H9068
RADO
601
05/01/2004

GROUP BOOKLET-CERTIFICATE FOR MEMBERS OF:

THE RADOS COMPANIES

ALL MEMBERS
Group Long Term Disability Insurance

Print Date: 05/14/2004

This page left blank intentionally

Your insurance has been designed to provide financial help for you when a covered loss occurs. This plan has chosen benefits provided by a Group Policy issued by Us, Principal Life Insurance Company. To the extent that benefits are provided by the Group Policy, the administration and payment of claims will be done by Us as an insurer.

Members rights and benefits are determined by the provisions of the Group Policy. This booklet briefly describes those rights and benefits. It outlines what you must do to be insured. It explains how to file claims. It is your certificate while you are insured.

The effective date of your insurance is as shown on your enrollment card. You should keep your enrollment card, any change of beneficiary or change of name forms, or other similar forms with your booklet after the form has been recorded by Us and returned to you.

THIS BOOKLET REPLACES ANY PRIOR BOOKLET THAT YOU MAY HAVE RECEIVED. Please remove your enrollment material from your prior booklet, place it with this booklet, and destroy your prior booklet. If you have any questions about this new booklet, please contact your employer. In the event of future Group Policy changes, you will be provided with a new booklet-certificate or a booklet-certificate rider.

PLEASE READ YOUR BOOKLET CAREFULLY. We suggest that you start with a review of the terms listed in the DEFINITIONS Section (at the back of the booklet). The meanings of these terms will help you understand the insurance.

The group insurance policy and your insurance under the Group Policy may be discontinued or altered by the Policyholder or Us at any time without your consent.

We reserve complete discretion to construe or interpret the provisions of this group insurance, to determine eligibility for benefits, and to determine the type and extent of benefits, if any, to be provided. Our decisions in such matters will be controlling, binding, and final as between Us and persons covered by the Group Policy, subject to the Claims Procedures found on GH 146.

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

PRINCIPAL LIFE
INSURANCE COMPANY
Des Moines, IA 50392-0001

TABLE OF CONTENTS

SUMMARY OF BENEFITS
(Effective May 1, 2004)

This section highlights the benefits provided under the Group Policy. The purpose is to give you quick access to the information you will most often want to review. **Please read the other sections of this booklet for a more detailed explanation of your benefits and any limitations or restrictions that might apply.**

LONG TERM DISABILITY INSURANCE

If you become Totally or Residually Disabled while insured, and if you otherwise qualify, benefits will be payable to you during each month of a Benefit Payment Period.

In addition, if you die while in a Disability Benefit Payment Period, a Survivor Benefit will be payable to your estate or survivors.

The Benefit Payable will be subject to the Proof of Good Health requirements as shown in the Group Policy.

Elimination Period

An Elimination Period will start on the date you are Disabled. An Elimination Period will be completed when Disability has been continuous for three months.

A Benefit Payment Period will be established on the later of:

- the date you complete an Elimination Period; or
- the date six months before We receive written proof of your Disability.

Benefit Payable for Total Disability

The Benefit Payable to you for each full month of a Benefit Payment Period will be your Primary Monthly Benefit less Other Income Sources.

Benefit Payable for Residual Disability with Work Incentive Benefit

The Benefit Payable to you for each full month of a Benefit Payment Period will be:

- for the first 12 months, the lesser of:
    - 100% of Indexed Predisability Earnings, less Other Income Sources, less earnings from your regular job or any occupation; or
    - the Primary Monthly Benefit less Other Income Sources; and

- thereafter, your Primary Monthly Benefit, less Other Income Sources, multiplied by your Income Loss Percentage.

On each MARCH 1, following the date you become Disabled, your Predisability Earnings will be increased by the average rate of increase in the Consumer Price Index during the preceding calendar year, subject to an annual maximum of 10%.

If you have been Disabled for less than one year as of such date, the amount of the increase will be multiplied by the ratio of:

- the number of complete months of Disability as of such date;

- divided by 12 months.

Consumer Price Index means the U.S. City Average for Urban Consumers, all items, as published in the Consumer Price Index by the United States Department of Labor for the preceding calendar year.

The Consumer Price Index adjustment factor will be determined on each March 1.

Minimum Monthly Benefit

In no event will the Monthly Benefit Payable be less than the greater of 10 % of your Primary Monthly Benefit or $100 for each full month of a Benefit Payment Period, except that We will have the right to reduce the minimum Benefit Payable by any prior benefit overpayment made under this Group Policy. Also, the Benefit Payable for each day of any part of a Benefit Payment Period that is less than a full month will be the monthly benefit divided by 30.

