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01/01/2024

GROUP BOOKLET-CERTIFICATE FOR MEMBERS OF:

FIVE-TOWN HEALTH ALLIANCE INC DBA MOUNTAIN COMMUNITY HEALTH

ALL MEMBERS
GROUP VOLUNTARY ACCIDENT INSURANCE

Print Date: 01/18/2024

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CERTIFICATE OF COVERAGE RIDER
WELLNESS BENEFIT

Insurance under the Group Policy is amended to include coverage for Wellness Benefits.

Effective as of January 1, 2024, the booklet-certificate to which this Rider is attached is hereby amended with respect to and to the extent provided below.

The Group Policy will pay a wellness benefit if the Member or insured Dependent has one of the following wellness tests or procedures performed by a Physician.

One wellness benefit for the flat amount of $50 will be payable once per calendar year for the Member and insured Dependent.

The Member or insured Dependent must submit proof of the test or procedure performed. The Group Policy will pay a wellness benefit regardless of the results or the cost of the test or procedure.

Wellness tests or procedures covered are limited to:

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

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

See your employer if you have questions concerning this Rider.

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

PRINCIPAL LIFE INSURANCE COMPANY
711 High Street

Des Moines, Iowa 50392-0002

Executive Vice President,
General Counsel and Secretary

Chairman, President and
Chief Executive Officer

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

This booklet-certificate (including any supplement) may be utilized in part in meeting the Summary Plan Description requirements under ERISA for insured employees (or those listed on the front cover) of the Policyholder who are eligible for Group Voluntary Accident 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 Accident insurance. It provides a limited specified benefit. It is not a substitute for medical coverage. THIS POLICY DOES NOT MEET THE MINIMUM COVERAGE REQUIREMENTS OF THE AFFORDABLE CARE ACT. YOU SHOULD NOT PURCHASE THIS POLICY UNLESS YOU ARE ALREADY COVERED BY COMPREHENSIVE MAJOR MEDICAL 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 Covered Persons subject to the terms, conditions, limitations and exclusions of the Group Policy. Principal Life issues the Group Policy based on the employer application and payment of the required policy premium. The Group Policy, the incorporated Certificate of Coverage, and the attached employer application make up the entire contract.

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

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

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

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

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

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

Accident

An act, event or occurrence that is not reasonably foreseeable, or that could not have been expected or anticipated.

Active Work; Actively at Work

Employees are considered Actively at Work if they are able and available for active performance of all regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered Active Work provided an Employee is able and available for active performance of all regular duties on the effective date of coverage and was working the day immediately prior to the date of absence.

Covered Accident

An Accident that:

- occurs while the Group Policy and the Covered Person's coverage is in force; and
- results in an Injury; and
- is not otherwise excluded under the terms of this policy.

Covered Person

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

Date of Issue

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

Dentist

- A person licensed to practice dentistry; and
- A licensed Physician who provides dental Treatment or Service.

Dependent

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

Dependent Child(ren)

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

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

- An Employee's stepchild, if that child:

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

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

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

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

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

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

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 disability, cerebral palsy, epilepsy, or other neurological disorder; and

- is Diagnosed by a Physician as a permanent or long-term continuing condition.

Diagnosed or Diagnosis

A definitive identification of the Injury made by a Physician and supported by documentation of all appropriate and defined studies:

- based upon the usage of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations; and

- meeting any diagnostic requirements stated in the Group Policy for the particular Injury being diagnosed.

Employee

Any PERSON who is residing in the United States, who is a U.S. citizen or is legally working in the United States, who is regularly scheduled to work for the Policyholder for at least 30 hours per week. The Employee must be compensated by the Policyholder and either the Policyholder or Employee must be able to show taxable income on

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

Grace Period

The first 31 day period following a premium due date.

Group Policy

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

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

Home Confined

Due to sickness or injury, the Dependent is unable to carry on the regular and usual activities of a healthy person of the same age and sex and unable to leave his or her home except to receive medical treatment.

Hospital

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

Immediate Family

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

Incur or Incurred

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

Injury

Bodily injury directly caused by an Accident which is not the result of disease or bodily infirmity.

