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10/01/2022

GROUP BOOKLET-CERTIFICATE FOR MEMBERS OF:

LONG FALLS PAPERBOARD LLC

ALL MEMBERS
Group Vision Care Expense Insurance

Print Date: 10/17/2022

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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 Vision Care Expense 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)
Des Moines, Iowa 50392-0002

Certificate of Coverage

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

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

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

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

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

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

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

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

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DEFINITIONS

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

Active Work; Actively at Work

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

Calendar Year

January 1 through December 31 of each year.

Claims Administrator

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

Copayment

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

Date of Issue

The date the Group Policy is placed in force: October 1, 2022.

Dependent

- A Member's spouse, if that spouse:
    - is not in the Armed Forces of any country; and
    - is not insured under the Group Policy as a Member.
- A Member's Dependent Child(ren) as defined below.

Dependent Child(ren)

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

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

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

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

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.

Employee

Any PERSON, residing in the United States, who is a U.S. citizen or is legally working in the United States, who is regularly scheduled to work for the Policyholder for at least 24 hours a week. The person must be compensated by the Policyholder and either the employer or employee must be able to show taxable income on federal or state tax forms. Work must be at the Policyholder's usual place or places of business or at another place to which an employee must travel to perform his or her regular duties. A person is considered to be residing in the United States if his or her main home or permanent address is in the United States or if the person is in the United States for six months or more during any 12-month period.

An owner, proprietor, or partner of the Policyholder's business will be deemed to be an eligible employee for purposes of the Group Policy, provided he or she is regularly scheduled to work for the Policyholder for at least 24 hours a week and otherwise meets the definition of Employee.

Grace Period

The first 31 day period following a premium due date.

Group Policy

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

- the Policyholder provision; and

- the Certificate of Coverage provisions for the Member and Dependent.

Immediate Family

A Member's spouse, natural or adoptive parent, natural or adoptive child, sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild or spouse of grandparent or grandchild.

Insurance Month

Calendar month.

Member

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

Necessary Contact Lenses

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

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

Non-Preferred Provider/Non-PPO Provider

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

Participating Retail Chain Provider

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

Physical or Mental Incapacity

A Dependent Child's substantial Physical or Mental Incapacity, 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.

Placement for Adoption; Placement

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

Policy Anniversary

January 1, 2024 and the same day of each following year.

Policyholder

LONG FALLS PAPERBOARD LLC.

Preferred Provider/PPO Provider

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

Preferred Provider Organization (PPO)

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

Premium Period

A monthly basis on which the premium is due.

Vision Examinations

Comprehensive examination of visual function and prescription of corrective eyewear.

HOW TO BE INSURED - MEMBERS

VISION CARE EXPENSE INSURANCE

Eligibility

Only Employees will be eligible for insurance.

Anyone meeting the definition of Employee on October 1, 2022, will be eligible on that date.

Anyone meeting the definition of Employee later will be eligible on the date the Employee begins Active Work.

Effective Dates - Actively at Work

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

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

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

Individual Incontestability

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

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

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

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

Effective Date for Non-Contributory Insurance

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

Effective Date for Contributory Insurance

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

- the date the Employee is eligible, if the request is made on or before that date; or
- the date of the Employee's request, if the Employee makes the request within 31 days after the date the Employee is eligible; or

- the Policy Anniversary date following the date of the Employee's request, if the Employee makes the request more than 31 days after the date the Employee is eligible.

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

Annual Enrollment Period

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

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

- during any previous Annual Enrollment Period; or

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

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

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

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

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

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

Court-Ordered Coverage Under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN): A Member or the Member's Dependent Child can enroll if:

- the Member is enrolled (or eligible to be enrolled but failed to enroll during a previous enrollment period); and

- the Member failed to enroll a Dependent Child during a previous enrollment period; and

- the Member is required by a QMCSO or NMSN as defined by applicable federal law and state insurance laws to provide vision coverage for a Dependent Child.

The request for enrollment:

- may be made at any time after the issue date of the QMCSO or NMSN; and

- will apply only to the Member and/or any Dependent Child(ren) listed in the QMCSO or NMSN.

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

- will be the date of the request for enrollment; and

- will not be subject to the Actively at Work provisions described in this section.

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

Special Enrollment Period

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

The Special Enrollment Periods are:

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

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

  The effective date of insurance will be the date of the request for enrollment provided contribution has been received for the requested insurance.

  NOTE: For the purpose of (ii) above:

  "Loss of eligibility" does not include:

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

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

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

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

  (i) in the event of marriage, the date of such marriage; or
  (ii) in the event of a Dependent Child's birth, the date of such birth; or
  (iii) in the event of a Dependent Child's adoption or Placement for Adoption, the date of such adoption or Placement for Adoption, whichever is earlier.