HOW TO BE INSURED - MEMBERS

LONG TERM DISABILITY INSURANCE

Eligibility

To be eligible for insurance you must be a Member.

Member means any PERSON who is a Full-Time Employee of the Policyholder.

This requirement will be waived when you:

- are absent from Active Work because of a regularly scheduled day off, holiday, or vacation day; and

- were Actively at Work on your last scheduled workday before the date of your absence; and

- were capable of Active Work on the day before the scheduled effective date of your insurance.

If you are a Member on May 1, 2004, you will be eligible on the later of that date or the first of the Insurance Month coinciding with or next following the date you complete three consecutive months of continuous Active Work. If you are not a Member until later, you will be eligible on the first of the Insurance Month coinciding with or next following the date you complete three consecutive months of continuous Active Work.

Proof of Good Health

In some instances, Proof of Good Health will be required to place your insurance in force. The type and form of required proof will be determined by Us. You will need to file Proof of Good Health:

- If you request insurance more than 31 days after the date you are eligible. You must pay the cost of obtaining proof in this instance.

- If, on the date you are eligible, fewer than ten Members are insured. We will pay the reasonable cost of proof required in this instance.

- To become insured for any future increases in Benefit Payable amount if, at the time those increases would otherwise be effective, fewer than ten Members are insured. We will pay the reasonable cost of proof required in this instance.

Individual Incontestability and Eligibility

All statements made by any person insured will be representations and not warranties. In the absence of fraud, these statements may not be used to contest the person’s insurance unless:

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

- the statement is in written form signed by the insured person; and

- a copy of the form which contains the statement is given to the insured person or the insured person's beneficiary at the time insurance is contested.

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

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

We may at any time terminate a Member's eligibility under the Group Policy:

- in writing and with 31-day notice, if the individual submits any claim that contains false or fraudulent elements under state or federal law;

- in writing and with 31-day notice, upon finding in a civil or criminal case that a Member has submitted claims that contain false or fraudulent elements under state or federal law;

- in writing and with 31-day notice, when a Member has submitted a claim which, in good faith judgment and investigation, a Member knew or should have known, contains false or fraudulent elements under state or federal law.

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

You must request initial insurance on a form provided by Us.

If you are required to contribute toward the cost of your insurance, your insurance will normally be in force on:

- the date you are eligible, if you make your request on or before that date; or

- the first of the Insurance Month coinciding with or next following the date of your request, if you make your request within 31 days after the date you are eligible.

If you are not required to contribute toward the cost of your insurance, your insurance will normally be in force on the date you are eligible.

However, if you are not Actively at Work on the date insurance would otherwise be effective, your insurance will not be in force until the day you return to Active Work.

Effective Date for Initial Insurance

(Proof of Good Health Required)

If Proof of Good Health is required, your insurance will normally be in force on the later of:

- the date insurance would have been effective had proof not been required; or

- the first of the Insurance Month coinciding with or next following the date proof is approved by Us.

However, if you are not Actively at Work on the date insurance would otherwise be effective, your insurance will not be in force until the day you return to Active Work.

Effective Date for Benefit Changes
(Proof of Good Health Not Required)

If Proof of Good Health is not required, a change in your Benefit Payable amount because of a change in your status (insurance class or compensation) will normally be effective on the first of the Insurance Month coinciding with or next following the date of the change. If your earnings fall under the following definitions: Partners K-1, Sole Proprietors, or Subchapter S Corporations, a change in status will normally be effective on January 1.

However, if you are not Actively at Work on the date the change would otherwise be effective, the change will not be in force until the day you return to Active Work.

Effective Date for Benefit Changes
(Proof of Good Health Required)

If Proof of Good Health is required, a change in your Benefit Payable amount will normally be effective on the later of:

- the date the change would have been effective had Proof of Good Health not been required; or

- the first of the Insurance Month that next follows the date Proof of Good Health is approved by Us.

However, the exceptions noted above, when Proof of Good Health is not required, will also apply when Proof of Good Health is required.

Termination

Your insurance will cease on the earliest of:

- the date the Group Policy terminates; or

- the end of the Insurance Month in which you cease to belong to a class for which insurance is provided; or

- the end of the Insurance Month in which you cease to be a Member; or

- the end of the Insurance Month in which you cease Active Work.

If you cease Active Work because of sickness or injury, you might be eligible for limited continuation of insurance.

In addition, by paying the required contribution, if any, your insurance may be continued under the continuation provisions described on GH 117 C.

