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06/01/2024

GROUP BOOKLET-CERTIFICATE FOR MEMBERS OF:

KESSLER TOPAZ MELTZER & CHECK, LLP

ALL MEMBERS
GROUP HOSPITAL INDEMNITY INSURANCE

Print Date: 10/18/2024

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

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

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

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

Certificate of Coverage

Important Notice: This is Hospital Indemnity insurance. It provides a limited specified benefit. THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. Please read this Certificate of Coverage carefully to fully understand what it covers, limits, and excludes. Principal Life suggests starting with a review of the terms listed in the DEFINITIONS section. Knowing the meaning of these terms will help with understanding the insurance.

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

This insurance has been designed to provide a benefit payment for a Covered Sickness or Injury. The benefits are provided by a Group Policy issued by Principal Life. To the extent that benefits are provided by that Group Policy, the administration and payment of claims will be done by Principal Life as an insurer.

The provisions of the Group Policy determine Members' rights and benefits. This Certificate of Coverage briefly describes those rights and benefits. It outlines what the Employee 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.

If you have an electronic booklet this booklet can be found at www.principal.com. Paper copies of this booklet-certificate are also available without cost. Please contact your employer if you would like to request a paper copy.

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

Principal Life reserves complete discretion to construe or interpret the provisions of the Group Policy, to determine eligibility for benefits, and to determine the type and extent of benefits, if any, to be provided. Principal Life's decisions in such matters will be controlling, binding, and final, in accordance with the Unfair Insurance Practices Act as between Principal Life and Covered Persons, subject to the Claim Procedures.

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

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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.

Accident

An act, event or occurrence that is not reasonably foreseeable, or that could not have been expected or anticipated sustained by the Covered Person which are the direct and independent cause of the loss and occur while the insurance is in force. An Accident is caused by an identifiable event that has a definitive time and place.

Active Work; Actively at Work

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

Complications of Pregnancy

A condition whose Diagnosis is adversely affected or caused by pregnancy, such as

- acute nephritis or nephrosis;
- cardiac decompensation;
- missed abortion;
- Physician prescribed bed rest for intra-uterine growth retardation, funneling, incompetent cervix, and multiple births, or bed rest for a condition considered to be a Complication of Pregnancy;
- termination of ectopic pregnancy;
- an extra-uterine pregnancy;
- a complication that requires intra-abdominal surgery after termination of pregnancy;
- a miscarriage;
- placenta previa and placenta abruption;
- premature rupture of membranes;
- pernicious vomiting of pregnancy (hyperemesis gravidarum);
- toxemia (eclampsia or pre-eclampsia);
- puerperal infection; or
- similar medical and surgical conditions of comparable severity.

However, Complications of Pregnancy will not include:

- cesarean section;
- false labor, occasional spotting, or morning sickness;
- Physician prescribed rest during the period of pregnancy, not related to condition considered a Complication of Pregnancy; or

Conditions of comparable severity associated with the management of a difficult pregnancy.

Confined/Confinement

The admission to, and assignment to a bed as a resident inpatient in, any of the following medical facilities for a period of at least 18 consecutive hours for which a charge for room and board is made, on the advice of a Physician:

- Hospital.

Covered Injury

An Injury which:

- occurs on or after the Covered Person's coverage effective date;
- occurs while the Covered Person is insured under the Policy; and
- is not excluded or limited by name, specific description, or any other provision of the Policy.

Covered Person

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

Covered Sickness

A Sickness that is not caused by or the result of an Accident or Injury, which

- occurs on or after the Covered Person's coverage effective date;
- occurs while the Covered Person is insured under the Policy; and
- is not excluded or limited by name, specific description, or any other provision of the Policy.

Date of Issue

The date the Group Policy is placed in force: June 1, 2024.

Dependent

- An Employee's spouse, if that spouse:

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

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

Dependent Child(ren)

- An Employee's natural, legally adopted child or stepchild, if that child:

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

  An adopted child will be considered a Dependent Child from the date of placement with the Employee for the purposes of adoption. Coverage will be continuous unless the placement is disrupted prior to legal adoption and the child is removed from placement.

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

  - meets the requirements above; and
  - is approved in writing by Principal Life as a Dependent Child.

- The child of an Employee's insured dependent son or daughter, if:

  - the child meets the requirements above; and
  - the Employee's son or daughter remains an eligible Dependent Child as defined above.

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, as determined by Principal Life, which:

- results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder; and
- is Diagnosed by a Physician as a permanent or long-term continuing condition.

Diagnosed or Diagnosis

A definitive identification of an Injury or Sickness made by a Physician (where applicable) specializing in a particular area of medicine and supported by documentation of all appropriate and defined studies:

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

Emergency Room

A specified area within a Hospital that is designated for emergency care. This area must:

- be staffed and equipped to handle trauma;
- be supervised and provide Treatment by Physicians; and
- provide care 24 hours per day, 7 days per week.

Emergency Room does not include an Urgent Care Facility.