Insurance Month

Calendar month.

Member

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

Natural Tooth

Any tooth or part of a tooth that is organic and formed by the natural development of the body (i.e. not manufactured).

Period of Limited Activity

Any period of time during which a Dependent is:

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

Physical or Mental 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.

Physician

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

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

Policy Anniversary

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

Policyholder

FIVE-TOWN HEALTH ALLIANCE INC DBA MOUNTAIN COMMUNITY HEALTH

Sickness

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

Skilled Nursing Facility

An institution (including one providing sub-acute care), or distinct part thereof, that is licensed by the proper authority of the state in which it is located to provide skilled nursing care and that:

- is supervised on a full-time basis by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) or a licensed registered nurse (R.N.); and
- has transfer arrangements with one or more Hospitals, a utilization review plan, and operating policies developed and monitored by a professional group that includes at least one M.D. or D.O.; and

- has an existing contract for the services of an M.D. or D.O., maintains daily records on each patient, and is equipped to dispense and administer drugs; and

- provides 24-hour nursing care and other medical treatment.

Not included are rest homes, homes for the aged, nursing homes, or places for treatment of mental disease, drug addiction, or alcoholism.

Treatment or Service

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

HOW TO BE INSURED - EMPLOYEES

Eligibility

Only Employees are eligible for insurance.

Anyone meeting the definition of Employee on January 1, 2024, will be eligible on that date.

Anyone meeting the definition of Employee later will be eligible on the first of the Insurance Month coinciding with or next following the date the Employee completes 30 consecutive days of continuous Active Work.

Effective Date - Actively at Work

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

Individual Incontestability

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

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

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

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

Effective Date for Initial Insurance

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

Insurance will normally be effective on:

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

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

Scheduled Benefit Changes

A Member's benefits may be changed due to:

- change in insurance class; or
- changes by policy amendment; or

- change in the Member's family status:

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

- marriage or divorce;
- death of a spouse or child;
- birth or adoption of a child;
- termination of employment by the Member's spouse or a change in the spouse's employment that causes loss of group Accident coverage.

Effective Date for Scheduled Benefit Changes

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

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

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

Effective Date for Changes - Actively at Work

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

Annual Enrollment Period

Eligibility

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

- failed to enroll
  - during the first period in which the Employee was eligible to enroll; or
  - during any previous annual enrollment period.
- previously terminated insurance under this Group Policy and wants to re-enroll.

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

Enrollment Period

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

Effective Date

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

Termination

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

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

Termination for Fraud

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

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

Insurance While Outside of the United States

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

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

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

HOW TO BE INSURED - DEPENDENTS

Eligibility

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

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

Effective Date

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

- In no event will Dependent Accident Insurance be in force if the Employee is not insured for Member Accident Insurance.
- If a Dependent is in a Period of Limited Activity on the date initial Dependent Accident Insurance or an increase in Dependent Accident Insurance Scheduled Benefit would otherwise be effective, the Dependent will not be insured or an increase will not be effective until the Period of Limited Activity ends.
- If Dependent Accident Insurance is then in force for any other Dependent, a new Dependent (other than a newborn child) will be insured on the date acquired, provided the new Dependent is not in a Period of Limited Activity. Requests for insurance are not required provided Principal Life has been notified of the new Dependent within 31 days after the date the Dependent is acquired.
- If Dependent Accident Insurance is then in force for any other Dependent, a newly born child will be insured from the moment of live birth, provided the child meets the definition of a Dependent Child.

Individual Incontestability

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

Termination

Insurance for Dependents will terminate on the earliest of:

- the date Member Accident Insurance ceases; or
- the date Dependent Accident Insurance is removed from the Group Policy; or
- the date the last premium is paid for a Dependent's insurance; or
- any date desired, if requested by the Member before that date.

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

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

Insurance While Outside of the United States

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

CONTINUATION OF COVERAGE

FMLA 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, 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.