If you are interested in continuing your insurance beyond the date it would normally terminate, you should consult with the Policyholder before your insurance terminates.

FEDERAL FAMILY AND MEDICAL LEAVE ACT (FMLA)

Continuation

Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

This is a general summary of the FMLA and how it affects the Group Policy. See your employer for details on this continuation provision.

FMLA and Other Continuation Provisions

If your employer is an Eligible Employer and if the continuation portion of the FMLA applies to your 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 Group Policy for sickness, injury, layoff, or approved leave of absence, if any.

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

Eligible Employer

Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year.

Eligible Employee

Eligible Employee means an employee who has worked for the Eligible Employer:

- for at least 12 months; and

- for at least 1,250 hours (approximately 24 hours per week) during the year preceding the start of the leave; and

- at a work-site where the Eligible Employer employs at least 50 employees within a 75-mile radius.

For this purpose, "employs" has the meaning provided by the Federal Family and Medical Leave Act (FMLA).

Mandated Unpaid Leave

Eligible Employers are required to allow 12 workweeks of unpaid leave during any 12-month period to Eligible Employees for one or more of the following reasons:

- The birth of a child of an Eligible Employee and in order to care for the child.
- The placement of a child with the Eligible Employee for adoption or foster care.
- To care (physical or psychological care) for the spouse, child, or parent of the Eligible Employee, if they have a "serious health condition."
- A "serious health condition" that makes the Eligible Employee unable to perform the functions of his or her job.

Reinstatement

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.

See your employer for details on this reinstatement provision.

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

Reinstatement

For Long Term Disability Insurance, a longer reinstatement period may be allowed for an approved leave of absence taken in accordance with the provisions of the federal law regarding USERRA.

See your employer for details on this reinstatement provision.

DESCRIPTION OF BENEFITS

LONG TERM DISABILITY INSURANCE

Benefit Qualification

To qualify for Disability benefits, all of the following must occur:

- You must become Disabled while insured under the Group Policy.
- Your Disability must not be subject to any of the limitations listed later in this section.
- You must complete an Elimination Period and establish a Benefit Payment Period.
- You must be under the regular care and attendance of a Physician.
- You must satisfy the requirements listed in the CLAIM PROCEDURES Section.

Elimination Period

An Elimination Period will start on the date you are Disabled. An Elimination Period will be completed when Disability has been continuous for three months.

A Benefit Payment Period will be established on the later of:

- the date you complete an Elimination Period; or
- the date six months before We receive written proof of your Disability.

Temporary Recovery During the Elimination Period

If you are in the process of satisfying an Elimination Period and recover from the Disability for a short period of time, and then again become Disabled from the same or related cause, the recovery from Disability will not require you to start a new Elimination Period provided the recovery is not longer than 15 working days.

The period of recovery from Disability will not count toward satisfaction of the Elimination Period.

Benefit Payable for Total Disability

The Benefit Payable to you for each full month of a Benefit Payment Period will be your Primary Monthly Benefit less Other Income Sources.

The determination of Other Income Sources will be subject to the requirements discussed in the CLAIM PROCEDURES Section.

Benefit Payable for Residual Disability with Work Incentive Benefit

The Benefit Payable to you for each full month of a Benefit Payment Period will be:

- for the first 12 months, the lesser of:
    - 100% of Indexed Predisability Earnings, less Other Income Sources, less earnings from your regular job or any occupation; or
    - the Primary Monthly Benefit less Other Income Sources; and
- thereafter, your Primary Monthly Benefit, less Other Income Sources, multiplied by your Income Loss Percentage;

On each MARCH 1, following the date you become Disabled, your Predisability Earnings will be increased by the average rate of increase in the Consumer Price Index during the preceding calendar year, subject to an annual maximum of 10%.

If you have been Disabled for less than one year as of such date, the amount of the increase will be multiplied by the ratio of:

- the number of complete months of Disability as of such date;
- divided by 12 months.

Consumer Price Index means the U.S. City Average for Urban Consumers, all items, as published in the Consumer Price Index by the United States Department of Labor for the preceding calendar year.

The determination of Other Income Sources will be subject to the requirements discussed in the CLAIM PROCEDURES Section.

Minimum Monthly Benefit

In no event will the Monthly Benefit Payable be less than the greater of 10% of your Primary Monthly Benefit or $100 for each full month of a Benefit Payment Period, except that We will have the right to reduce the minimum Benefit Payable by any prior benefit overpayment made under the Group Policy. Also, the Benefit Payable for each day of any part of a Benefit Payment Period that is less than a full month will be the monthly benefit divided by 30.

