

SUN LIFE ASSURANCE COMPANY OF CANADA

Executive Office:
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Wellesley Hills, MA 02481

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Sun Life Assurance Company of Canada certifies that it has issued and delivered a Group Insurance Policy to the Policyholder shown below.

Policy Number:	555555-001
Policy Effective Date:	August 1, 2021
Policyholder:	Sample Certificate
Employer:	SAMPLE
Issue State:	Iowa

NOTICE TO BUYER: THIS IS A LIMITED BENEFIT HEALTH COVERAGE CERTIFICATE. THIS CERTIFICATE PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE.

PLEASE READ YOUR CERTIFICATE CAREFULLY.

This Certificate contains the terms, benefits, exclusions and conditions that affect your insurance. This Certificate is part of the Group Insurance Policy.

This Certificate is governed by the laws of the Issue State shown above unless preempted by the federal Employee Retirement Income Security Act.

Signed at Wellesley Hills, Massachusetts.



Dean A. Connor
President and Chief Executive Officer



Troy Krushel
Vice-President, Associate General Counsel and
Corporate Secretary

Group Hospital Indemnity Insurance Certificate
24-Hour Covered Accident
Non-Participating



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1. BENEFIT HIGHLIGHTS

Eligible Classes: All Full-Time United States Employees working in the United States scheduled to work at least 20 hours per week.

Eligibility Waiting Period: Until the first of the month following 30 days of employment

1. BENEFIT HIGHLIGHTS

Benefit Plan: LOW

Benefit Coverage Type: 24-Hour Covered Accident
Covered Sickness will be provided on a 24-Hour basis

Pregnancy Waiting Period: 10 Months

Covered Benefits

At the time of enrollment, you may be eligible to select a plan of Hospital Indemnity Insurance. We will pay benefits corresponding to the elections you made as shown below. You may change your, your Spouse's and your Dependent Children's plan of Hospital Indemnity Insurance according to the When can you make Changes in Insurance provision.

Unless otherwise specified, the following benefits will be payable for each Insured as a result of a Covered Accident or Covered Sickness. Please see Covered Hospital Indemnity Benefits and Exclusions and Limitations for a complete description of benefits, limitations and exclusions. Any limitation or exclusion applies separately to each Insured.

	Benefit Amount
Confinement Benefit(s) (All benefits are payable per Insured.)	
First Day Hospital Confinement: Limited to 1 day per Benefit Year	\$1,000 per day
Hospital Confinement: Limited to 30 day(s) per Benefit Year	\$100 per day
Intensive Care Unit (ICU) Confinement: Limited to 10 day(s) per Benefit Year	\$100 per day
Additional and Enhanced Benefit(s) (All benefits are payable per Benefit Year per Insured.)	
Extended Hospitalization:	\$100 per day
Family Care Benefit(s) (All benefits are payable per Benefit Year per Insured.)	
Wellness Screening: Limited to 1 wellness screening test(s)	\$50 per day
Contributions: The cost of your insurance is paid for entirely by you. This is your Contributory insurance.	

1. BENEFIT HIGHLIGHTS

Benefit Plan: HIGH

Benefit Coverage Type: 24-Hour Covered Accident
Covered Sickness will be provided on a 24-Hour basis

Pregnancy Waiting Period: 10 Months

Covered Benefits

At the time of enrollment, you may be eligible to select a plan of Hospital Indemnity Insurance. We will pay benefits corresponding to the elections you made as shown below. You may change your, your Spouse's and your Dependent Children's plan of Hospital Indemnity Insurance according to the When can you make Changes in Insurance provision.

Unless otherwise specified, the following benefits will be payable for each Insured as a result of a Covered Accident or Covered Sickness. Please see Covered Hospital Indemnity Benefits and Exclusions and Limitations for a complete description of benefits, limitations and exclusions. Any limitation or exclusion applies separately to each Insured.

