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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 Critical Illness Insurance

Print Date: 01/18/2024

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CERTIFICATE OF COVERAGE RIDER
HEALTH SCREENING BENEFIT

Insurance under the Group Policy is amended to include a Health Screening Benefit.

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.

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

Health screening tests or procedures covered are limited to:

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

The Covered Person must submit proof of the test or procedure within one year of the date the test or procedure was performed.

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

CERTIFICATE OF COVERAGE RIDER
INFECTIOUS DISEASE BENEFIT

Insurance under the Group Policy is amended to include an Infectious Disease Benefit.

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

Infectious Disease means one of the covered infectious or contagious diseases shown in the Benefits Payable table that is Diagnosed by a Physician and, as a direct result of such diagnosis, a Covered Person is confined to a Hospital.

Benefit Qualification

To qualify for benefit payment, all of the following must occur while insured under this Rider:

- the Covered Person Incurs an Infectious Disease; and
- the Covered Person is confined to a Hospital for at least 3 consecutive days for the treatment of the Infectious Disease or dies after being confined but before meeting the confinement requirement.

Benefits Payable

Covered infectious diseases include:

Critical Illness	% of Scheduled Benefit for First Occurrence	% of Scheduled Benefit for Additional Occurrences
COVID-19	25%	25%
Diphtheria	25%	25%
Encephalitis	25%	25%
Legionnaire's Disease	25%	25%
Lyme Disease	25%	25%
Malaria	25%	25%
Meningitis	25%	25%
Methicillin-resistant staphylococcus aureus (MRSA)	25%	25%
Necrotizing Fasciitis	25%	25%
Osteomyelitis	25%	25%
Poliomyelitis	25%	25%
Rabies	25%	25%
Sepsis	25%	25%
Tetanus	25%	25%
Tuberculosis	25%	25%

The Infectious Disease will be deemed to be Incurred on the date it is Diagnosed.

We will only pay for infectious diseases specifically listed in this Rider.

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 Critical Illness insurance.

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

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

Certificate of Coverage

Important Notice: **This is Critical Illness insurance. It provides a limited specified benefit. It is not a substitute for medical coverage. 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, and any Employee applications make up the entire contract.

This insurance has been designed to provide a benefit payment when a covered Critical Illness occurs. 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 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 Scheduled Benefits Summary, 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.

TABLE OF CONTENTS

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

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

Activities of Daily Living (ADL)

- Bathing: the ability to wash oneself in the tub or shower or by sponge with or without equipment or adaptive devices.
- Dressing: the ability to put on and take off garments and medically-necessary braces or artificial limbs usually worn and to fasten or unfasten them.
- Eating/feeding: the ability to get nourishment into the body by any means once it has been prepared and made available.
- Toileting: the ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene and to care for clothing.
- Transferring: the ability to move in and out of a chair or bed with or without equipment such as canes, quad canes, walkers, crutches, grab bars or other support devices including mechanical or motorized devices.
- Continence: the ability to voluntarily control bowel and bladder function, or in the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

Alzheimer's Disease

A progressive degenerative disease of the brain resulting in loss of intellectual capacity involving impairment of memory and judgment. Alzheimer's Disease does not include other types of dementing organic brain disorders or psychiatric illnesses.

Diagnosis must be made by a board-certified psychiatrist, neurologist, geriatrician or neuropsychologist and certified by a Physician as requiring substantial physical assistance from another adult to perform at least 2 Activities of Daily Living (ADLs) simultaneously for at least 90 consecutive days beginning after the effective date of coverage and continuing while coverage is in force.

Diagnosis of Alzheimer's Disease must be supported by:

- formal neuropsychological testing; or
- laboratory tests and magnetic resonance imaging, computerized tomography or other reliable imaging techniques that have been completed as part of the evaluation to rule out etiologies other than Alzheimer's Disease.

Alzheimer's Disease will be deemed to be Incurred on the date the Covered Person is unable to perform at least 2 ADLs simultaneously for at least 90 consecutive days due to Alzheimer's Disease.

Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)

A progressive degenerative motor neuron disease marked by muscular weakness and atrophy with spasticity and hyperreflexia. Amyotrophic Lateral Sclerosis does not include other motor neuron diseases.

Diagnosis must be made by a board-certified neurologist and certified by a Physician as requiring substantial physical assistance from another adult to perform at least 2 Activities of Daily Living (ADLs) simultaneously for at least 90 consecutive days beginning after the effective date of coverage and continuing while coverage is in force.

Amyotrophic Lateral Sclerosis will be deemed to be Incurred on the date the Covered Person is unable to perform at least 2 ADLs simultaneously for at least 90 consecutive days due to Amyotrophic Lateral Sclerosis.