Survivor Benefit

In the event a Benefit Payment Period ends because of your death, a Survivor Benefit will be payable. This Survivor Benefit will be three times your Primary Monthly Benefit.

Accelerated Survivor Benefit

- **Definition of Terminally Ill**

  You will be considered Terminally Ill under the Group Policy if you have experienced a Qualifying Event and are expected to die within 12 months of the date you request payment of Accelerated Survivor Benefit.

- **Definition of Qualifying Event**

  A Qualifying Event is a medical condition which would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span. Such conditions may include, BUT ARE NOT LIMITED TO, one or more of the following:

  - coronary artery disease resulting in an acute infarction or requiring surgery;
  - permanent neurological deficit resulting from cerebral vascular accident;
  - end stage renal failure; or
  - acquired immune deficiency syndrome (AIDS).

- **Eligibility**

  We will pay you an Accelerated Survivor Benefit if you request such payment and meet the following requirements. You must:

  - satisfy the Benefit Qualifications listed in this section; and
  - provide proof that you are Terminally Ill by submitting to Us:
    - a statement from your Physician; and
    - any other medical information that We believe necessary to confirm your status; and
  - be living on the date of payment of the Accelerated Survivor Benefit.

- **Benefit**

  The Accelerated Survivor Benefit will be an amount equal to three times your Primary Monthly Benefit. It will be paid in a single lump sum to you. This benefit is paid in addition to your regular Benefit Payable.

- **Effect on Survivor Benefit**

  If an Accelerated Survivor Benefit is paid, no Survivor Benefit will be payable.

Payment Termination

Your Benefit Payment Period will end on the earliest of:

- the date of your death; or
- the date Disability ends unless a Recurring Disability exists as explained in this section; or
- the date you fail to provide any required proof of Disability; or
- the date you fail to submit to any required medical examination; or
- the date you fail to report income from Other Income Sources; or
- if reasonably entitled, the date ten days after receipt of notice from Us if you fail to pursue Social Security Benefits as outlined in this booklet; or
- if your Disability results from alcoholism, drug abuse, or a Mental Health Condition, the date 24 months after the Benefit Payment Period begins; or
- if your Disability begins before you are age 65, the later of the date 36 months after your Benefit Payment Period begins or the date you attain Social Security Normal Retirement Age; or
- if your Disability begins on or after you are age 65, the later of the date of Social Security Normal Retirement Age or the date of completion of the number of months, shown below, after your Benefit Payment Period begins:

Attained Age (On the date Disability begins)	**Months of the Benefit Payment Period (Beginning with the date the Benefit Payment Period begins)**
65-67	24
68-69	18
70-71	15
72 and over	12

- the date you are no longer under the regular care and attendance of a Physician.

Continued Benefit Payment Period

In some instances your Disability Benefit Payment Period may be continued beyond the normal termination date. These instances are discussed under these headings:

- **Recurring Disability**
- **Treatment of Alcoholism, Drug Abuse, or a Mental Health Condition**

Recurring Disability

A Recurring Disability will exist under the Group Policy if:

- after you have completed an Elimination Period, you cease to be Disabled; and
- you then return to Active Work; and
- while insured under the Group Policy but before completing six continuous months of Active Work, you are again Disabled; and
- your current Disability and the Disability for which you completed the Elimination Period result from the same or a related cause.

A Recurring Disability will be treated as if the initial Disability had not ended, except that no benefits will be payable for the time between Disabilities. You will not be required to complete a new Elimination Period. Benefits will be payable from the first day of each Recurring Disability, but only for the remainder, if any, of the Benefit Payment Period established for the initial Disability.

Treatment of Alcoholism, Drug Abuse, or a Mental Health Condition

When Disability results from alcoholism, drug abuse, or a Mental Health Condition, the maximum number of Benefits Payable is limited to 24 months. However, if at the end of that 24 months you are confined in a Hospital or other facility qualified to provide necessary care and treatment for alcoholism, drug abuse, or a Mental Health Condition, then the Benefit Payment Period may be extended to include the time during which you remain confined. However, this extension will be subject to all of the other Disability Payment Termination provisions listed earlier.

Limitations

Benefits will not be paid for any Disability that:

- results from willful self-injury; or
- results from war or act of war; or
- results from participation in an assault or felony; or
- is a new Disability that begins after a prior Disability Benefit Payment Period has ended and you have not returned to Active Work; or
- is a continuation of a Disability for which a Benefit Payment Period has ended and you have not returned to Active Work (except as provided for a Recurring Disability in this section); or
- is subject to the Preexisting Conditions Exclusion as described in this section.