Employee

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

Grace Period

The first 31 day period following a premium due date.

Group Policy

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

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

Home Confined

Due to Sickness or Injury, the Covered Person is unable to carry on the regular and usual activities of a healthy person of the same age and sex and unable to leave his or her home except to receive medical Treatment.

Hospice Facility

A healthcare facility or distinct unit within a Hospital or other institution which is licensed, certified or otherwise authorized by applicable laws to provide Hospice Care under the supervision of a Physician 24 hours per day, 7 days per week.

Hospital

An institution that is licensed as a Hospital by the proper authority of the state in which it is located.

A Hospital does not include any institution, or part thereof, that is used primarily as a:

- Assisted living facility;
- Convalescent home;
- Custodial care facility;
- Extended care facility;
- Hospice Facility;
- Mental Disorder Treatment Facility;
- Nursing home;
- Rehabilitation Facility;
- Rest home or home for the aged;
- Skilled Nursing Facility; or
- Substance Abuse Treatment Facility.

Immediate Family

A Covered Person, a Covered Person's spouse, natural or adoptive parent, natural or adoptive child, sibling, stepparent, stepchild, stepbrother or stepsister.

Incur or Incurred

A Covered Accident is deemed to be Incurred on the date the Injury was sustained.

A Covered Sickness is deemed to be Incurred on the date it is Diagnosed.

Injury or Injured

Accidental bodily injuries sustained by the Covered Person which are the direct and independent cause of the loss and occur while the insurance is in force.

Insurance Month

Calendar month.

Intensive Care Unit

A specifically designated area of a Hospital that:

- provides the highest level of medical care;
- is restricted to patients who are critically ill or injured and who require intensive, comprehensive observation and care;
- is separate and apart from the surgical recovery room and from rooms, beds, wards and units customarily used for patient confinement;
- is permanently equipped with special lifesaving equipment and medical apparatus for the care of the critically ill or injured;
- is under continuous observation by a specially trained nursing staff assigned exclusively to the Intensive Care Unit on a 24 hour basis; and

- has a Physician assigned to the Intensive Care Unit on a full-time basis.

An Intensive Care Unit includes a Hospital unit with the following (or similar) name: burn unit; cardiac care unit; coronary care unit; critical care unit; intensive care nursery; neonatal intensive care unit; pulmonary care unit; and transplant unit.

An Intensive Care Unit does not include any type of facility not meeting the definition of Intensive Care Unit, including but not limited to: intermediate care unit; Observation Unit; private monitored room; progressive care unit; sub-acute intensive care unit; and any other lesser care treatment unit.

Member

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

Mental Disorder

A psychiatric or psychological condition listed as a mental or nervous disorder in the most recent edition of the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM), usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar methods.

Mental Disorder does not include conditions, diseases or disorders related to:

- alcohol or drug dependency; or
- Alzheimer's Disease and other organic senile dementias.

Mental Disorder Inpatient Treatment Facility

An appropriately licensed healthcare facility or other institution which is primarily engaged in providing a planned program of psychiatric care by or under the supervision of a Physician for the Diagnosis, evaluation, and Treatment of Mental Disorders.

A Mental Disorder Treatment Facility does not include a facility that is mainly a place for rest, care of the aged/elderly, care of persons with Substance Abuse disorders, transitional living, or similar establishment.

Observation Unit

A specified area or room within a Hospital, separate from the Emergency Room, where a patient can be monitored on a short term basis by a Physician and which:

- is under the direct supervision of a Physician or registered nurse;
- is staffed by nurses assigned specifically to that unit; and
- provides care 24 hours per day, 7 days per week.

A short term basis is defined as less than 18 hours in the unit.

Period of Limited Activity

Any period of time during which a Dependent is:

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

Physical or Mental Disability

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

- results from Injury, Accident, congenital defect or Sickness; and

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

Physician

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

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

Policy Anniversary

June 1, 2025 and the same day of each following year.

Policyholder

KESSLER TOPAZ MELTZER & CHECK, LLP

Premium Period

A monthly basis on which the premium is due.

Rehabilitation Facility

An appropriately licensed facility or unit that is designated, staffed and equipped to provide restorative services on an inpatient basis by or under the direct supervision of a trained and experienced rehabilitation Physician. Services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by a Covered Sickness or Injury to achieve the highest possible functional ability.

Sick or Sickness

A disease, illness, pregnancy or other condition, which is not an Injury and not caused by an Accident, including infection except when due to an accidental cut or wound. Sickness includes:

- complications of pregnancy;
- routine nursery care or well-baby care for a newborn child.

Sickness does not include:

- Mental Disorder;
- Substance Abuse;
- routine pregnancy;
- routine childbirth.

Skilled Nursing Facility

An appropriately licensed inpatient healthcare facility or other institution that:

- provides skilled nursing care and related services 24 hours per day, 7 days per week to individuals who are not able to care for themselves; and
- is under the direct supervision of a duly licensed Physician.