Benign Brain Tumor

A non-malignant/non-cancerous tumor or cyst in the brain, cranial nerves or meninges within the skull that results in surgery, radiation treatment or permanent neurological deficit with persisting clinical symptoms, including but not limited to loss of vision, loss of hearing or balance disruption. Benign Brain Tumor does not include tumors of the skull, pituitary adenomas, angiomas or germinomas.

Diagnosis must be made by a board-certified neurologist or neurosurgeon and confirmed by imaging and examination findings.

A Clinical Diagnosis will be accepted only if:

- a pathological Diagnosis cannot be made because it is medically inappropriate or life threatening; and
- there is medical evidence to support the Diagnosis; and
- a Physician is treating the Covered Person for Benign Brain Tumor.

Benign Brain Tumor will be deemed to be Incurred on the date of the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

Carcinoma In Situ

- Chronic lymphocytic leukemia that has not progressed beyond Rai stage 0;
- Carcinoma in situ, which means a malignant neoplasm limited to the epithelium and confined within the basement membrane;
- Early stage melanoma, which means a malignant melanoma of up to 1.0 mm maximum thickness (regardless of Clark level or ulceration) as determined by histological examination using the Breslow method;
- Early stage prostate cancer, which means a localized cancer histologically classified as Gleason score 6 or less, and TNM classification T1aN0M0;
- Papillary microcarcinoma of the thyroid, which means a papillary carcinoma of the thyroid (1 cm or less in diameter) and confined to the thyroid; and
- Noninvasive papillary cancer of the bladder histologically described as TNM classification TaN0m0.

Carcinoma In Situ does not include:

- Carcinoma and melanoma in situ of the skin and all skin cancers; or
- Evidence of cancer cells or cancer genetic material detected by molecular or biochemical probes only (including but not limited to proteomic or DNA/RNA-based techniques) with no lesion amenable to tissue diagnosis.

Diagnosis of Carcinoma In Situ must be based on microscopic (histologic) examination of:

- fixed tissues; or
- preparations of blood or bone marrow.

Such examination must be documented in a written report by a Physician who is board-certified in pathology, hematology or oncology.

A Clinical Diagnosis will be accepted only if:

- a pathological Diagnosis cannot be made because it is medically inappropriate or life threatening; and
- there is medical evidence to support the Diagnosis; and
- a Physician is treating the Covered Person for Carcinoma In Situ.

Carcinoma In Situ will be deemed to be Incurred on the date the Diagnosis is made.

Childhood Conditions

The following covered childhood conditions apply only to children who meet the definition of Dependent Children.

Cerebral Palsy

A group of non-progressive disorders affecting movement, muscle tone and posture caused by the abnormal development of or damage to the motor control centers of the brain. The motor disorders are often accompanied by disturbances of sensation, cognition, communication, perception and/or behavior, as well as seizures and secondary musculoskeletal problems. Cerebral Palsy does not include other similar conditions such as degenerative nerve disorders, genetic diseases, muscle diseases, metabolic disorders, nervous system tumors, coagulation disorders, or other injuries or disorders which may delay early development but can be outgrown.

Diagnosis must be made by a board-certified neurologist or pediatrician who specializes in neurodevelopmental disorders and confirmed by diagnostic testing.

Cerebral Palsy will be deemed to be Incurred on the first date after live birth it is Diagnosed.

Cleft Lip / Palate

Cleft Lip is a congenital failure of the upper lip to close resulting in a narrow opening or gap in the skin of the upper lip that extends to the nostril on one or both sides of the mouth. Cleft Palate is a congenital failure to close an opening in the roof of the mouth that extends to the nasal cavity.

Diagnosis must be made by a board-certified pediatrician, neonatologist or other Physician appropriately specialized and confirmed by diagnostic testing if applicable.

Cleft Lip or Cleft Palate will be deemed to be Incurred on the first date after live birth it is Diagnosed.

If Cleft Lip and Cleft Palate are both present, only one benefit is payable.

Cystic Fibrosis

A progressive genetic disease characterized by the production of abnormally viscous mucus, leading to the blockage of the pancreatic ducts, intestines and bronchi and often resulting in severe damage to the lungs and digestive system and nutritional deficiencies.

Diagnosis must be made by a board-certified pediatrician, pulmonologist or other Physician appropriately specialized and confirmed by a positive sweat test with results of chloride concentrations greater than 60 mmol/L or genetic testing.

Cystic Fibrosis will be deemed to be Incurred on the first date after live birth it is Diagnosed.

Down Syndrome

A congenital disorder arising from a chromosome defect involving chromosome 21, causing intellectual impairment, physical abnormalities and developmental delays.

