specialty Benefits Division (SBD) Compliance, Principal Life Insurance Company, 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: Compliance Privacy Consultant, Specialty Benefits Division (SBD) Compliance, 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 Grievance Coordinator, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002 or to the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

If you have any questions or need any assistance regarding this Notice or your privacy rights, you may contact the Group Call Center at Principal Life Insurance Company at (800) 843-1371.

STATEMENT OF RIGHTS

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

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

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries,

Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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Principal Life Insurance Company
Des Moines, Iowa 50392-0002