A Skilled Nursing Facility does not include any institution, or part thereof, that is used primarily as a:

- assisted living facility;
- convalescent home;

- custodial care facility;
- extended care facility;
- Hospice Facility;
- Mental Disorder Treatment Facility;
- nursing home;
- Rehabilitation Facility;
- rest home or home for the aged; or
- Substance Abuse Treatment Facility.

Substance Abuse

The harmful or hazardous use of and dependence on psychoactive substances, including alcohol and illicit drugs. The consumption of Prescription Drugs in a manner or dose other than prescribed, including when originally prescribed to another person, is also considered Substance Abuse.

Substance Abuse Inpatient Treatment Facility

An appropriately accredited and licensed healthcare facility or other institution which is primarily engaged in providing a planned Treatment program by or under the supervision of a Physician for persons with chemical dependencies resulting from Substance Abuse.

A Substance Abuse Treatment Facility does not include a facility that is mainly a place for rest, care of the aged/elderly, care of persons with Mental Disorders, transitional living, or similar establishment.

Treatment or Service

The consultation, care, or services provided by a Physician, including diagnostic tests and the prescription or use of prescribed drugs and medicines.

Urgent Care Facility

A licensed, freestanding healthcare facility, other than a Hospital, whose primary purpose is to provide urgent or immediate, short-term medical care and Treatment, without an appointment. The facility must be supervised by a Physician and provide Treatment by Physicians.

Year

The period of time from January 1 through December 31.

HOW TO BE INSURED - EMPLOYEES

Eligibility

Only Employees are eligible for insurance.

ALL MEMBERS

Anyone meeting the definition of Employee will be eligible on the first of the Insurance Month next following the date the Employee begins Active Work.

Effective Date - Actively at Work

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

Individual Incontestability

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

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

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

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

Effective Date for Initial Insurance

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

Insurance will normally be effective on:

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

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

Scheduled Benefit Changes

A Member's benefits may be changed due to:

- change in insurance class; or

- changes by policy amendment; or

- change in the Member's family status:

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

- marriage or divorce;

- death of a spouse or child;

- birth or adoption of a child;

- termination of employment by the Member's spouse or a change in the spouse's employment that causes loss of coverage.

Effective Date for Scheduled Benefit Changes

A change in the Scheduled Benefit will normally be effective on the first of the Insurance Month coinciding with or next following the date the Member is eligible.

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

A change requested by the Member will normally be effective on the first of the Insurance Month coinciding with or next following the date of the request.

Effective Date for Changes - Actively at Work

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

Annual Enrollment Period

Eligibility

An annual enrollment period will be available for any Employee every year who:

- failed to enroll

    - during the first period in which the Employee was eligible to enroll; or
    - during any previous annual enrollment period.

- previously terminated insurance under this Group Policy and wants to re-enroll.

To qualify for enrollment during the annual enrollment period, the Employee and Dependents must meet the eligibility requirements described in the Group Policy.

Enrollment Period

The annual enrollment period is the calendar month period immediately prior to the Policy Anniversary date or another period of time requested by the Policyholder and accepted by Principal Life.

Effective Date

The effective date for any such individual requesting insurance during the annual enrollment period will be the first of the Insurance Month coinciding with or next following the date of completion of the annual enrollment period.

Termination

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

- the date the Group Policy terminates; or
- the last day of the Grace Period, if the premium due is not paid by the last day of the Grace Period; or
- any date desired, if requested by the Member before that date; or
- the date the Member ceases to be an Employee; or
- the date the Member ceases to belong to a class for which insurance is provided; or
- the date the Member retires; or
- the date the Member ceases Active Work.

Termination for Fraud

Principal Life may at any time terminate a Covered Person's insurance under the Group Policy in writing and with 31-day notice:

- if the Covered Person submits any claim that contains false or fraudulent elements under state or federal law; or
- upon finding in a civil or criminal case that a Covered Person has submitted claims that contain false or fraudulent elements under state or federal law; or
- when a Covered Person has submitted a claim, which, in good faith judgment and investigation, they knew or should have known, contains false or fraudulent elements under state or federal law.

Insurance While Outside of the United States

If a Covered Person is temporarily outside the United States, the Covered Person may choose to continue insurance, subject to premium payment for a period of six months or less for one of the following reasons:

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

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

HOW TO BE INSURED - DEPENDENTS

Eligibility

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

- the date the Employee is eligible for Member Hospital Indemnity Insurance; or
- the date the Member first acquires a Dependent.