Down Syndrome includes:

- Trisomy 21: The child has three instead of two chromosome 21's.
- Translocation: An extra part of chromosome 21 is attached to another chromosome.
- Mosaicism: The child has an extra chromosome 21 in only some of the cells but not all of them. The other cells have the usual pair of chromosome 21's.

Diagnosis must be made by a board-certified pediatrician or other Physician appropriately specialized and must include a chromosome test that positively reveals Down Syndrome.

Down Syndrome will be deemed to be Incurred on the first date after live birth it is Diagnosed.

Muscular Dystrophy

A group of genetic diseases characterized by progressive weakness and degeneration of the skeletal or voluntary muscles that control movement.

Diagnosis must be made by a board-certified pediatrician or other Physician appropriately specialized and be based on testing methods, including but not limited to electromyography, muscle biopsy, nerve conduction tests or blood enzyme tests.

Muscular Dystrophy will be deemed to be Incurred on the first date after live birth it is Diagnosed.

Spina Bifida

A congenital defect of the spine in which part of the spinal cord and its meninges are exposed through a gap in the backbone. Spina Bifida includes the conditions of meningocele and myelomeningocele. Spina Bifida does not include spina bifida occulta.

Diagnosis must be made by a board-certified pediatrician, neonatologist, pediatric surgeon or other Physician who specializes in treating congenital defects and confirmed by diagnostic testing.

Spina Bifida will be deemed to be Incurred on the first date after live birth it is Diagnosed.

Clinical Diagnosis

An identification of Invasive Cancer or Carcinoma In Situ based on observation and history, diagnostic and laboratory studies and symptoms.

Coma

A continuous state of profound unconsciousness due to disease lasting at least 7 consecutive days characterized by the absence of eye opening, motor response, and verbal response, and requiring intubation for respiratory assistance. Coma does not include a medically-induced coma or a coma directly resulting from alcohol or drug use.

Diagnosis must be made by a board-certified neurologist and supported by medical evidence.

Coma will be deemed to be Incurred on the date the Covered Person has been in a Coma for at least 7 consecutive days.

Coronary Artery Disease Requiring Coronary Artery Bypass Graft (CAD)

Narrowing or blockage of one or more coronary arteries leading to a recommendation for Coronary Artery Bypass Graft.

Diagnosis must be made by a board-certified cardiologist or cardiothoracic surgeon and supported by pre-operative angiographic evidence.

Coronary Artery Disease Requiring Coronary Artery Bypass Graft will be deemed to be Incurred on the date the Covered Person's coronary artery disease has progressed to an extent such that a Coronary Artery Bypass Graft is medically necessary.

Covered Person

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

Critical Illness

The illnesses listed under Benefits Payable and defined within this Certificate of Coverage.

Date of Issue

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

Dependent

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

Dependent Child(ren)

- An Employee's natural 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 Critical Illness made by a Physician (where applicable) specializing in a particular area of medicine and supported by documentation of all appropriate and defined studies:

- based upon the usage of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations; and
- meeting any diagnostic requirements stated in the Group Policy for the particular Critical Illness 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, and 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 their regular duties. This excludes any person who is scheduled to work for the Policyholder on a seasonal, temporary, contracted, or part-time basis. A person is considered to be residing in the United States if their 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.

First Occurrence

The first time the Covered Person meets the definition of a Critical Illness after being insured under the Group Policy.

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.

Heart Attack

Death of heart muscle due to inadequate blood supply. All of the following criteria must be satisfied:

- typical clinical symptoms, for example central chest pain; and
- diagnostic increase of specific cardiac markers for myocardial infarction; and
- new electrocardiographic changes of infarction.

Heart Attack does not include sudden cardiac arrest or any heart attack that occurred during or within 24 hours after a cardiac or coronary artery procedure.

Proof of Heart Attack requires submission of medical records. In the event of death, an autopsy confirmation and/or death certificate identifying Heart Attack as the cause of death will be accepted.

The Heart Attack will be deemed to be Incurred on the date it is Diagnosed by a Physician who is a board-certified cardiologist.

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

An event or incident as defined within each Critical Illness for the purposes of the Group Policy.

Insurance Month

Calendar month.

Invasive Cancer

A malignant tumor characterized by uncontrolled growth of malignant cells and invasion of normal tissue. Invasive Cancer also covers the following blood cancers: Lymphoma, leukemia and multiple myeloma.