	Benefit Amount
Confinement Benefit(s) (All benefits are payable per Insured.)	
First Day Hospital Confinement: Limited to 2 day per Benefit Year	\$2,000 per day
Hospital Confinement: Limited to 30 day(s) per Benefit Year	\$200 per day
First Day Intensive Care Unit (ICU) Confinement: Limited to 1 day per Benefit Year	\$2,000 per day
Intensive Care Unit (ICU) Confinement: Limited to 10 day(s) per Benefit Year	\$200 per day
Intermediate Step-Down Unit Confinement: Limited to 10 day(s) per Benefit Year	\$100 per day
Newborn Nursery Confinement: Limited to 3 day(s) per Benefit Year	\$100 per day
Rehabilitation Unit: Limited to 60 day(s) per Benefit Year	\$100 per day
Inpatient Surgery: Limited to 1 day(s) per Benefit Year	\$2,000 per day
Additional and Enhanced Benefit(s) (All benefits are payable per Benefit Year per Insured.)	
Annual Benefit Increase: Limited to a maximum of 5 years	\$50
Annual Wellness Increase: Limited to a maximum of 5 years	\$10 of wellness screening benefit amount

1. BENEFIT HIGHLIGHTS

Emergency Room (ER) Treatment - Accident Only: Limited to 1 day(s)	\$200 per day
Employer Facility:	
	\$1,000 per day a First Day Hospital Confinement benefit is payable
	\$100 per day a Hospital Confinement benefit is payable
	\$1,000 per day a First Day Intensive Care Unit (ICU) Confinement benefit is payable
	\$100 per day an Intensive Care Unit (ICU) Confinement benefit is payable
	\$100 per day an Intermediate Step-Down Unit Confinement benefit is payable
	\$100 per day an Emergency Room (ER) Treatment - Accident Only benefit is payable
	\$100 per day an Observation Unit Stay benefit is payable
	\$100 per day a Rehabilitation Unit benefit is payable
	\$1,000 per day an Inpatient Surgery benefit is payable
Extended Hospitalization:	\$200 per day
Observation Unit Stay: Limited to 1 day(s)	\$100 per day
Family Care Benefit(s) (All benefits are payable per Benefit Year per Insured.)	
Family Care: Limited to 5 day(s)	\$200 per day
Lodging: Limited to 5 day(s)	\$100 per day
Transportation: Limited to 2 day(s)	\$250 per day
Wellness Screening: Limited to 1 wellness screening test(s)	\$50 per day
Contributions:	The cost of your insurance is paid for entirely by you. This is your Contributory insurance.

2. DEFINITIONS

24-Hour Covered Accident means coverage is provided under the Policy for Injuries resulting from Covered Accidents incurred on and off the job.

Accident or Accidental means an external event that an average person would consider sudden and unforeseeable and:

- that results, directly and independently of all other causes; and
- is independent of any illness, disease or other bodily malfunction.

Accident or Accidental does not mean an unintentional accident caused by or during medical Treatment or surgery for Sickness or Injury.

Actively at Work means that you perform all the regular duties of your job for a full work day at your Employer's normal place of business, a site approved by your Employer or a site where your Employer's business requires you to travel.

You will be considered Actively at Work if you usually perform the regular duties of your job at your home as long as you can perform all the regular duties of your job for a full work day and could do so at your Employer's normal place of business.

You are considered Actively at Work on any day that is not your regular scheduled work day (e.g., you are on vacation or holiday) as long as you were Actively at Work on your immediately preceding scheduled work day, and you are neither Confined nor disabled due to an Injury or Sickness.

Anesthesia means a general or spinal anesthetic. It does not include injection of a topical or local anesthetic or peripheral nerve blocks.

Benefit Year means a calendar year beginning on January 1 and ending on December 31 of that year.