Effective Date

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

- In no event will Dependent Hospital Indemnity Insurance be in force if the Employee is not insured for Member Hospital Indemnity Insurance.
- If a Dependent is in a Period of Limited Activity on the date initial Dependent Hospital Indemnity Insurance or an increase in Dependent Hospital Indemnity Insurance Scheduled Benefit would otherwise be effective, the Dependent will not be insured or an increase will not be effective until the Period of Limited Activity ends.
- If Dependent Hospital Indemnity Insurance is then in force for any other Dependent Child, a new Dependent Child (other than a newborn child or newly adopted child) will be insured on the date acquired, provided the new Dependent Child is not in a Period of Limited Activity. Requests for insurance are not required provided Principal Life has been notified of the new Dependent Child within 31 days after the date the Dependent Child is acquired.
- A newly born child will be insured from the moment of live birth and a newly adopted child will be insured on the date of placement for the purposes of adoption, provided the child meets the definition of a Dependent Child. If payment of a specific premium is required to provide coverage for a Dependent Child, the Member must notify Principal Life of the birth within 31 days after the date it occurs in order to have the child's coverage continue beyond the 31-day period. If such notice is not given to Principal Life within the 31-day period, the child's insurance will terminate. If the child's insurance terminates because the Member fails to request coverage for the child (or make the required premium payment) within the 31-day period following the child's date of birth or adoption, benefits will be payable only for covered Treatment or Service by the child during the 31-day period in which insurance was in force.

Individual Incontestability

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

Termination

Insurance for Dependents will terminate on the earliest of:

- the date Member Hospital Indemnity Insurance ceases; or
- the date Dependent Hospital Indemnity Insurance is removed from the Group Policy; or
- the last day of the Grace Period, if the premium due is not paid by the last day of the Grace Period; or
- any date desired, if requested by the Member before that date.

Insurance for any one Dependent will terminate on the date he or she ceases to be a Dependent.

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

Termination for Fraud

Dependents will be subject to the Termination for Fraud provisions as described earlier for Member insurance.

Insurance While Outside of the United States

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

CONTINUATION OF COVERAGE

FMLA, State Family and Medical Leave and Other Continuation Provisions

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

If the continuation portion of the State Family and Medical Leave or FMLA applies to the Member's insurance, these FMLA continuation provisions:

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

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

Sickness or Injury

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

- the date insurance would cease as described in Termination, except for Active Work; or
- the date the Member recovers; or
- coverage has been continued under this section for 90 consecutive days.

Layoff or Approved Leave of Absence

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

- the date insurance would cease as described in Termination, except for Active Work; or
- the date the layoff or approved leave of absence ends; or
- the date the Member becomes eligible for any other hospital indemnity coverage; or
- the date one month after the date Active Work ends.

Dependent Child Insurance - Developmentally, Physically or Mentally Disabled Children

Qualification

Dependent Hospital Indemnity Insurance for a child may be continued after the child reaches the maximum age for Dependent Children provided that:

- the child is incapable of self-support as the result of a Developmental, Physical or Mental Disability and they became so before reaching the maximum age and is dependent on the Member for primary support; and
- except for age, the child continues to be a Dependent Child; and
- proof of the child's incapacity is sent to Principal Life within 31 days after the date the child reaches the maximum age.

Period of Continuation

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

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

REINSTATEMENT

Terminated insurance will be reinstated if:

- insurance ceased because of layoff or approved leave of absence; and
- the Member returned to Active Work for the Policyholder within 6 months of the date insurance ceased.

Reinstated insurance will be in force on the date of return to work. However, the Actively at Work and Period of Limited Activity provisions will apply.

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

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

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

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

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

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

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

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

- the Employee or Dependent returns to the United States within 6 months of the date on which insurance terminated because they were outside of the United States; and
- for the Employee, the Employee returns to Active Work in the United States for the Policyholder for a period of at least 30 consecutive days. The Employee will be eligible for insurance on the day immediately following completion of the 30 consecutive days of Active Work; and
- for the Dependent, they remain in the United States for 30 consecutive days. If the Dependent does so, they will be eligible for reinstatement of insurance on the day after completion of the 30 consecutive days of residence.

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

DESCRIPTION OF BENEFITS
BENEFIT PROVISIONS

HOSPITAL INDEMNITY INSURANCE

Benefit Qualification

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

- the Covered Person must Incur a Covered Sickness or Covered Injury while insured for Hospital Indemnity Insurance under this Group Policy; and
- the Covered Injury must be through accidental means; and
- the Covered Person must meet the terms and conditions for an applicable benefit listed below; and
- the Covered Injury must be the direct and sole cause of the Injury; and
- Limitations and Exclusions must not apply; and
- Claim Procedures must be satisfied.

Schedule of Insurance

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

The specific Scheduled Benefit for each Covered Person is shown on the Scheduled Benefits Summary below.

Class	Scheduled Benefit
ALL MEMBERS	The Scheduled Benefit amount will be subject to the provisions below.
Dependent Spouse	The spouse's Scheduled Benefit will be 100% of the Member Scheduled Benefit.
Dependent Children	Dependent Children Scheduled Benefit will be 100% of the Member Scheduled Benefit.