Sickness or Injury

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

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

Layoff or Approved Leave of Absence

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

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

Dependent Child Accident Insurance - Developmentally, Physically or Mentally Disabled Children

Qualification

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

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

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

- further proof that the child remains incapable of self-support is provided when Principal Life requests; 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 of return to work. However, the Actively at Work and Period of Limited Activity provisions will apply.

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

- will not be considered an interruption of continuous coverage; and

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

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

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

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 and Period of Limited Activity requirements of the Group Policy.

Reinstatement of Insurance for a Covered Person When Insurance Ends due to Living Outside of the United States

If insurance for a Covered Person terminates because the Covered Person is outside of the United States, the Covered Person may become eligible again for insurance under the Group Policy, but only if:

- the Employee or Dependent returns to the United States within six months of the date on which insurance terminated because they were outside of the United States; and

- for the Employee, the Employee returns to Active Work in the United States for the Policyholder for a period of at least 30 consecutive days. The Employee will be eligible for insurance on the day immediately following completion of the 30 consecutive days of Active Work; and

- for the Dependent, he or she remains in the United States for 30 consecutive days. If the Dependent does so, he or she will be eligible for reinstatement of insurance on the day after completion of the 30 consecutive days of residence.

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

DESCRIPTION OF BENEFITS
BENEFIT PROVISIONS

ACCIDENT INSURANCE

Benefit Qualification

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

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

Class ALL MEMBERS

Benefits Payable

Injury	**Scheduled Benefit**	
Burn		
2nd degree up to 25% of body	$500	
2nd degree over 25% of body	$1,500	
3rd degree up to 25% of body	$2,500	
3rd degree over 25% of body	$5,000	
Coma	$15,000	
Concussion	$500	
Dental Injury	$500	
Dislocation	**Open Reduction** (surgical)	**Closed Reduction** (non-surgical)
Ankle	$3,000	$1,500
Collarbone	$3,000	$1,500
Elbow	$3,000	$1,500
Foot (excluding toes)	$3,000	$1,500
Hand (excluding fingers)	$3,000	$1,500

Hip	$7,500	$3,750
Knee	$5,000	$2,500
Lower jaw	$3,000	$1,500
Shoulder	$3,000	$1,500
Wrist	$3,000	$1,500
Eye Injury with Surgical Repair	$500	
Fracture	**Open Reduction** (surgical)	**Closed Reduction** (non-surgical)
Ankle	$3,000	$1,500
Arm	$3,000	$1,500
Collarbone	$3,000	$1,500
Elbow	$3,000	$1,500
Facial bones	$3,000	$1,500
Foot (excluding toes)	$3,000	$1,500
Hand (excluding fingers)	$3,000	$1,500
Hip	$10,000	$5,000
Jaw	$3,000	$1,500
Knee cap	$3,000	$1,500
Lower leg (fibula, tibia)	$5,000	$2,500
Pelvis	$5,000	$2,500
Rib	$1,000	$500
Shoulder blade	$3,000	$1,500
Skull (depressed)	$10,000	$5,000
Skull (non-depressed)	$5,000	$2,500
Sternum	$2,000	$1,000
Tailbone (coccyx)	$1,000	$500
Thigh (femur)	$10,000	$5,000
Vertebrae	$5,000	$2,500
Vertebral processes	$2,000	$1,000
Wrist	$3,000	$1,500
Injuries Not Specifically Listed	$100	
Internal Injury	$1,500	
Knee Cartilage Injury with Surgical Repair	$1,500	

Ruptured Disc with Surgical Repair	$1,500
Tendon / Ligament / Rotator Cuff Injury with Surgical Repair	$1,500

If a benefit is paid for an Injury and the Covered Person later qualifies for a higher Scheduled Benefit for the same Covered Accident, we will pay the appropriate Scheduled Benefit less any amount previously paid.

BURN - We will pay a Burn benefit when a Covered Person Incurs a 2nd or 3rd degree Burn as a result of a Covered Accident. The Burn must be Diagnosed and treated by a Physician.

Burn means:

- 2nd degree burns, which are those that have burned through the first layer of skin as well as the second layer of skin (dermis); and
- 3rd degree burns, which are those that burn through all layers of the skin and cause permanent tissue damage.