Preexisting Conditions Exclusion for Initial Insurance

A Preexisting Condition is any sickness, injury, Mental Health Condition, or drug or alcohol condition for which you:

- received medical treatment, consultation, care or services; or
- were prescribed or took prescription medications; or
- had symptoms or conditions which would cause a reasonably prudent person to seek diagnosis, care or treatment;

in the three month period before you became insured under the Group Policy.

No benefits will be paid for a Disability that results from a Preexisting Condition unless, on the date you became Disabled, you had been Actively at Work for one full day after completing 12 consecutive months during which you were insured under the Group Policy.

Preexisting Conditions Exclusion for Benefit Increases

A Preexisting Condition is any sickness, injury, Mental Health Condition, or drug or alcohol condition for which you:

- received medical treatment, consultation, care, or services; or
- were prescribed or took prescription medications; or
- had symptoms or conditions which would cause a reasonably prudent person to seek diagnosis, care or treatment;

in the three month period prior to an increase in benefits or change in the Group Policy provisions (excluding changes in Monthly Earnings).

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

- results from a Preexisting Condition; and
- begins within 12 months after the effective date of the increase in benefits or change in policy provisions.

CLAIM PROCEDURES

Notice of Claim

Written notice of claim must be given to Us within three months after the date of loss. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

Claim Forms

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

Proof of Loss

Written proof of loss must be furnished to the company, in case of claim for loss for which the Group Policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which the company is liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor 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 your legal capacity, later than one year from the time proof is otherwise required. Proof required includes the date, nature, and extent of the Disability.

Payment, Denial, and Review

The Employee Retirement Income Security Act (ERISA) permits up to 90 days for processing claims and up to 60 days for reviewing denied claims. State law permits up to 40 days after receipt of proof of Disability to determine if the claim will be paid or denied. If a determination cannot be made within 40 days, The Principal can request a 30-day extension in writing prior to the end of the original 40 days and every 30 days thereafter. (Exception: If there is a reasonable basis for The Principal to believe a claim is false or fraudulent, the 40-day limit is extended to 80 days.)

If it is determined that the claim will be paid, a Benefit Payment Period must begin within 30 days of:

- determination of Disability; or

- execution of a settlement agreement.

If the claim is denied, in whole or in part, The Principal 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.

Medical Examinations

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

Legal Action

Legal action for a claim may not be started earlier than 90 days after proof of loss is filed. Further, no legal action may be started later than three years after proof is required to be filed.

Time Limits

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

Determination of Other Income Sources

If you file a claim for Long Term Disability benefits, your Other Income Sources will be determined in this way:

- You must, when requested, report all such income to Us. Your report must include proof that you have applied for all income for which you are eligible and proof of rejection if any application is declined.

- If any income is payable to you in a lump sum, We will convert and apply that income on a monthly equivalent basis.

- Until exact amounts are known, we will estimate the Social Security benefits for which you and your Dependents are eligible and will include that estimate in your Other Income Sources.

If it is reasonable that you would be entitled to Disability benefits under the Federal Social Security Act, We will require that you:

- apply for these benefits within ten days after receipt of written notice from Us requesting you to apply for such benefits; and

- give satisfactory proof within 30 days after receipt of Our notice that you have applied for these benefits within the ten-day period; and

- request reconsideration of the application for Social Security benefits if the original application is denied and appeal any denial or reconsideration if an appeal appears reasonable.

Cost of Living Freeze

After the initial deduction for each of the Other Income Sources, benefits under the Group Policy will not be further reduced due to any cost of living increases payable under these Other Income Sources.

Social Security Estimates

Until exact amounts are known, We may estimate the Social Security benefits for which you and your Dependents are eligible and may include those estimates in your Other Income Sources.

If it is reasonable that you would be entitled to disability benefits under the Federal Social Security Act, We will require that you:

- Apply for disability benefits within ten days after receipt of written notice from Us requesting you to apply for such benefits; and

- Give satisfactory proof within 30 days after receipt of Our notice that you have applied for these benefits within the ten-day period; and

- Request reconsideration of the application for Social Security benefits if the original application is denied, and appeal any denial of reconsideration if an appeal appears reasonable.

Payments for Less Than A Full Month for Long Term Disability

The Benefit Payable for each day of any part of a Benefit Payment Period that is less than a full month will be the monthly benefit divided by 30.

Adjustment For Excess Payment

If excess benefits are paid because your income from Other Income Sources is understated, We will have the option to:

- reduce your future Benefits Payable by the full amount of the excess payment; or

- recover the excess payment directly from you.