Class ALL MEMBERS

Schedule of Benefits

Benefit	Benefit amount
Hospital Confinement Benefits	
First day Hospital Confinement - Sickness	$1000
First day Hospital Confinement - Injury	$1000
First day Hospital Intensive Care Unit Confinement - Sickness	$2000
First day Hospital Intensive Care Unit Confinement - Injury	$2000
Daily Hospital Confinement - Sickness	$100
Daily Hospital Confinement - Injury	$100
Daily Hospital Intensive Care Unit Confinement - Sickness	$200
Daily Hospital Intensive Care Unit Confinement - Injury	$200
Newborn Nursery Confinement	$100

Hospital Confinement Benefits

First day Hospital Confinement - We will pay the first day Hospital Confinement benefit for the first day a Covered Person is Confined to a Hospital due to a Covered Sickness or Covered Injury. The Confinement must begin within 90 days of the Covered Sickness or Covered Injury.

The first day Hospital Confinement benefit is payable only once per day per Covered Person, up to a maximum of 1 days per Covered Person per Year. If a Covered Person is eligible for multiple Confinement benefits for the same day or in the same Year, the highest applicable Confinement benefit will be payable.

The first day Hospital Confinement benefit is not payable for care received in an Emergency Room, Observation Unit, or Urgent Care Facility, for outpatient surgery, or for routine newborn post-natal care. This benefit is also not payable for Confinement in a Hospice Facility, Mental Disorder Inpatient Treatment Facility, Rehabilitation Facility, Skilled Nursing Facility, or Substance Abuse Inpatient Treatment Facility.

First day Intensive Care Unit Confinement - We will pay the first day Intensive Care Unit Confinement benefit for the first day a Covered Person is Confined to an Intensive Care Unit due to a Covered Sickness or Covered Injury. The Confinement must begin within 90 days of the Covered Sickness or Covered Injury.

The first day Intensive Care Unit Confinement benefit is payable only once per day per Covered Person, up to a maximum of 1 days per Covered Person per Year. If a Covered Person is eligible for multiple Confinement benefits for the same day or in the same Year, the highest applicable Confinement benefit will be payable.

The first day Intensive Care Unit Confinement benefit is not payable for care received in an Emergency Room, Observation Unit, or Urgent Care Facility, for outpatient surgery, or for routine newborn post-natal care. This benefit is also not payable for Confinement in a Hospice Facility, Mental Disorder Inpatient Treatment Facility, Rehabilitation Facility, Skilled Nursing Facility, or Substance Abuse Inpatient Treatment Facility.

Daily Hospital Confinement - We will pay the daily Hospital Confinement benefit for each day beginning on the second day a Covered Person is Confined to a Hospital due to a Covered Sickness or Covered Injury. The Confinement must begin within 90 days of the Covered Sickness or Covered Injury.

The daily Hospital Confinement benefit is payable only once per day per Covered Person, up to a maximum of 30 days per Covered Person per Year.

If a Covered Person is eligible for multiple Confinement benefits for the same day, only the highest applicable Confinement benefit is payable.

The daily Hospital Confinement benefit is not payable for care received in an Emergency Room, Observation Unit, or Urgent Care Facility, for outpatient surgery, or for routine newborn post-natal care. This benefit is also not payable for Confinement in a Hospice Facility, Mental Disorder Inpatient Treatment Facility, Rehabilitation Facility, Skilled Nursing Facility, or Substance Abuse Inpatient Treatment Facility.

Daily Hospital Intensive Care Unit Confinement - We will pay the daily Hospital Intensive Care Unit Confinement benefit for each day beginning on the second day a Covered Person is Confined to an Intensive Care Unit due to a Covered Sickness or Covered Injury. The Confinement must begin within 90 days of the Covered Sickness or Covered Injury.

The daily Hospital Intensive Care Unit Confinement benefit is payable only once per day per Covered Person, up to a maximum of 30 days per Covered Person per Year.

If a Covered Person is eligible for multiple Confinement benefits for the same day, only the highest applicable Confinement benefit is payable.

The daily Intensive Care Unit Confinement benefit is not payable for care received in an Emergency Room, Observation Unit, or Urgent Care Facility, for outpatient surgery, or for routine newborn post-natal care. This

benefit is also not payable for Confinement in a Hospice Facility, Mental Disorder Inpatient Treatment Facility, Rehabilitation Facility, Skilled Nursing Facility, or Substance Abuse Inpatient Treatment Facility.

Newborn Nursery Confinement - We will pay the newborn nursery Confinement benefit for each day after delivery a Covered Person's newborn child is Confined in a Hospital for routine nursing or well-baby care. The first day Hospital Confinement benefit and Daily Hospital Confinement benefit are not payable for a newborn child that receives only routine nursing or well-baby care.

The newborn nursery Confinement benefit is payable only once per day per Covered Person, up to a maximum of 1 day per Covered Person per Year.

If a Covered Person's newborn child is Confined in a Hospital for treatment of a physical illness, infirmity, disease or Injury (including congenital defects, birth abnormalities, and/or premature birth), we will pay the appropriate first day Hospital Confinement benefit or first day Intensive Care Unit Confinement benefit and daily Hospital Confinement benefit or daily Hospital Intensive Care Unit Confinement benefit instead of the newborn nursery Confinement benefit for each day after delivery a Covered Person's newborn child is Confined in a Hospital or Intensive Care Unit due to a Covered Sickness or Covered Injury.