If the burns meet more than one of the Burn benefit classifications, we will pay the single highest Burn benefit.

We will pay 150% of the Burn benefit if the Burn requires a Skin Graft performed.

Skin Graft means a procedure in which healthy skin is removed (harvested) and transferred to another area of the body where the skin has been severely damaged by burns.

We will pay one Burn benefit per Covered Accident.

COMA - We will pay a Coma benefit when a Covered Person has been in a Coma as a result of a Covered Accident. The Coma must require intubation for respiratory assistance and be Diagnosed and treated by a Physician.

Coma means a continuous state of profound unconsciousness for 15 or more consecutive days characterized by the absence of:

- eye opening,
- motor response, and
- verbal response.

The term coma does not include any medically induced coma.

We will pay one Coma benefit per Covered Accident.

CONCUSSION - We will pay a Concussion benefit when a Covered Person Incurs a Concussion as a result of a Covered Accident. The Concussion must be Diagnosed and treated by a Physician using a medical imaging procedure.

Concussion means a traumatic blow to the head that results in loss of consciousness, confusion, or loss of memory.

We will pay one Concussion benefit per Covered Accident.

DENTAL INJURY - We will pay a Dental Injury benefit when a Covered Person Incurs a broken tooth which requires extraction or repair with a crown, implant or denture as a result of a Covered Accident. The Dental Injury must be treated by a Dentist.

We will pay one Dental Injury benefit per Covered Accident. No benefit will be payable for an Injury to a tooth that is not a sound, natural tooth or for an Injury that is caused by biting or chewing.

DISLOCATION - We will pay a Dislocation benefit when a Covered Person Incurs a Dislocation requiring correction through Open or Closed Reduction as a result of a Covered Accident. The Dislocation must be Diagnosed and treated by a Physician.

Dislocation means a completely separated joint due to an Injury. The dislocation must require correction with anesthesia by a Physician. If a Physician corrects the Dislocation without anesthesia, we will pay 25% of the Scheduled Benefit amount for the applicable Dislocation.

Open Reduction means surgical repair of the Dislocation.

Closed Reduction means non-surgical manipulative repair of the Dislocation.

If a Physician Diagnoses the Dislocation as a Partial Dislocation, we will pay 25% of the Scheduled Benefit amount for the applicable Dislocation.

Partial Dislocation means a joint that is misaligned but not completely separated.

If multiple joints are dislocated due to the same Covered Accident, we will pay a maximum of 200% of the Scheduled Benefit amount for the Dislocation with the highest benefit for all dislocations combined.

We will pay a Dislocation benefit only for the first dislocation of a joint after the effective date of coverage for the Covered Person. Subsequent dislocations of the same joint will not be covered.

EYE INJURY WITH SURGICAL REPAIR - We will pay an Eye Injury with Surgical Repair benefit when a Covered Person Incurs an Eye Injury requiring surgical repair as a result of a Covered Accident. The Eye Injury must be Diagnosed and treated by a Physician.

We will pay one Eye Injury with Surgical Repair benefit per Covered Accident. An examination with or without anesthesia is not considered surgical repair. No benefit will be payable for an Injury which involves only the eyelid.

FRACTURE - We will pay a Fracture benefit when a Covered Person Incurs a Fracture requiring correction through Open or Closed Reduction as a result of a Covered Accident. The Fracture must be Diagnosed and treated by a Physician.

Fracture means a complete break in a bone which can be seen by x-ray.

Open Reduction means the surgical repair of the fracture.

Closed Reduction means non-surgical manipulative repair of the fracture, including immobilization.

If a Physician Diagnoses the Fracture as a Chip Fracture, we will pay 25% of the Scheduled Benefit amount for the applicable Fracture.

Chip Fracture means a Fracture in which a piece of the bone is completely broken off near a joint at a place where a ligament is usually attached.

We will pay one Fracture benefit per bone per Covered Accident. If multiple bones are fractured due to the same Covered Accident, we will pay a maximum of 200% of the Scheduled Benefit amount for the Fracture with the highest benefit for all fractures combined.