Complications of Pregnancy means any condition, whether or not a pregnancy is terminated, whose diagnosis is distinct from pregnancy but is adversely affected or caused by pregnancy. Complications of Pregnancy includes: acute nephritis; cardiac decompensation; disease of the endocrine, hemopoietic, nervous or vascular systems; ectopic pregnancy that is terminated; hyperemesis gravidarum; missed abortion; nephrosis; non-elective caesarean section; spontaneous termination of pregnancy that occurs during a period of gestation when a viable birth is not possible; or any similar condition(s) of comparable severity.

This definition does not include: elective caesarean section unrelated to a diagnosed complication of pregnancy; false labor; morning sickness; multiple gestation pregnancy; occasional spotting; physician prescribed rest during pregnancy; pre-eclampsia; any similar condition(s) associated with a difficult pregnancy but not considered a classifiable, distinct complication of pregnancy; or any other condition associated with pregnancy but has not been diagnosed by a Physician as a complication of pregnancy as defined.

Confined or Confinement means on the advice of a Physician, the assignment of a person to a bed as a resident inpatient in a Hospital or Rehabilitation Unit for not less than 20 continuous hours. There must be a charge for room and board. The requirement that an Insured be charged for room and board does not apply to confinement in a Veteran's Administration Hospital or other federal government operated Hospital. This definition does not include a newborn child's initial Confinement in a Hospital following birth for routine medical and nursing care, except as specifically provided for in the Newborn Nursery Confinement benefit.

Confinement does not include that period of time during which an Insured is in a Hospital Emergency Room, an observation room, a freestanding surgical facility or an outpatient facility.

Contributory means you pay all or part of the premium.

2. DEFINITIONS

Covered Accident means an Accident that is not excluded by the Policy or applicable riders or endorsements attached to it.

Covered Sickness means a Sickness that is not excluded by the Policy or applicable riders or endorsements attached to it.

Dependent means your insured Spouse and Dependent Children.

Dependent Child (Dependent Children) means your unmarried or married child from live birth to under age 26.

Dependent Child includes:

- your step-child;
- a foster child placed with you by a licensed agency;
- your grandchild who is a dependent for federal income tax purposes at the time application for coverage for such child is made;
- your adopted child, including any child placed with you for adoption; or
- a child of your Spouse.

If an unmarried child is age 26 or older and is:

- incapable of self-sustaining employment because of an intellectual disability, developmental disability or physical handicap; and
- chiefly dependent on you for his or her support;

that child will continue to be considered a Dependent Child under the Policy for as long as these conditions exist.

No person may be considered to be a Dependent Child of more than one Employee.

Dependent Child does not include:

- any person who is insured as an Employee; or
- any person residing outside the United States or Canada. This exclusion does not apply to a Dependent Child who:
 - resides with you while you are on a temporary work assignment outside the United States; or
 - is a full-time student attending school outside of the United States.

Dependent Family Member means:

- a Dependent Child; or
- a mentally or physically disabled Family Member, regardless of age, who is living with you or your Spouse and is dependent on you or your Spouse for support and maintenance.

Eligibility Waiting Period means the length of time you must be a member in an Eligible Class before you can apply for insurance. The Eligibility Waiting Period is shown in the Benefit Highlights. Any period of time you were Actively at Work for the Employer as a full-time Employee will count towards completion of the Eligibility Waiting Period.

Emergency Room means a specified area within a Hospital that is designated for the emergency care of Accidental Injuries and Sickness. This area must:

- be staffed and equipped to handle trauma;
- be supervised and provide Treatment by Physicians; and
- provide 24 hours a day service by registered graduate nurses (RNs).

2. DEFINITIONS

Employee means a person who is:

- employed by the Employer within the United States;
- a U.S. citizen or a U.S. resident;
- scheduled to work at least the minimum hours shown in the Benefit Highlights;
- paid regular earnings in accordance with applicable state and federal wage and hour laws; and
- has a legitimate federal tax identification number.

Employee does not include a seasonal or temporary employee whose annual work schedule is less than 12 months during a calendar year.