The following tumors are excluded from Invasive Cancer:

- Chronic lymphocytic leukemia that has not progressed to at least Rai stage I;
- All tumors that are histologically described as nonmalignant, benign, premalignant, noninvasive, dysplasia (all grades) or carcinoma in situ;
- All skin cancers, unless there is metastasis, or the tumor is a malignant melanoma of greater than 1.0 mm maximum thickness (regardless of Clark level or ulceration) as determined by histological examination using the Breslow method;
- Prostate cancer, unless histologically classified as Gleason score 7 or greater, or TNM classification T1bN0M0 or greater;
- Papillary carcinoma of the thyroid (1 cm or less in diameter) and confined to the thyroid, also known as microcarcinoma of the thyroid;
- Noninvasive papillary cancer of the bladder histologically described as TNM classification TaN0m0 or lower; and

- Evidence of cancer cells or cancer genetic material detected by molecular or biochemical probes only (including but not limited to proteomic or DNA/RNA-based techniques) with no lesion amenable to tissue diagnosis.

Diagnosis of Invasive Cancer must be based on microscopic (histologic) examination of:

- fixed tissues; or
- preparations of blood or bone marrow.

Such examination must be documented in a written report by a Physician who is board-certified in pathology, hematology or oncology.

A Clinical Diagnosis will be accepted only if:

- a pathological Diagnosis cannot be made because it is medically inappropriate or life threatening; and
- there is medical evidence to support the Diagnosis; and
- a Physician is treating the Covered Person for Invasive Cancer.

Invasive Cancer will be deemed to be Incurred on the date the Diagnosis is made.

Loss of Hearing

The total and irrevocable loss of hearing in both ears due to disease that results in the inability to hear sounds at or below 70 decibels which cannot be partially or totally corrected by any procedure, aid or device.

A Dependent Child must be at least 3 years old on the date of Diagnosis to receive a benefit. However, if an insured Dependent Child is Diagnosed prior to age 3, we will pay a benefit if the initial diagnosis occurred while insured by this Group Policy, and the Diagnosis is confirmed on or after the child reaches age 3 and remains insured by this Group Policy.

Diagnosis of the disease and confirmation of the loss of hearing must be made by a Physician and supported by audiometric testing.

Loss of Hearing will be deemed to be Incurred on the date the Covered Person is unable to hear sounds at or below 70 decibels in both ears which cannot be partially or totally corrected by any procedure, aid or device.

Loss of Sight

The total and irrevocable loss of sight in both eyes due to disease which cannot be partially or totally corrected by any procedure, aid or device. Sight must be reduced to a corrected visual acuity of 20/200 or less in both eyes or a visual field of 20 degrees or less in both eyes.

A Dependent Child must be at least 3 years old on the date of Diagnosis to receive a benefit. However, if an insured Dependent Child is Diagnosed prior to age 3, we will pay a benefit if the initial diagnosis occurred while insured by this Group Policy, and the Diagnosis is confirmed on or after the child reaches age 3 and remains insured by this Group Policy.

Diagnosis of the disease and confirmation of the loss of sight must be made by a board-certified ophthalmologist or neuro-ophthalmologist.

Loss of Sight will be deemed to be Incurred on the date the Covered Person's sight is reduced to a corrected visual acuity of 20/200 or less in both eyes or a visual field of 20 degrees or less in both eyes which cannot be partially or totally corrected by any procedure, aid or device.

Loss of Speech

The total and irrevocable loss of the ability to speak due to disease which cannot be partially or totally restored by any procedure, aid or device. Loss of Speech does not include congenital birth defects or developmental delays.

A Dependent Child must be at least 3 years old on the date of Diagnosis to receive a benefit. However, if an insured Dependent Child is Diagnosed prior to age 3, we will pay a benefit if the initial Diagnosis occurred while insured by this Group Policy, and the Diagnosis is confirmed on or after the child reaches age 3 and remains insured by this Group Policy.

Diagnosis of the disease must be made by a Physician, and confirmation of the loss of speech must be made by a speech pathologist or board-certified otolaryngologist or neurologist.

Loss of Speech will be deemed to be Incurred on the date it is Diagnosed.

Major Organ Failure

Irreversible end-stage failure of bone marrow, heart, kidney, liver, lung, or pancreas, and

- For kidney failure only, dialysis (either hemo or peritoneal) is initiated; or
- For all organs listed above, a transplant is recommended as soon as an appropriate donor is located, and the Covered Person is either listed with the United Network of Organ Sharing (UNOS) or a suitable donor is found without a UNOS listing.

The following are excluded:

- Bone marrow failure that results from the treatment process for cancer; and
- Failure of any other organ not listed above.

Proof of Major Organ Failure requires submission of medical records documenting major organ failure from a Physician who is board-certified in a medical specialty that is appropriate to the organ involved, and except for kidney failure on dialysis, documentation of either listing with the UNOS or documentation that a suitable donor has been found without a UNOS listing.