If we have paid benefits for a Fracture previously Incurred by a Covered Person, any new claim for a Fracture will be payable only if the Fracture is the result of a separate and distinct Covered Accident that occurred after the previous Fracture has completely healed.

INJURIES NOT SPECIFICALLY LISTED - We will pay an Injuries Not Specifically Listed benefit when a Covered Person Incurs an Injury not otherwise specifically listed as a result of a Covered Accident. The Injury must be Diagnosed and treated by a Physician.

We will pay 200% of the Injuries Not Specifically Listed benefit if the Injury is surgically repaired by a Physician.

We will pay one Injuries Not Specifically Listed benefit per Covered Accident.

INTERNAL INJURY - We will pay an Internal Injury benefit when a Covered Person Incurs an Internal Injury as a result of a Covered Accident. The Injury must be Diagnosed and treated by a Physician.

Internal Injury means a trauma that involves an organ within the cranial, abdominal pelvic cavity or thoracic cavity or internal bleeding into a body cavity.

We will pay 200% of the Internal Injury benefit if the Internal Injury is surgically repaired by a Physician.

We will pay one Internal Injury benefit per Covered Accident. This benefit is not payable for exploratory surgery without repair or for injuries related to a hernia.

KNEE CARTILAGE INJURY WITH SURGICAL REPAIR - We will pay a Knee Cartilage Injury with Surgical Repair benefit when a Covered Person Incurs a torn, ruptured or severed knee cartilage (meniscus) in one or both knees requiring surgical repair as a result of a Covered Accident. The Injury must be Diagnosed and treated by a Physician and surgically repaired by a Physician.

We will pay one Knee Cartilage Injury with Surgical Repair benefit per Covered Accident. This benefit is not payable for exploratory surgery without repair.

RUPTURED DISC WITH SURGICAL REPAIR - We will pay a Ruptured Disc with Surgical Repair benefit when a Covered Person Incurs one or more ruptured discs in the spine requiring surgical repair as a result of a Covered Accident. The Injury must be Diagnosed and treated by a Physician and surgically repaired by a Physician.

We will pay one Ruptured Disc with Surgical Repair benefit per Covered Accident. This benefit is not payable for exploratory surgery without repair.

TENDON / LIGAMENT / ROTATOR CUFF INJURY WITH SURGICAL REPAIR - We will pay a Tendon / Ligament / Rotator Cuff Injury with Surgical Repair benefit when a Covered Person Incurs one or more torn, ruptured or severed tendons, ligaments and/or rotator cuffs requiring surgical repair as a result of a Covered Accident. The Injury must be Diagnosed and treated by a Physician and surgically repaired by a Physician.

We will pay up to two Tendon / Ligament / Rotator Cuff Injury with Surgical Repair benefits per Covered Accident. This benefit is not payable for exploratory surgery without repair.

DESCRIPTION OF BENEFITS

LIMITATIONS AND EXCLUSIONS

Limitations

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

- intentionally self-inflicted injury, unless the illness, treatment or medical condition arising therefrom is caused by a mental condition as defined in 8 V.S.A. 4089b; or
- voluntary participation in an auto-erotic activity; or
- war or act of war; or
- voluntary participation in a felony, insurrection, or riot; or
- duty as a member of a military organization; or
- injuries Diagnosed outside of the United States unless the Diagnosis can be confirmed by a Physician in the United States; or
- deliberate use of poison, gas, fumes, or household items (such as aerosols), whether by ingestion, injection, inhalation or absorption; or
- sickness, disease, medical or surgical treatment of disease, or complications following the surgical treatment of disease; or
- operating, learning to operate, or serving as a crew member or flight for life personnel of any aircraft or hot air balloon except as a crew member in a Policyholder owned or leased aircraft on company business; or
- jumping, parachuting, or falling from any aircraft or hot air balloon, including those which are not motor-driven; parasailing, bungee jumping or other aeronautic activities; or
- riding in or driving any motor driven vehicle in a race, stunt show or speed test; or
- any Dental Injury that occurs from biting or chewing; or
- practicing for or participating in any semi-professional or professional competitive athletic activity, including officiating or coaching, for which any type of compensation or remuneration is received; or
- any Injury to a Dependent Child received during child birth.