If you are an Employee and you are working on a temporary assignment outside of the United States for 12 months or less, you will be deemed to be working within the United States. If you are an Employee and you are working on a temporary assignment outside of the United States for more than 12 months, you will not be considered an Employee under the Policy unless we agree in Writing.

Employer means the Employer named on the cover page of this Certificate and includes any subsidiary or affiliated company named in the application.

Employer Facility means a Hospital, outpatient facility, free-standing outpatient surgical centers, or other facilities owned or operated by the Employer or Policyholder. A list or description of the Employer Facilities will be provided at the time you apply for this insurance. A current list of Employer Facilities is available from us or the Policyholder upon request.

Enrollment Period means the period of time each year not to exceed 30 days during which eligible Employees may elect or change insurance under the Policy. The Enrollment Period cannot exceed 30 days or occur more than once in any 12-month period, unless we agree in Writing.

Family Member means your Spouse and the following relatives of you or your Spouse:

- parent;
- grandparent;
- child;
- grandchild;
- brother;
- sister;
- aunt;
- uncle;
- first cousin;
- nephew or niece.

This includes adopted, in-law and step-relatives.

Family Status Change means one of the following events:

- your marriage or divorce;
- the birth of your child;
- the adoption of a child by you;
- the placement of a child with you, pending adoption;
- the death of your Spouse or child; or
- the commencement or termination of employment of your Spouse.

Hospice Care means specialized care, medical services and emotional support for an Insured who is in the last stages of an advanced illness, focusing on comfort and quality of life rather than cure.

2. DEFINITIONS

Hospice Facility means an appropriately licensed healthcare facility that:

- provides Hospice Care and related services 24 hours per day, 7 days per week;
- is under the direct supervision of a Physician and has a Physician or Medical Professional available at all times; and
- is not mainly a place for rest, care of the aged/elderly, care of persons with Substance Abuse issues/disorders, care of persons with Mental and Nervous Disorders, or a hotel or similar establishment.

Hospital means a facility licensed in the applicable jurisdiction that provides medical care and Treatment to sick and injured persons on an Inpatient basis with 24 hour nursing service by or under the supervision of a Physician. Hospital does not include:

- a rest home;
- a Skilled Nursing Facility;
- an extended care facility;
- a place of convalescence;
- a Rehabilitation Unit;
- a Hospice Facility;
- a place providing custodial care;
- a Mental and Nervous Disorder Facility; or
- a Substance Abuse Facility.

Hospital Intensive Care Unit (ICU) means a specifically designated part of a Hospital called an intensive care unit that:

- provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care, including a neonatal intensive care unit specializing in the care of ill or premature newborn infants;
- is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement;
- is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24 hour basis; and
- has an assigned Physician on a full-time basis.

A hospital intensive care unit is not any of the following step-down units:

- a progressive care unit;
- an intermediate care unit;
- a private monitored room;
- sub-acute intensive care unit; or
- an Observation Unit.

Hospital Intermediate Step-Down Unit means a specifically designated part of a Hospital that:

- provides a level of medical care below intensive care, but above a regular private or semi-private room or ward;
- is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement;
- is permanently equipped with special lifesaving equipment for the care of the critically ill or injured; and
- is under constant and continuous observation by a specially trained nursing staff.

An intermediate step-down unit can be any of the following:

- a progressive care unit;
- an intermediate care unit; or
- sub-acute intensive care unit.

2. DEFINITIONS

Injury or Injuries means bodily injury that is the direct result of an Accident. Injuries must be independent of Sickness, disease, bodily infirmity and other causes.

Inpatient or Inpatient Treatment means the Insured who receives Treatment as a resident patient using and being charged for the room and board facilities of a Hospital or Rehabilitation Unit. The requirement that an Insured be charged does not apply to confinement in a Veteran's Administration Hospital or other federal government operated Hospital.