Facility of Payment

Long Term Disability benefits will be payable at the end of each month of a Benefit Payment Period, provided complete and proper proof of Disability has been received by Us. Any unpaid balance that remains after a Benefit Payment Period ceases will be immediately

payable.

Benefits will normally be paid directly to you. However, in the special instances listed below, payment will be as indicated. All payments so made will discharge Us to the full extent of those payments.

- If payment amounts remain due upon your death, those amounts may, at Our option, be paid to your estate, spouse, child, or parent.

- For Long Term Disability Insurance, if We believe a person is not legally able to give a valid receipt for a benefit payment, and no guardian has been appointed, We may pay whoever has assumed the care and support of the person. Any payment due a minor will be at the rate of not more than $200 a month.

NOTE: For additional Claims Procedures information, see GH 198 ERISA Claims.

STATEMENT OF RIGHTS

Federal law requires that this section be included in your booklet:

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.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan or the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. See GH 451, if applicable, for further

information concerning preexisting condition exclusions.

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.

DEFINITIONS
(For Long Term Disability Insurance)

Several words and phrases used to describe your plan are capitalized whenever they are used in this booklet. These words and phrases have special meanings as explained in this section.

Active Work; Actively at Work mean the active performance of all of a Member's normal job duties at the Policyholder's usual place or places of business.

Benefit Payment Period (for Long Term Disability Insurance) means the period of time during which benefits are payable. This period will begin, and benefits will begin to accrue, on the later of the date you complete an Elimination Period or the date six months before We receive written proof of your Disability.

Covered Monthly Earnings mean the first $8,333 of your Monthly Earnings.

Dependent means your spouse and children, if they qualify for benefits under the Federal Social Security Act as a result of your Disability or retirement.

Disability; Disabled mean Total or Residual Disability as defined in this section.

Elimination Period means the period of time you must be Disabled before benefits begin to accrue. An Elimination Period must be satisfied for each separate period of Disability.

Full-Time Employee means any person who is regularly scheduled to work for the Policyholder for at least 30 hours a week. Work must be at the Policyholder's usual place or places of business or at another place to which an employee must travel to perform his or her regular duties. This excludes any person who is scheduled to work for the Policyholder on a seasonal, temporary, contracted, or part-time basis.

Group Policy means the policy of group insurance issued to the Policyholder by Us which describes benefits and provisions for insured Members.

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

Income Loss Percentage (for Long Term Disability Insurance) means your Income Loss Percentage is equal to:

- your Indexed Predisability Earnings less any earnings from your regular job or other occupation; divided by

- your Indexed Predisability Earnings.

Insurance Month means calendar month.

Indexed Predisability Earnings mean your Predisability Earnings adjusted for increases in the Consumer Price Index as outlined in this booklet.

Member means any PERSON who is a Full-Time Employee of the Policyholder.

Mental Health Condition means any condition which is:

- manifested by a psychiatric disturbance including, but not limited to, a biologically or chemically based disorder; and

- categorized in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

Monthly Earnings mean, on any date, your basic monthly (or monthly equivalent) wage then in force as established by the Policyholder. Basic wage does not include commissions, bonuses, tips, or overtime pay. Basic wage does include any deferred earnings in a qualified deferred compensation plan and any amount of voluntary earnings reduction under a qualified Section 125 Cafeteria Plan.

Monthly Earnings (Partners K-1) mean on any date, the monthly equivalent of your annual (or annual equivalent) earnings as established by the Policyholder, that:

- if you have been a partner for at least two calendar years, were reported as net earnings (loss) from self-employment for the prior two years on Schedule K-1 of Partnership Return of Income, Form 1065, excluding amounts derived from return of capital, interest, or dividends; or

- if you have been a partner for less than two calendar years but at least one calendar year, were reported as net earnings (loss) from self-employment on Schedule K-1 of Partnership Return of Income, Form 1065, excluding amounts derived from return of capital, interest, or dividends, for the completed calendar years that you have been a partner; or

- if you have been a partner for less than one calendar year, is your average draw during your period as a partner.

Monthly Earnings (Sole Proprietors) mean on any date, the monthly equivalent (1/12) of your annual net profit that:

- if you have been a sole proprietor for at least two calendar years, was reported on Form 1040 Schedule C for the last two calendar years as the gross income less total deductions, minus depreciation, and averaged over the last two years; or

- if you have been a sole proprietor for less than two calendar years, was reported on Form 1040 Schedule C for the completed calendar years the you have been a sole proprietor, as the gross income less total deductions, minus depreciation, and

averaged over the completed years.