Exclusions

No benefits will be paid for any Injury:

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

CLAIM PROCEDURES

Notice of Claim

Written notice of claim must be given to Principal Life within 20 days of the Covered Accident. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

Claim Forms

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

Proof of Covered Accident

Completed claim forms and other information needed to prove the Covered Accident should be filed promptly. Written proof of the Covered Accident should be sent to Principal Life within 180 days after the date of the Covered Accident. Proof required includes the date, nature, and extent of the Injury. Principal Life may request additional information to substantiate a Covered Accident or require a signed unaltered authorization to obtain that information from the provider. Failure to comply with such request could result in declination of the claim. 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 Principal Life.

Payment, Denial, and Review

Vermont state law requires that any claim liability be affirmed or denied within a reasonable time and payment offered within 30 calendar days of receipt of due proof of loss. If Principal Life fails to pay the claim 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 proof of loss has not been established from the claimant to process a claim, ERISA further allows a claimant up to 45 days from the request to provide all additional information.

In actual practice, benefits under this Group Policy will be payable sooner, provided Principal Life received complete and proper proof of Disability. Further, if a claim is not payable or cannot be processed, Principal Life will submit a detailed explanation of the basis for its denial. The explanation will include:

- The specific reason(s) for the adverse benefit determination;
- Reference to the specific plan provision(s) on which the determination is based;
- A description of any additional material or information necessary for the claimant to complete the claim;
- A description of Principal Life's review procedures including time limits applicable to such procedures and the claimant's right to civil action following an adverse benefit on review;
- 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 adverse benefit determination is based on necessity or experimental treatment or similar exclusion, either an explanation of the scientific or clinical judgment for the determination or a statement that an explanation will be provided free of charge upon request.

A claimant may request an appeal of a claim denial by written request to Principal Life within 180 days of receipt of notice of the denial. Principal Life will make a full and fair review of the claim. Principal Life may require additional information to make the review. Principal Life will notify the claimant in writing of the appeal decision within 60 days after the receipt of the appeal request. The first level of appeal review must be completed before filing a civil action or pursuing any other legal remedies. The notification will include:

- The specific reason or reasons for the adverse benefit determination;

- Reference to the specific plan provision(s) on which the determination is based;

- 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;

- 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;

- If the adverse benefit determination is based on necessity or experimental treatment or similar exclusion, either an explanation of the scientific or clinical judgment for the determination or a statement that an explanation will be provided free of charge upon request;

- 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.

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

Settlement of Proceeds

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

Facility of Payment

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

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

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

Medical Examinations

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

Legal Action

Legal action to recover benefits under the Group Policy may not be started earlier than 60 days after proof of the Covered Accident 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

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: 26-3010066

2. **Type of Administration:**

   Accident: Insurance Contract.

3. **Plan Administrator:**

   FIVE-TOWN HEALTH ALLIANCE INC DBA MOUNTAIN COMMUNITY HEALTH
   61 PINE STREET
   BRISTOL VT 05443

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

4. **Plan Sponsor:**

   FIVE-TOWN HEALTH ALLIANCE INC DBA MOUNTAIN COMMUNITY HEALTH
   61 PINE STREET
   BRISTOL VT 05443

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

   FIVE-TOWN HEALTH ALLIANCE INC DBA MOUNTAIN COMMUNITY HEALTH
   61 PINE STREET
   BRISTOL VT 05443
   Telephone: (802)453-3911

   Legal process may also be served upon the plan administrator.

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

   All active full-time employees of FIVE-TOWN HEALTH ALLIANCE INC DBA MOUNTAIN COMMUNITY HEALTH, and provided you are a Member as defined in the DEFINITIONS Section of this booklet (page GH 8012).

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

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

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

   September 30

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Principal Life Insurance Company
Des Moines, Iowa 50392-0002