Effective Date for Benefit Changes

A change in the Member's Scheduled Benefit amount because of a change in status (insurance class) will normally be effective on the date of the change in status.

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

A change in the Member's Scheduled Benefit amount because of a change in benefits provided under the Group Policy will normally be effective on the date of change.

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

Termination

Unless continued as provided on GH 9016, the Member's insurance under the Group Policy will cease on the earliest of:

- the date the Group Policy terminates; or
- the date the last contribution is made for the Member's insurance; or
- for contributory insurance any date desired, if requested by the Member before that date; or
- the date the Member ceases to belong to a class for which insurance is provided; or
- the date the Employee ceases to be a Member; or
- the date the Member ceases Active Work.

Termination for Fraud

Principal Life may at any time terminate a Member's or Dependent's insurance under the Group Policy:

- in writing and with 31-day notice, if the Member or Dependent submits any claim that contains fraudulent elements under state or federal law; or
- in writing and with 31-day notice, upon finding in a civil or criminal case that a Member or Dependent has submitted claims that contains fraudulent elements under state or federal law; or
- in writing and with 31-day notice, when a Member or Dependent has submitted a claim, which, in good faith judgment and investigation, they knew or should have known, contains fraudulent elements under state or federal law.

HOW TO BE INSURED - DEPENDENTS

VISION CARE EXPENSE INSURANCE

Eligibility

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

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

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

Effective Date

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

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

Individual Incontestability

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

Termination

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

- the date the Member ceases to belong to a class for which Dependent insurance is provided; or
- the date Dependent Vision Care Expense Insurance is removed from the Group Policy; or
- the date Member insurance ceases; or
- the date the last contribution is made for Dependent insurance; or
- for contributory insurance 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 the Member's Dependent. However, a spouse who no longer resides with the Member will not cease to be a Dependent until legally separated or divorced, provided the spouse otherwise continues to be a Dependent.

However, insurance will be continued beyond the maximum age for a Dependent Child who is incapable of self-support because of a Developmental or Physical Incapacity 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.

CONTINUATION OF COVERAGE

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

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

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

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

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

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

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

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

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

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

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

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

- for the Member and the Member's Dependents:
  - the date the Group Policy is terminated; or
  - the end of the premium period for which premium is paid if the Member fails to make timely payment of a required premium; or
  - the date 24 months after the date the Member enters active military duty; or
  - the date after the day in which the Member fails to return to Active Work or apply for reemployment with the Policyholder.
- for the Member's Dependents:
  - the date Dependent insurance would otherwise cease as provided on GH 9015; or

- any date desired, if requested by the Member before that date.

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

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

MEMBER INSURANCE - SICKNESS OR INJURY

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

- the date insurance would otherwise cease as provided in GH 9014; or
- the date the Member recovers; or
- the Member is covered under the USERRA continuation provision.
- coverage has been continued under this section for 12 consecutive month(s).

If insurance under the Group Policy is subject to COBRA, this continuation period will run concurrent with the COBRA continuation period.

MEMBER INSURANCE - LAYOFF OR APPROVED LEAVE OF ABSENCE

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

- the date insurance would otherwise cease as provided in GH 9014; or
- the date the layoff or approved leave of absence ends; or
- the date the Member becomes eligible for any other group vision care coverage; or
- the date one month after the date Active Work ends.

If insurance under the Group Policy is subject to COBRA, this continuation period will run concurrent with the COBRA continuation period.

DEPENDENT INSURANCE – DEVELOPMENTALLY, PHYSICALLY OR MENTALLY DISABLED CHILDREN

Qualification

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

- the child is incapable of self-support as the result of a Developmental, Physical or Mental Disability and they became so before reaching the maximum age and is dependent on the Member for primary support; and
- except for age, the child continues to be a Dependent Child as defined in GH 9012; and
- proof of the child's incapacity is sent to Principal Life within 31 days after the date the child reaches the maximum age; and
- further proof that the child remains incapable of self-support is provided when Principal Life requests; and

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

Period of Continuation

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

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

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

REINSTATEMENT

Terminated insurance will be reinstated if:

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

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

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

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

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

Federal Required Family and Medical Leave Act (FMLA)

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

DESCRIPTION OF BENEFITS

VISION CARE EXPENSE INSURANCE (PAYMENT PROVISIONS)

Benefit Qualification

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

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

Benefits Payable

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

Payment Conditions

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

Class	Scheduled Benefits
All Members and Dependents	As shown below

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

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

as described below.