Monthly Earnings (Subchapter S Corporations) mean on any date, the monthly equivalent of your annual (or annual equivalent) earnings as established by the Policyholder, that:

- if you have been a shareholder for at least two calendar years, were reported as net earnings (loss) from self-employment for the prior two years on Schedule K-1 of Partnership Return of Income, Form 1065, excluding amounts derived from return of capital, interest, or dividends; or

- if you have been a shareholder for less than two calendar years but at least one calendar year, were reported as net earnings (loss) from self-employment on Schedule K-1 of Partnership Return of Income, Form 1065, excluding amounts derived from return of capital, interest, or dividends, for the completed calendar years that you have been a shareholder; or

- if you have been a shareholder for less than one calendar year, is your average draw during your period as a shareholder.

Other Income Sources mean:

- all disability payments for the month that you and your Dependents receive under the Federal Social Security Act, Railroad Retirement Act, or any similar act of any federal, state, provincial, municipal, or other governmental agency; and

- if you have reached Social Security Normal Retirement Age or older, all retirement payments for the month that you and your Dependents receive under the Federal Social Security Act, Railroad Retirement Act, or any similar act of any federal, state, provincial, municipal, or other governmental agency; and

- if you are less than Social Security Normal Retirement Age, all retirement payments for the month that you and your Dependents receive under the Federal Social Security Act, Railroad Retirement Act, or any similar act of any federal, state, provincial, municipal, or other governmental agency; and

- all loss of wages payments for the month (other than payments from the Veterans' Administration) that you receive under a Workers' Compensation Act, or other similar law; and

- all sick pay or salary continuance payments excluding any payments attributable to individual disability insurance policies for the month that the Member receives from the Policyholder; and

- all retirement payments attributable to employer contributions and all disability payments attributable to employer contributions for the month that you receive under a pension plan sponsored by the Policyholder. A pension plan is a defined benefit plan or defined contribution plan providing disability or retirement benefits for employees attributable to employer contributions. A pension plan does not

include a profit sharing plan, a thrift savings plan, a nonqualified deferred compensation plan, a 401(k) plan, an Individual Retirement Account (IRA), a Tax Deferred Annuity (TDA), or a stock ownership plan, or a Keogh (HR-10) plan with respect to partners; and

- all payments for the month that you receive for loss of income under no-fault auto laws. Supplemental disability benefits purchased under a no-fault auto law will not be counted; and

- any income benefit for which the Member is eligible under the California Unemployment Insurance Code.

For all state, provincial, municipal, or other government agencies, the disability and retirement payments specified above will include only those payments attributable to employer contributions.

Physician means:

- a licensed Doctor of Medicine (M.D.) or Osteopathy (D.O.); and

- any other licensed health care practitioner that state law requires be recognized as a Physician under the Group Policy.

Policyholder means THE RADOS COMPANIES.

Predisability Earnings (for Long Term Disability Insurance) mean your Monthly Earnings in effect on the date Disability begins.

Primary Monthly Benefit means, on any date, 60% of your Covered Monthly Earnings as of the date Disability starts. The Primary Monthly Benefit will not exceed $5,000.

Proof of Good Health means written evidence that a person is insurable under Our general underwriting standards. This proof must be provided in a form satisfactory to Us.

Residual Disability; Residually Disabled (for Long Term Disability Insurance) mean you are working on a limited or part-time basis and solely and directly because of sickness or injury:

- during the Elimination Period and the Benefit Payment Period:

    - are unable to perform the majority of the material duties of your normal occupation; and

    - are unable to earn more than 80% of your Indexed Predisability Earnings.

Residual Disability; Residually Disabled (For Pilots) mean you are working on a limited or part-time basis and solely and directly because of sickness or injury:

- are unable to perform the majority of the material duties of any occupation for which you are or may reasonably become qualified based on education, training, or experience; and

- are unable to earn more than 80% of your Indexed Predisability Earnings.

The loss of a pilot's license for any reason does not in itself constitute Disability.

Social Security Normal Retirement Age (SSNRA) means:

Year of Birth	Normal Retirement Age
Before 1938	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943 - 1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
After 1959	67

Total Disability; Totally Disabled (for Long Term Disability Insurance) mean you are not working for wage or profit and, solely and directly because of sickness or injury during the Elimination Period and the Benefit Payment Period, are unable to perform the majority of the material duties of your normal occupation.

Total Disability; Totally Disabled (For Pilots) mean you are not working for wage or profit and, solely and directly because of sickness or injury, are unable to perform the majority of the material duties of any occupation for which you are or may reasonably become qualified based on education, training, or experience.