DESCRIPTION OF BENEFITS

HEALTH SCREENING BENEFIT

This benefit is intended to pay for health screening tests or procedures a Covered Person receives on an outpatient basis and used to evaluate risk or promote prevention of a Sickness or Injury.

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

Health screening tests or procedures covered are limited to:

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

Limitations

Benefits will not be paid for a Sickness or Injury caused indirectly or directly by, contributed to, or resulting from:

- willful self-injury or self-destruction; or
- voluntary participation in an auto-erotic activity; or
- war or act of war; or
- voluntary participation in or attempt to commit a felony or participating in an illegal occupation; or
- duty as a member of a military organization; or
- Sickness or Injuries Diagnosed outside of the United States unless the Diagnosis can be confirmed by a Physician in the United States; or
- any Mental Disorder; or
- voluntary intoxication (as defined by the law of the jurisdiction in which the Sickness or Injury occurred) or while under the influence of any narcotic, drug or controlled substance, unless administered by or taken according to the instruction of a Physician or medical professional; or
- voluntary intoxication through use of poison, gas or fumes, whether by ingestion, injection, inhalation or absorption; or
- the operation by the Member of a motor vehicle or motor boat if, at the time of the Injury, the Member's alcohol concentration exceeds the legal limit allowed by the jurisdiction where the Injury occurs; or
- Substance Abuse; or
- operating, learning to operate, or serving as a crew member or flight for life personnel of any aircraft or hot air balloon except as a crew member in a Policyholder owned or leased aircraft on company business; or
- jumping, parachuting, or falling from any aircraft or hot air balloon, including those which are not motor-driven; parasailing, bungee jumping or other aeronautic activities; or
- riding in or driving any motor driven vehicle in a race, stunt show or speed test; or
- any Injury to a Covered Person's tooth that occurs from biting or chewing; or
- practicing for or participating in any semi-professional or professional competitive athletic activity, including officiating or coaching, for which any type of compensation or remuneration is received; or
- a cosmetic surgery or other elective procedures that are not medically necessary; or
- normal pregnancy or childbirth when it begins prior to the date coverage under this Group Policy has been in force for the Covered Person for 10 consecutive months, except that benefits will be paid if it results from Complications of Pregnancy.

Exclusions

No benefits will be paid for any Injury or Sickness:

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

DESCRIPTION OF BENEFITS

PORTABILITY

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

Hospital Indemnity Portability Insurance

Eligibility

If Member Hospital Indemnity Insurance under the Group Policy ends because the Member ceases to meet the definition of an Employee, they may be eligible to continue such insurance under the Group Hospital Indemnity Portability Insurance Policy.

In order to continue insurance under the Group Hospital Indemnity Portability Insurance Policy:

- the Member must have been insured under the Group Policy for 12 consecutive months; and
- for Member Hospital Indemnity Portability Insurance, the Member must be less than age 70; and
- for Dependent Hospital Indemnity Portability Insurance, the Dependent spouse must be less than age 70; and
- for any Dependent, Member Hospital Indemnity must be continued.

Insurance may not be continued for the Covered Person under the Group Hospital Indemnity Portability Insurance Policy if:

- insurance under the Group Policy ends because the Group Policy terminates and is replaced by another hospital indemnity insurance policy; or
- for Dependent Hospital Indemnity Portability Insurance, the Dependent ceases to be a Dependent; or
- the Member dies.

Ported Coverage

The insurance that is available for continuation will be the benefits as shown on the Scheduled Benefits Summary and on the Description of Benefits Benefit Provisions section that are in force on the date insurance terminates under the Group Policy.

The Health Screening Benefits are not portable.

Request for Insurance/Effective Date

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

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

CLAIM PROCEDURES

Notice of Claim

Written notice of claim must be given to Principal Life within 20 days after the date of Treatment or Service. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible. Notice given by or provided on behalf of the Covered Person to: Principal Life Insurance Company, 711 High Street, Des Moines, Iowa 50392, or to any authorized agent of Principal Life, with information sufficient to identify the insured, will be deemed notice to Principal Life.

Claim Forms

Claim forms and other information needed to prove the claim must be filed with Principal Life in order to obtain payment of benefits. The Policyholder will provide forms to assist the Member in filing claims. If the forms are not provided within 15 days after Principal Life receives such notice, the Member will be considered to have complied with the requirements of the Group Policy upon submitting, within the time specified below for filing proof of the claim, written proof covering the occurrence, character and extent of the Treatment or Service.

Proof of Treatment or Service

Completed claim forms and other information needed to prove Treatment or Service should be filed promptly. Written proof of Treatment or Service should be sent to Principal Life within 90 days after the date of the Treatment or Service. Proof required includes the date, nature, and extent of the Injury. Principal Life may request additional information to substantiate a Treatment or Service or require a signed unaltered authorization to obtain that information from the provider. Failure to comply with such request could result in declination of the claim. Receipt of claim will be considered to be met when the appropriate claim form is received by Principal Life.

Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time; provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the date proof is otherwise required.

Payment, Denial, and Review

Claims will normally be processed within 45 days from receipt of the claim. If a claim cannot be processed due to incomplete information, Principal Life will send a written explanation prior to the expiration of the 45 days. A claimant is then allowed up to 45 days to provide all additional information requested. Principal Life is permitted two 30-day extensions for processing an incomplete claim. Written notification will be sent to a claimant regarding the extension.

Benefits under the Group Policy will be payable immediately, provided Principal Life receives complete and proper proof of Treatment or Service. Further, if a claim is not payable or cannot be processed, Principal Life will submit a detailed explanation of the basis for the denial.

A claimant may request an appeal of a claim denial by written request to Principal Life within 180 days of the receipt of notice of the denial. Principal Life will make a full and fair review of the claim. Principal Life may require additional information to make the review. Principal Life will notify the claimant in writing of the appeal decision within 45 days after receipt of the appeal request. If the appeal cannot be processed within the 45-day period because Principal Life did not receive the requested additional information, Principal Life will send a written explanation prior to the expiration of the 45 days. The claimant is then allowed 45 days to provide all additional information requested. Principal Life is permitted a 45-day extension for the review. Written notification will be sent to the claimant regarding the extension.

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

Settlement of Proceeds

When Principal Life receives written proof of Treatment or Service, the Scheduled Benefit in force for the Covered Person, less any unpaid premium, will be paid in a single lump sum.

Facility of Payment

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

If payment amounts remain due upon the Member's death, those amounts may, at the option of Principal Life, be paid to the Member's spouse, child or parent.

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

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

Physical Examination and Autopsy

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

Principal Life may have the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

Legal Action

Legal action to recover benefits under the Group Policy may not be started earlier than 60 days after required proof of Treatment or Service has been filed. Further, no legal action may be started later than three years after that proof is required to be filed.

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

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

Time Limits

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

STATEMENT OF RIGHTS

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

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

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S.

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

SUPPLEMENT TO YOUR CERTIFICATE OF COVERAGE

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

1. **Employer Plan Identification Number:**

   EIN: 23-2977382

2. **Type of Administration:**

   Hospital Indemnity: Insurance Contract.

3. **Plan Administrator:**

   KESSLER TOPAZ MELTZER & CHECK, LLP
   280 KING OF PRUSSIA RD
   RADNOR PA 19087

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

4. **Plan Sponsor:**

   KESSLER TOPAZ MELTZER & CHECK, LLP
   280 KING OF PRUSSIA RD
   RADNOR PA 19087

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

   KESSLER TOPAZ MELTZER & CHECK, LLP
   280 KING OF PRUSSIA RD
   RADNOR PA 19087
   Telephone: (610)822-2201

   Legal process may also be served upon the plan administrator.

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

   All active full-time employees of KESSLER TOPAZ MELTZER & CHECK, LLP, and provided you are a Member as defined in the DEFINITIONS Section of this booklet (page GH 2212).

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

   Employee pays all of employee's contribution.
   Employee pays all of Dependent's contributions.

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

   May 31

Notice of Privacy Practices for Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes the practices of Principal Life Insurance Company for safeguarding individually identifiable health information. The terms of this Notice apply to members, their spouses and dependents for their group dental expense, group vision care expense, group hospital indemnity, and/or group critical illness insurance with us ("insurance"). As used in this Notice, the term "health information" means information about you that we create, receive or maintain in connection with your insurance; that relates to your physical or mental condition or payment for health care provided to you; and that can reasonably be used to identify you. This Notice was effective April 14, 2003 and revisions to this Notice are effective May 15, 2024.

We are required by law to maintain the privacy of our members' and dependents' health information and to provide notice of our legal duties and privacy practices with respect to their health information. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all health information maintained by us. Copies of revised Notices will be mailed to plan sponsors for distribution to the members then covered by our insurance. You have the right to request a paper copy of the Notice, although you may have originally requested a copy of the Notice electronically by e-mail.

Uses and Disclosures of Your Health Information

Authorization. Except as explained below, we will not use or disclose your health information for any purpose unless you have signed a form authorizing a use or disclosure. Unless we have taken any action in reliance on the authorization, you have the right to revoke an authorization if the request for revocation is in writing and sent to: HIPAA Privacy Officer, Enterprise Privacy Office, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002. Once we receive your request, a form to revoke an authorization will be sent to your attention for completion.

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

Uses and Disclosures for Payment. We will use and disclose your health information as necessary for payment purposes. For instance, we may use your health information to process or pay claims, for subrogation, to provide a pre-determination of benefits or to perform prospective reviews. We may also forward information to another insurer in order for it to process or pay claims on your behalf. Unless we agree in writing to do otherwise, we will send all mail regarding a member's spouse or dependents to the member, including information about the payment or denial of insurance claims.