Major Organ Failure will be deemed to be Incurred:

- For kidney failure only, the date dialysis is initiated; or
- For all organs listed above, the date the Covered Person is either listed with the UNOS or a suitable donor is found without a UNOS listing.

Member

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

Multiple Sclerosis

A chronic disease involving damage to the sheaths of nerve cells in the brain and spinal cord. Symptoms may include numbness, impairment of speech and of muscular coordination, blurred vision, and severe fatigue. Such neurological deficits must be present for at least six months.

Diagnosis must be made by a board-certified neurologist and supported by:

- neurological examination demonstrating functional impairments; and
- imaging studies of the brain or spine demonstrating lesions consistent with Multiple Sclerosis; or
- analysis of cerebrospinal fluid consistent with the diagnosis.

Multiple Sclerosis will be deemed to be Incurred on the date the Covered Person has had neurological deficits present for at least six months due to Multiple Sclerosis.

Occupational Infectious Disease

Accidental exposure in the workplace to contaminated blood or other bodily fluids that results in a positive test for Human Immunodeficiency Virus (HIV) or Hepatitis B, C or D. The exposure must occur while performing normal occupational duties for which compensation is earned. Occupational Infectious Disease does not include infection as a result of intravenous drug use or sexual transmission.

Diagnosis must include all of the following:

- An incident report describing the accidental exposure is filed with the employer within 48 hours of the exposure and recorded by the appropriate person according to the applicable legislation, regulations, standards or guidelines that apply to the occupation;
- The accident is investigated, and a written investigation report is completed by the employer;
- A blood test is performed by a state certified and licensed laboratory within 5 days of the exposure and is negative for HIV or Hepatitis B, C or D; and
- A follow-up blood test is performed by a state certified and licensed laboratory between 90 days and 180 days after the exposure and is positive for HIV or Hepatitis B, C or D.

Occupational Infectious Disease will be deemed to be Incurred on the date a positive blood test for HIV or Hepatitis B, C or D is confirmed.

Paralysis

A total and irrevocable loss of use of two or more arms or legs due to disease which has continued for 90 consecutive days. Paralysis must be determined by a Physician to be permanent, complete and irreversible.

Diagnosis must be confirmed by a board-certified neurologist and supported by neurological evidence.

Paralysis will be deemed to be Incurred on the date it is Diagnosed.

Parkinson's Disease

A progressive disease of the nervous system marked by muscle rigidity, tremors, and changes in speech and gait which has progressed to a classification of Stage 4 or greater on the Hoehn and Yahr scale. Parkinson's Disease does not include other Parkinsonian syndromes or substance-induced diseases.

Diagnosis must be made by a board-certified Physician of the appropriate specialty based on abnormal findings from neurological examination and cognitive testing, or results of imaging studies.

The initial Diagnosis of any stage of Parkinson's Disease must occur while insured under this Group Policy.

Parkinson's Disease will be deemed to be Incurred on the date the Covered Person has progressed to a Stage 4 or greater classification on the Hoehn and Yahr scale due to Parkinson's Disease.

Period of Limited Activity

Any period of time during which a Dependent is:

- confined in a Hospital for any cause or confined in a Skilled Nursing Facility; or
- unable to leave their home except to receive medical treatment.

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.

Proof of Good Health

Written evidence that an Employee or Dependent is insurable under Principal Life underwriting standards. This proof must be provided in a form satisfactory to Principal Life.

Scheduled Benefits Summary

The page, to be attached to the Member's Certificate of Coverage, that contains benefit and other information pertaining to insurance under the Group Policy.

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.

Skin Cancer

Cancer that forms in the tissues of the skin and includes:

- Non-melanoma skin cancer including basal cell carcinoma and squamous cell carcinoma of the skin
- Melanoma in situ
- Melanoma of 1.0 mm or less maximum thickness as determined by histological examination using the Breslow method

Diagnosis must be made by a board-certified oncologist or pathologist and based on the date of microscopic examination of skin biopsy samples.

Skin Cancer will be deemed to be Incurred on the date it is Diagnosed.

State Family and Medical Leave

A state mandated law that provides employees with paid family and/or medical leave.

Stroke

Death of brain tissue due to an acute cerebrovascular event. All of the following criteria for Stroke must be satisfied:

- clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage;
- clear evidence on a CT, MRI or similar imaging technique that a stroke has occurred; and
- permanent neurologic deficit measured thirty days or more after the event that results in a score of 2 or higher on the Modified Rankin Scale for stroke outcome.

Stroke does not include symptoms due to transient ischemic attack, migraine, hypoxia, traumatic injury to brain tissue or blood vessels, and vascular disease affecting the eye, optic nerve or vestibular functions.