The loss of a pilot's license for any reason does not in itself constitute Disability.

We, Us, and Our mean Principal Life Insurance Company, Des Moines, Iowa.

BOOKLET-CERTIFICATE NOTICE

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

Principal Life Insurance Company
711 High Street
Des Moines, Iowa 50392-0001

Disability claim-related inquiries:
Attn: Group Claim - Disability Info Line Services
Phone: 1-800-245-1522

For administration-related inquiries:
Attn: Group Call Center
Phone: 1-800-247-6699

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

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

Persons may call or write to:

California Insurance Department
Claims Services Bureau
11th Floor
300 South Spring Street
Los Angeles, CA 90013
Phone: 1-800-927-HELP (In State)
1-213-897-8921 (Out of State)

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

BOOKLET-CERTIFICATE RIDER

Subject: Employee Retirement Income Security Act (ERISA) Claims Procedures for Life, STD and LTD Insurance (Effective January 1, 2002)

The provisions described below will replace the provisions described in your booklet-certificate.

The Department of Labor has promulgated regulations regarding claims procedure requirements. If your plan of benefits includes Life, STD and/or LTD, the Claims Procedures section of your group booklet-certificate has been changed to comply with the above referenced regulation.

Note: Changes have been made only to reflect the requirements of the ERISA. Any special state requirements relating to payment of claims remain unchanged unless they prevent the application of the ERISA requirements.

CLAIM PROCEDURES

Notice of Claim

Written notice of claim must be given to Us within 20 days (3 months for LTD) after the date of loss for which claim is being made. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

Claim Forms

Claim forms and other information needed to provide proof of loss must be filed with Us in order to obtain payment of benefits. The Employer will provide appropriate claim forms to assist you in filing claims. If the forms are not provided within 15 days after We receive notice of claim, you will be considered to have complied with the requirements of the Group Policy regarding proof of loss upon submitting, within the time specified below for filing proof of loss, written proof covering the occurrence, character and extent of the loss.

Proof of Loss

For Life Insurance booklet-certificates

Claim forms and other information needed to prove loss should be filed promptly. Written proof of loss should be sent to Us within 90 days after the date of loss. Proof required includes the date, nature, and extent of the loss. We may request additional information to substantiate your loss or require a signed unaltered authorization to obtain that information from the provider. Your 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 Us.

For STD and LTD Insurance policies

Claim forms and other information needed to prove loss should be filed promptly. Written proof of loss should be sent to Us within 90 days after you complete your Elimination Period. (For Long Term Disability Insurance, written proof that Disability exists and has been continuous must be sent to Us within six months after you complete your Elimination Period.) Proof required includes the date, nature, and extent of the loss. We may request additional information to substantiate your loss or require a signed unaltered authorization to obtain that information from the provider. Your 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 Elimination Period has been completed and the appropriate claim form is received by Us.

Payment, Denial, and Review

ERISA permits up to 45 days from receipt of claim for processing the claim. If a claim cannot be processed due to incomplete information, We 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. We are permitted two 30-day extensions for processing an incomplete claim. Written notification will be sent to a claimant regarding the extension.

In actual practice, benefits will be payable sooner, provided We receive complete and proper proof of loss. Furthermore, if a claim is not payable or cannot be processed, We will submit a detailed explanation of the basis for Our denial.

A claimant may request an appeal of a claim denial by written request to Us within 180 days of receipt of notice of the denial. We will make a full and fair review of the claim. We may require additional information to make the review. We will notify a 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 We did not receive the requested additional information, We are permitted a 45-day extension for the review. Written notification will be sent to a claimant regarding the extension. After exhaustion of the formal appeal process, the claimant may request an additional appeal. However, this appeal is voluntary and does not need to be filed before asserting rights to legal action.

For purposes of this section, for Life insurance policies, "claimant" means you, your Dependent or beneficiary. For STD and LTD insurance policies, "claimant" means you.

Legal Action

Legal action with respect to a claim may not be started earlier than 90 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 proof is required to be filed.

Please keep this rider with your booklet-certificate(s). Your booklet-certificate(s) will be updated sometime in the future to incorporate these provisions.

Nothing in this rider will vary, alter, or extend any provision or condition of the group policy(ies) other than as stated in this rider.

PRINCIPAL LIFE INSURANCE COMPANY
DES MOINES, IOWA 50392-0001

This page left blank intentionally

PLAN ARRANGED BY

JOHN M WAYLAND
PO BOX 891630
TEMECULA CA
92589-1630

Principal Life Insurance Company
Des Moines, Iowa 50392-0002