Uses and Disclosures for Health Care Operations. We will use and disclose your health information as necessary for health care operations. For instance, we may use or disclose your health information for quality assessment and quality improvement, credentialing health care providers, premium rating, conducting or arranging for medical review or compliance. We may also disclose your health information to another insurer, health care facility or health care provider for activities such as quality assurance or case management. We participate in an organized health care arrangement with the health plan of a member's employer. We may disclose your health information to your health plan for certain functions of its health care operations. This Privacy Notice does not cover the privacy practices of that plan. We may contact your health care providers concerning prescription drug or treatment alternatives.

Other Health-Related Uses and Disclosures. We may contact you to provide reminders for appointments; information about treatment alternatives; or other health-related programs, products or services that may be available to you.

Information Received Pre-enrollment. We may request and receive from you and your health care providers health information prior to your enrollment under the insurance. We will use this information to determine whether you are eligible to enroll under the insurance and to determine the rates. We will not use or disclose any genetic information we obtain about you or provided from your family history. If you do not enroll, we will not use or disclose the information we obtained about you for any other purpose. Information provided on enrollment forms or applications will be utilized for all coverages being applied for, some of which may be protected by the state, not federal, privacy laws.

Business Associate. Certain aspects and components of our services are performed by outside people or organizations pursuant to agreements or contracts. It may be necessary for us to disclose your health information to these outside people or organizations that perform services on our behalf. We require them to appropriately safeguard the privacy of your health information. Principal Life Insurance Company may itself be a business associate of your health plan or health insurance company. We may disclose your health information to your health plan or insurance company and its business associates as needed to fulfill our contractual obligations to them. Please see the notice of privacy practices issued by your plan or insurance company for information about how it uses and discloses your health information.

Plan Sponsor. We may disclose your health information to the plan sponsor the minimum necessary amount of your health information that it needs to perform administrative functions on behalf of the plan (if any), provided that the plan sponsor certifies that the information will be maintained in a confidential manner and will not be utilized or disclosed for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.

Family, Friends and Personal Representatives. With your approval, we may disclose to family members, close personal friends, or another person you identify, your health information relevant to their involvement with your care or paying for your care. If you are unavailable, incapacitated or involved in an emergency situation, and we determine that a limited disclosure is in your best interests, we may disclose your health information without your approval. We may also disclose your health information to public or private entities to assist in disaster relief efforts.

Other Uses and Disclosures. We are permitted or required by law to use or disclose your health information, without your authorization, in the following circumstances:

- For any purpose required by law;
- For public health activities (for example, reporting of disease, injury, birth, death or suspicion of child abuse or neglect);
- To a governmental authority if we believe an individual is a victim of abuse, neglect or domestic violence;
- For health oversight activities (for example, audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions);
- For judicial or administrative proceedings (for example, pursuant to a court order, subpoena or discovery request);
- For law enforcement purposes (for example, reporting wounds or injuries or for identifying or locating suspects, witnesses or missing people);
- To coroners and funeral directors;
- For procurement, banking or transplantation of organ, eye or tissue donations;
- For certain research purposes;
- To avert a serious threat to health or safety under certain circumstances;
- For military activities if you are a member of the armed forces; for intelligence or national security issues; or about an inmate or an individual to a correctional institution or law enforcement official having custody; and
- For compliance with workers' compensation programs.

We will adhere to all state and federal laws or regulations that provide additional privacy protections. We are prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of determining eligibility for coverage, the amount of benefits or premiums or discounts, including rebates, payments in kind, or other premium or benefit differential mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program. We will not request, use or disclose

psychotherapy notes without your authorization (except to defend ourselves in a legal action brought by you.) We will not sell your protected health information or use or disclose it for marketing purposes without your authorization, except as permitted by law. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information.

Your Rights

Restrictions on Use and Disclosure of Your Health Information. You have the right to request restrictions on how we use or disclose your health information for treatment, payment or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your care or the paying of your care. We are not required to agree to your request for a restriction. If your request for a restriction is granted, you will receive a written acknowledgement from us.

Receiving Confidential Communications of Your Health Information. You have the right to request communications regarding your health information from us by alternative means (for example by fax) or at alternative locations. We will accommodate reasonable requests.

Access to Your Health Information. You have the right to inspect and/or obtain a copy of your health information we maintain in your designated record set, with a couple of exceptions. A fee will be charged for copying and postage.

Amendment of Your Health Information. You have the right to request an amendment to your health information to correct inaccuracies. We are not required to grant the request in certain circumstances.

Accounting of Disclosures of Your Health Information. You have the right to receive an accounting of certain disclosures of your health information made by us during the 6 year period before your request. The first accounting in any 12-month period will be free; however, a fee will be charged for any subsequent request for an accounting during that same time period.

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

Complaints. If you believe your privacy rights have been violated, you can send a written complaint to us at Complaint Handler, Workplace Benefits, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002 or to the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

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

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Principal Life Insurance Company
Des Moines, Iowa 50392-0002