Diagnosis of stroke with permanent neurological deficit must be confirmed in writing by a Physician who is board-certified in neurology and requires submission of medical records.

The Stroke will be deemed to be Incurred on the date of the event.

HOW TO BE INSURED - EMPLOYEES

Eligibility

Only Employees will be eligible for insurance.

Employees hired on or prior to January 1, 2024: Anyone meeting the definition of Employee will be eligible on the first of the Insurance Month coinciding with or next following the date they become an Employee.

Employees hired after January 1, 2024: Anyone meeting the definition of Employee 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 Covered Person's insurance unless:

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

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

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

Proof of Good Health

In some instances, Proof of Good Health will be required to place an Employee's insurance in force. Principal Life will determine the type and form of required proof. An Employee will need to file Proof of Good Health:

- If insurance is requested more than 31 days after the date an Employee is eligible including any insurance they refuse and later request.
- If an Employee failed to provide required Proof of Good Health or has been refused insurance under the Group Policy at any prior time.
- If a Member elects to terminate insurance and, more than 31 days later, requests to be insured again.
- To make effective any Member Critical Illness Scheduled Benefit that is in excess of $20,000.
- If less than 10% participation or five Members, to make effective any Scheduled Benefit for Covered Persons.
- To make effective any request for a Scheduled Benefit increase.

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

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 of the request, 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.

Effective Date for Initial Insurance
(Proof of Good Health Required)

If Proof of Good Health is required, and approved by Principal Life, insurance will normally be effective on the later of:

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

- the first of the Insurance Month coinciding with or next following the date Proof of Good Health is approved by Principal Life.

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 an increase in Scheduled Benefits or 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 critical illness coverage.

Effective Date for Scheduled Benefit Changes

A change in the Scheduled Benefit for which Proof of Good Health is not required (see above) 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 Requested by the Member for any other Reason

A change requested by the Member for which Proof of Good Health is not required (see above) 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
(Proof of Good Health Required)

A change requested by the Member for which Proof of Good Health is required (see above) will be effective on the later of:

- the date the change would otherwise be effective if Proof of Good Health had not been required; or
- the first of the Insurance Month coinciding with or next following the date Proof of Good Health is approved by Principal Life.

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.

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 Critical Illness Insurance; or
- the date the Member first acquires a Dependent.

Effective Date

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

- In no event will Dependent Critical Illness Insurance be in force if the Employee is not insured for Member Critical Illness Insurance.
- If a Dependent spouse is in a Period of Limited Activity on the date initial Dependent Critical Illness Insurance or an increase in Dependent Critical Illness Insurance Scheduled Benefit would otherwise be effective, the Dependent spouse will not be insured or an increase will not be effective until the Period of Limited Activity ends.
- A newly born child will be insured from the moment of live birth, provided the Employee is a Member and the child meets the definition of a Dependent Child.
- A new Dependent Child (other than a newborn child) will be insured on the date acquired.

Proof of Good Health

In some instances, Proof of Good Health will be required to place Dependent insurance in force. Principal Life will determine the type and form of required proof. Any required Proof of Good Health will be with respect to the health of the Dependent(s). The Member will need to file Proof of Good Health for Dependent Insurance:

- If insurance is requested more than 31 days after the date the Dependent is eligible including any insurance the Dependent refuses and later requests.
- If a Dependent failed to provide required Proof of Good Health or has been refused insurance under the Group Policy at any prior time.
- If a Dependent elects to terminate insurance and, more than 31 days later, requests to be insured again.
- To make effective any Scheduled Benefit for the Dependent spouse that is in excess of $10,000.
- If less than 10% participation or five Members, to make effective any Scheduled Benefit for the Dependent.
- To make effective any request for a Scheduled Benefit increase.

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 Critical Illness Insurance ceases; or
- the date Dependent Critical Illness 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, State Family and Medical Leave and Other Continuation Provisions

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

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

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

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

Sickness or Injury

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

- the date insurance would otherwise 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 otherwise 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 critical illness coverage; or
- the date one month after the date Active Work ends.

Dependent Child Insurance – Developmentally, Physically or Mentally Incapacitated Children

Qualification

Dependent Critical Illness 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 Incapacity 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 Employee 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. Also, Proof of Good Health will be required to place in force any Scheduled Benefit that would have been subject to Proof of Good Health had the Employee remained continuously insured.

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

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

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

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

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

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

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

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

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

- the Employee or Dependent returns to the United States within 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, they remain in the United States for 30 consecutive days. If the Dependent does so, they will be eligible for reinstatement of insurance on the day after completion of the 30 consecutive days of residence.