Preferred Provider or Participating Retail Chain Provider Benefits

Obtaining Benefits from Preferred Providers

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

Copayment

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

The Copayment does not apply to elective contact lenses.

Vision Examination

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

Lenses (Glass or Plastic)

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

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

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

Frames

Covered up to $150* (after the Copayment) (one set per 24 month period).

*$80 at selected Participating Retail Chain Providers

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

Contact Lenses

Elective contact lens fitting and evaluation services are covered in full (once per 12 month period), after a $60 Copayment. Elective contact lenses (materials only) are covered up to $150 (per 12 month period).

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

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

Low Vision

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

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

Covered in full (after Copayment)

Supplemental aids

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

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

Non-Preferred Provider Benefits

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

Maximum Payment Limit

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

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

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

Low Vision

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

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

Covered up to $125

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

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

DESCRIPTION OF BENEFITS

VISION CARE EXPENSE LIMITATIONS AND EXCLUSIONS

Limitations

No benefits will be paid for:

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

Exclusions

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

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

COORDINATION WITH OTHER BENEFITS

Applicability

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

Definitions

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

- **Plan**

  Any vision care expense benefits provided under:

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

  The term Plan will not include benefits provided under a student accident policy, nor will the term Plan include benefits provided under a state medical assistance program where eligibility is based on financial need.

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

- **Allowable Expense**

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

- **Claim Determination Period**

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

Effect on Benefits

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

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

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

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

Order of Benefit Determination

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

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

  - Secondary to the Plan covering the person as a Dependent; and

  - Primary to the Plan covering the person as other than a Dependent (e.g., a retired employee);

  then the benefits of the Plan covering the person as a Dependent are determined before those of the Plan covering that person as other than a Dependent.

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

  However, if another Plan does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits

- Dependent Child--Separated or Divorced Parents. If two or more Plans cover a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

  - first, the Plan of the parent with custody of the child;

  - then, the Plan of the spouse of the parent with custody of the child; and

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

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

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

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

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

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

    - second, the benefits under the continuation coverage.

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

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

Medicare Exception

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

Exchange of Information

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

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

Facility of Payment

The Claims Administrator may reimburse any other Plan if:

- benefits were paid by that other Plan; but

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

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

Right of Recovery

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

- the person to or for whom the benefits were paid; or

- the other companies or organizations liable for the benefit payments.

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

CLAIM PROCEDURES

Notice of Claim

Written notice of claim must be given to the Claims Administrator within 20 calendar days 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 the claim must be filed with the Claims Administrator in order to obtain payment of benefits. The Policyholder will provide appropriate forms to assist the Member in filing claims. If the forms are not provided within 15 calendar days after the Claims Administrator 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 loss, written proof covering the occurrence, character and extent of the loss.

Proof of Loss

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

Payment, Denial, and Review

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

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

If a claim is not payable or cannot be processed, the Claims Administrator will provide a detailed explanation including:

a. the specific reason(s) for the adverse benefit determination;

b. reference to the specific plan provision(s) on which the determination is based;

c. a description of any additional material or information necessary for the Claimant to complete the claim;

d. a description of the review procedures of the Claims Administrator including time limits applicable to such procedures and the Claimant's right to civil action following an adverse benefit on review;

e. if an internal rule, guideline, protocol, other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that

such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request.

If the claim is not paid within thirty (30) days of receipt of proof of loss, and the delay or denial is due to lack of a good faith attempt to settle the claim, the claim bears interest at the rate established by state law from the expiration of thirty (30) days from the receipt of proof of loss.

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

A Claimant may request an appeal of a claim denial by written request to the Claims Administrator within 180 calendar days of receipt of notice of the denial. The Claims Administrator will make a full and fair review of the claim. The Claims Administrator may require additional information to make the review. The Claims Administrator will notify the Claimant in writing of the appeal decision within 30 calendar days of receiving the appeal request. The notification will include:

a. the specific reason or reasons for the adverse benefit determination;

b. reference to the specific plan provision(s) on which the determination is based;

c. upon request and free of charge, the Claimant is entitled to receive reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim for benefits;

d. if an internal rule, guideline, protocol, other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; and

e. the Claimant and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office and the State insurance regulatory agency.

The first level of appeal review must be completed before filing a civil action or pursuing any other legal remedies.

After exhaustion of the formal appeal process, a Claimant may request a secondary appeal. The appeal must be requested in writing. The Claimant may submit written comments, documents, records, and other information relating to the claim for benefits within 60 calendar days after receipt of the Claims Administrator's response to the initial appeal. The Claims Administrator will communicate its final determination within 45 calendar days of request for a secondary appeal. However, if the appeal cannot be processed due to incomplete information, the Claims Administrator will send a written explanation of the additional information that is required or an authorization for the Claimant's Signature so information can be obtained from the provider. This information must be sent to the Claims Administrator within 45 calendar days of the date of the written request for the information or as required by state law. Failure to comply with the request for additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 30 calendar days of the receipt of all necessary information to properly review the appeal request or as required by state law.