Insured means any person covered under the Policy.

Intoxicated or Intoxication means at or above the minimum blood alcohol level for which the Insured would be considered operating a motorized vehicle under the influence of alcohol in the jurisdiction where the Accident or Injury occurred.

For the purposes of this definition, "operating" includes allowing the engine to run even if not seated in the vehicle and "motorized vehicle" includes: automobiles, motorcycles, boats and snowmobiles.

Layoff means that you are temporarily not Actively at Work for a period of time your Employer agreed to in Writing. Your normal vacation time is not considered a temporary Layoff.

Leave of Absence means that you are temporarily not Actively at Work for a period of time your Employer agreed to in Writing. Your normal vacation time is not considered a temporary Leave of Absence.

Medical Professional means a person who is appropriately licensed to provide Treatment, including a nurse practitioner (NP/APRN), physician's assistant (PA) or registered nurse (RN). The medical professional must be acting within the scope of his/her license. A medical professional does not include an Insured.

Mental and Nervous Disorder(s) means any condition, disease or disorder listed as a mental or nervous disorder in the most recent edition of the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM), where improvement can be reasonably expected with therapy.

This definition does not include conditions, diseases or disorders related to Substance Abuse.

Mental and Nervous Disorder Facility means an appropriately licensed healthcare facility or other institution, that:

- specializes in psychiatric care for Mental and Nervous Disorders;
- is under the direct supervision of a Physician;
- has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
- is not mainly a place for rest, care of the aged/elderly, care of persons with Substance Abuse disorders/issues, or a hotel or similar establishment.

Newborn Nursery Care means routine well baby care provided to a newborn baby while Confined immediately following an Insured's childbirth of such baby.

Observation Unit means a specified area within a Hospital, apart from the Emergency Room, where a patient can be monitored by a Physician and which:

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

2. DEFINITIONS

Open Surgery means surgery involving direct visualization of the impacted area. Open Surgery requires Anesthesia.

Outpatient or Outpatient Treatment means Treatment received by the Insured at a Hospital or other medical facility and there is no charge for room and board.

Participation in a Riot, Rebellion or Insurrection, the words "Participation" and "Riot" in this phrase mean:

- Participation includes promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but will not include actions taken in defense of public or private property, or actions taken in your own defense, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firefighters.
- Riot includes all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether or not acting with a common intent and whether or not damage to person or property or unlawful act or acts is the intent or the consequence of such disorder.

Physician means a person who is operating within the scope of his or her license and is either:

- licensed in the United States or Canada as a medical doctor and authorized to practice medicine and prescribe and administer drugs or to perform surgery; or
- any other duly licensed medical practitioner who is deemed by applicable state or provincial law to have the same authority as a legally qualified medical doctor.

The Physician cannot be you, a business associate or any Family Member.

Policy means the group insurance policy under which this Certificate is issued.

Policyholder means the entity to which the Policy is issued.

Pregnancy Waiting Period means the continuous period of time an Insured must be covered under the Policy during which no benefits are payable for normal pregnancy or childbirth.

Prior Policy means the insurance policy(ies) for hospital indemnity insurance issued to the Policyholder that was in effect immediately prior to the Policy.

Proof means any medical, financial or other information that we require to make a claim determination.

Rehabilitation Unit means a distinct unit within a Hospital that provides rehabilitation care services on an Inpatient basis. Rehabilitation care services consist of multidisciplinary physical restorative services to achieve the highest possible functional ability for disability due to Sickness or Injury. Services are provided by or under the supervision of a trained and experienced rehabilitation Physician.

A rehabilitation unit is not:

- a freestanding rehabilitative facility;
- a nursing home;
- an extended care facility;
- a Skilled Nursing Facility;
- a rest home or home for the aged;
- a Hospice Facility;
- a facility for the Treatment of alcoholism or drug addiction; or
- an assisted living facility.