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

DESCRIPTION OF BENEFITS
BENEFIT PROVISIONS

CRITICAL ILLNESS INSURANCE

Benefit Qualification

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

- the Covered Person must Incur the Critical Illness and the initial diagnosis of any stage of the illness must be made while insured for that Critical Illness under this Group Policy; and
- for Childhood Conditions, the Critical Illness must be Diagnosed before the age of 18; and
- for Childhood Conditions, a Diagnosis made prior to birth is covered if the Member was insured under this Group Policy at the time of Diagnosis and the Dependent Child became insured at live birth; and
- the Covered Person must meet the terms and conditions for an applicable Critical Illness listed below; and
- the Covered Person must submit proof of Diagnosis which requires submission of medical records; and
- Limitations and Exclusions must not apply; and
- Claim Procedures must be satisfied.

Schedule of Insurance

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

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

Class	***Scheduled Benefit**
All Members	An amount in increments of $5,000 as applied for by the Member and approved by Principal Life. The Scheduled Benefit amount will not exceed $50,000, subject to the provisions below.
Dependent Spouse	An amount in increments of $2,500 as applied for by the Member and approved by Principal Life. The spouse's Scheduled Benefit will not exceed $25,000, subject to the provisions below.
Dependent Child(ren)	25% of the Member Scheduled Benefit

*The Scheduled Benefit is subject to the Proof of Good Health requirements. Because of the Proof of Good Health requirements, the amount of insurance approved by Principal Life may be different than the Scheduled Benefit. If the approved amount of insurance is different than the Scheduled Benefit, the approved amount will apply.

In no event will a Dependent spouse's Scheduled Benefit be more than 50% of the Member's Scheduled Benefit. If the Member elects a Dependent spouse's Critical Illness benefit in excess of 50% of the Member's Scheduled Benefit amount, the Dependent spouse will be given the highest amount available, not to exceed 50%.

Benefits Payable

Critical Illness	% of Scheduled Benefit for First Occurrence	% of Scheduled Benefit for Additional Occurrences
Alzheimer's Disease	100%	0%
Amyotrophic Lateral Sclerosis	100%	0%
Benign Brain Tumor	100%	0%
Carcinoma In Situ	25%	25%
Coma	100%	0%
Coronary Artery Disease	25%	25%
Heart Attack	100%	100%
Invasive Cancer	100%	100%
Loss Of Hearing	100%	0%
Loss Of Sight	100%	0%
Loss Of Speech	100%	0%
Major Organ Failure	100%	100%
Multiple Sclerosis	100%	0%
Occupational Infectious Disease	100%	0%
Paralysis	100%	0%
Parkinson's Disease	100%	0%
Skin Cancer	$250	$0
Stroke	100%	100%
Childhood Conditions		
Cerebral Palsy	100%	0%
Cleft Lip / Palate	100%	0%
Cystic Fibrosis	100%	0%
Down Syndrome	100%	0%
Muscular Dystrophy	100%	0%
Spina Bifida	100%	0%

Benefits for a First Occurrence of a different Critical Illness will be payable if the Critical Illness is Incurred more than 12 months from the date the preceding Critical Illness was Incurred.

Benefits for additional occurrences of the same Critical Illness will be payable if the Critical Illness is Incurred more than 12 months from the date the preceding Critical Illness was Incurred and the Covered Person has not received treatment for that Critical Illness for at least 12 consecutive months prior to the last occurrence. For the purpose of this provision, treatment does not include preventive medications in the absence of disease or routine scheduled follow-up visits to a Physician.

Total payment for all Critical Illnesses that result from the same illness or disease will not exceed the Scheduled Benefit.

DESCRIPTION OF BENEFITS

LIMITATIONS AND EXCLUSIONS

Limitations

Benefits will not be paid for a Critical Illness caused 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
- war or act of war; or
- voluntary participation in a felony, insurrection, or riot; or
- duty as a member of a military or organization; or
- conditions diagnosed outside of the United States unless the diagnosis can be confirmed by a licensed Physician in the United States; or
- a cosmetic surgery or other elective procedures that are not medically necessary; or
- a Preexisting Condition as described below.

Exclusions

No benefits will be paid for any Critical Illness:

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

Preexisting Conditions Exclusion for Initial Coverage

A Preexisting Condition is any sickness or injury, including all related conditions and complications, or a pregnancy, for which a Covered Person:

- received medical treatment, consultation, care, or services; or
- was prescribed or took prescription medications;

in the six month period before the Covered Person became insured under the Group Policy.

No benefits will be paid for a Critical Illness that results from a Preexisting Condition unless, on the date the Covered Person Incurs the Critical Illness, the Member has been Actively At Work for one full day for the Member's Critical Illness or the Dependent has been insured for one full day for a Dependent's Critical Illness, after completing 12 consecutive months during which the Covered Person was insured under the Group Policy.