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

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

Complaints and Grievances

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

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

Facility of Payment

The Claims Administrator will normally pay all Non-PPO benefits directly to the Member. Also, in the special instances listed below, payment will be as indicated with proper legal documentation. All payments so made will discharge Principal Life to the full extent of those payments.

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

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

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

Legal Action

Legal action to recover benefits under the Group Policy may not be started earlier than 60 calendar days after proof of loss is filed and before the appeal procedures have been exhausted. Further, no legal action may be started later than three years after that proof is required to be filed.

Time Limits

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

VERMONT MANDATORY CIVIL UNION NOTICE
Applicable only to Members with Civil Unions established before September, 2009

PURPOSE:

Vermont law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons. This Notice is a part of the booklet certificate and complies with Vermont law.

DEFINITIONS, TERMS, CONDITIONS, AND PROVISIONS:

The definitions, terms, conditions, and any other provisions of the Group Policy, contract, certificate, and/or riders and endorsements to which this mandatory Notice is attached are hereby revised and superseded as follows:

Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage," "spouse," "husband," "wife," "dependent," "next of kin," "relative," "beneficiary," "survivor," "immediate family," and any other such terms include the relationship created by a civil union established according to Vermont law.

Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage," "divorce decree," "termination of marriage," and any other such terms include the inception or dissolution of a civil union established according to Vermont law.

"Dependent" means a spouse, a party to a civil union established according to Vermont law, and a child or children (natural, stepchild, legally adopted, or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

"Child or covered child" means a child (natural, stepchild, legally adopted, or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE

Vermont law grants parties to a civil union the same benefits, protections, and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections, and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a civil union. For example, federal law, the Employee Income Retirement Security Act of 1974 known as "ERISA," controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer health benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer's enrollment of a party to a civil union in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of a party to a civil union if the public employer provides health benefits to the dependents of married persons.

Federal law also controls group health insurance continuation rights under "COBRA" for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a civil union and their families may or may not have access to certain benefits under the Group Policy, contract, certificate, rider, or notice that derive from federal law. You are advised to seek expert advice to determine your rights under the contract.

PRINCIPAL LIFE INSURANCE COMPANY

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 August 1, 2022.

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

Uses and Disclosures of Your Health Information

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

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

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

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

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

Information Received Pre-enrollment. We may request and receive from you and your health care providers health information prior to your enrollment under the insurance. We will use this information to determine whether you are eligible to enroll under the insurance and to determine the rates. We will not use or disclose any

genetic information we obtain about you or provided from your family history. If you do not enroll, we will not use or disclose the information we obtained about you for any other purpose. Information provided on enrollment forms or applications will be utilized for all coverages being applied for, some of which may be protected by the state, not federal, privacy laws.

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

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

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

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

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

We will adhere to all state and federal laws or regulations that provide additional privacy protections. We are prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of determining eligibility for coverage, the amount of benefits or premiums or discounts, including rebates, payments in kind, or other premium or benefit differential mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program. We will not request, use or disclose psychotherapy notes without your authorization (except to defend ourselves in a legal action brought by you.) We will not sell your protected health information or use or disclose it for marketing purposes without your authorization, except as permitted by law. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information.

Your Rights

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

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

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

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

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

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

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

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

STATEMENT OF RIGHTS

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

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

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

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

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: 32-0575389

2. **Type of Administration:**

   Vision: Insurance Contract.

3. **Plan Administrator:**

   LONG FALLS PAPERBOARD LLC
   161 WELLINGTON RD
   BRATTLEBORO VT 05301

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

4 **Plan Sponsor:**

   LONG FALLS PAPERBOARD LLC
   161 WELLINGTON RD
   BRATTLEBORO VT 05301

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

   LONG FALLS PAPERBOARD LLC
   161 WELLINGTON RD
   BRATTLEBORO VT 05301
   (802)257-5961

   Legal process may also be served upon the plan administrator.

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

   All active full-time employees of LONG FALLS PAPERBOARD LLC, and provided you are a Member as defined in the DEFINITIONS Section of this booklet (page GH 9012).

7. Sources and Methods of Contributions to the Plan:

   Employee pays all of employee's contribution.
   Employee pays all of Dependent's contributions (if employee elects to enroll Dependents in plan).

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

   December 31

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Principal Life Insurance Company
Des Moines, Iowa 50392-0002