Preexisting Conditions Exclusion for Benefit Increases

A Preexisting Condition is any sickness or injury, including all related conditions and complications, or a pregnancy, for which a Covered Person:

- received medical treatment, consultation, care, or services; or

- was prescribed or took prescription medications;

in the six month period prior to a 25% or greater increase in the Scheduled Benefit or change in the Group Policy.

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

- results from a Preexisting Condition; and

- begins within six consecutive months after the effective date of the increase in benefits or change in the Group Policy provisions.

The increase in benefits or change in the Group Policy provisions will be payable if the Covered Person has received no treatment, consultation, care, or service, and no prescription medication was prescribed or taken for the Preexisting Condition in the 12 consecutive months following the effective date of the increase in benefits or change in the Group Policy provisions. Following this 12 month period, the Member must be Actively at Work for one full day for the Member's Critical Illness or the Dependent must be insured for one full day for a Dependent's Critical Illness.

DESCRIPTION OF BENEFITS

PORTABILITY

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

Critical Illness Portability Insurance

Eligibility

If Member Critical Illness Insurance under the Group Policy ends because the Member ceases to meet the definition of an Employee, they may be eligible to continue such insurance under the Group Critical Illness Portability Insurance Policy without submitting Proof of Good Health.

In order to continue insurance under the Group Critical Illness Portability Insurance Policy:

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

Insurance may not be continued for the Covered Person under the Group Critical Illness Portability Insurance Policy if:

- insurance under the Group Policy ends because the Group Policy terminates and is replaced by another critical illness insurance policy; or
- a Critical Illness was Incurred, regardless of whether a benefit was payable, other than the Health Screening Benefit; or
- for Dependent Critical Illness Portability Insurance, the Dependent ceases to be a Dependent; or
- the Member dies.

Ported Coverage

The insurance that is available for continuation will be the benefits as shown on the Scheduled Benefits Summary and on the Description of Benefits Benefit Provisions section that are in force on the date insurance terminates under the Group Policy. The Health Screening Benefit is not portable.

Termination of Ported Coverage

Ported insurance under the Group Critical Illness Portability Insurance Policy will terminate on the earliest of:

- the date ending the period for which the last premium is paid; or
- for Member insurance, the May 1 next following the Member's 70th birthday; or

- for Dependent insurance for the Dependent spouse, the May 1 next following the Dependent spouse's 70th birthday; or

- for Dependent insurance, the date the Dependent no longer qualifies as a Dependent, due to divorce or the Member's death; or

- for Dependent insurance for a Dependent Child(ren), the date the child(ren) no longer meets the definition of a Dependent Child(ren); or

- for Dependent insurance, the date Member Critical Illness Insurance ceases.

Request for Insurance/Effective Date

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

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

CLAIM PROCEDURES

Notice of Claim

Written notice of claim must be given to Principal Life within 20 days after the date the Critical Illness was Incurred. 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 notice is given and the completed 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 Critical Illness, written proof covering the occurrence, character and extent of the Critical Illness.

Proof of Critical Illness

Completed claim forms and other information needed to prove the Critical Illness should be filed promptly. Written proof of the Critical Illness should be sent to Principal Life within 180 days after the date the Critical Illness was Incurred. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible. Proof required includes the date, nature, and extent of the Critical Illness. Principal Life may request additional information to substantiate a Critical Illness or require a signed unaltered authorization to obtain that information from the provider. Failure to comply with such request could result in declination of the claim. Receipt of claim will be considered to be met when the appropriate claim form is received by Principal Life.

Payment, Denial, and Review

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

State law requires that benefits payable under the Group Policy will be payable not more than 30 calendar days after receipt of proof and subject to proof of Disability. In actual practice, benefits under the Group Policy will be payable sooner, provided Principal Life receives complete and proper proof of the Critical Illness. Further, if a claim is not payable or cannot be processed, Principal Life will submit a detailed explanation of the basis for the denial.

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

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

Right to Recover Overpayments

If an overpayment of benefits occurs under the Group Policy, Principal Life will have the option to:

- reduce or withhold any future benefits Principal Life determines to be due; or
- recover the overpayment directly from the Member; or
- take any other legal action.

Facility of Payment

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

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

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

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

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 required proof of the Critical Illness has been filed. Further, no legal action may be started later than three years after that proof is required to be filed.

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

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

Time Limits

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

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: 26-3010066

2. **Type of Administration:**

   Critical Illness: 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 5712 (CI)).

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

   Employee pays all of employee's contribution.

   Employee pays all of Dependent's contributions.

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

   September 30

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Principal Life Insurance Company
Des Moines, Iowa 50392-0002