Sickness means physical or mental disease or illness, including diseases or infections resulting from bug bites, stings or infestations by microorganisms and Substance Abuse. This definition includes normal pregnancy and childbirth (subject to the Pregnancy Waiting Period) and Complications of Pregnancy.

2. DEFINITIONS

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

Skilled Nursing Facility means an appropriately licensed healthcare facility or other institution, that:

- provides skilled nursing care and related services 24 hours per day, 7 days per week;
- is under the direct supervision of a Physician and has a Physician or Medical Professional available at all times;
- has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
- is not mainly a place for rest, care of the aged/elderly, care of persons with Substance Abuse issues/disorders, care of persons with Mental and Nervous Disorders, or a hotel or similar establishment.

Confinement in a skilled nursing facility must be at the direction of a Physician. This definition does not include a Hospice Facility, nursing home, Rehabilitation Unit or swing bed hospitals that are authorized to provide and be paid for extended care services.

Spouse means any person who is a party to a marriage and under state, federal or provincial law is recognized as a spouse or civil union partner.

Spouse does not include:

- any person who is insured as an Employee; or
- any person residing outside the United States or Canada. This exclusion does not apply to your Spouse who resides with you while you are on a temporary work assignment outside the United States.

Substance Abuse means the harmful or hazardous use of and dependence on psychoactive substances, including alcohol and illicit drugs. The consumption of prescription drugs in a manner or dose other than prescribed, including when originally prescribed to another person, will also be considered substance abuse.

Substance Abuse Facility means an appropriately licensed healthcare facility or other institution, which:

- specializes in habilitation, rehabilitation, Treatment and related services for persons with chemical dependencies resulting from Substance Abuse;
- is under the direct supervision of a Physician;
- has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
- is not mainly a place for rest, care of the aged/elderly, care of persons with Mental and Nervous Disorders, or a hotel or similar establishment.

Confinement in a substance abuse facility must be at the direction of a Physician.

Treatment means a Physician's consultation, care or services; diagnostic measures; or the prescription, refill or taking of prescribed drugs or medicines.

We, Us, Our (we, us, our) means Sun Life Assurance Company of Canada.

Written or Writing means a record which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

You, Your (you, your) means an Employee who is eligible for insurance under the Policy.

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF EMPLOYEE INSURANCE

When are you eligible for Employee Hospital Indemnity Insurance?

You are initially eligible for Employee Hospital Indemnity Insurance on the latest of:

- July 1, 2021;
- the first day of the month following the date your Eligibility Waiting Period ends; or
- the date you first are Actively at Work in an Eligible Class.

You are also eligible for Employee Hospital Indemnity Insurance during any Enrollment Period or as a result of a Family Status Change, provided you are Actively at Work and in an Eligible Class.

When must you enroll for Employee Hospital Indemnity Insurance?

You must enroll within 90 days of the date you are initially eligible for Employee Hospital Indemnity Insurance.

If you refuse your insurance and do not enroll when you are eligible, then you will not be allowed to enroll until the next Enrollment Period or within 31 days of the date of a Family Status Change.

When does your Employee Hospital Indemnity Insurance start?

For Contributory Employee Hospital Indemnity Insurance, your insurance starts on the later of the date:

- you are eligible; or
- you enroll and agree to make any required contribution toward the cost of insurance; and you are Actively at Work on that date.

If you are not Actively at Work on that date, your insurance will not start until you resume being Actively at Work.

When can you make changes in Employee Hospital Indemnity Insurance?

You may request a change in your Employee Hospital Indemnity Insurance benefit elections during any Enrollment Period while the Policy is in force.

You may also request a change in Employee Hospital Indemnity Insurance at any time due to a Family Status Change. Such request must be made within 31 days of the date the Family Status Change occurred.

Any increase in Employee Hospital Indemnity Insurance is subject to the Pregnancy Waiting Period.

When does a change in Employee Hospital Indemnity Insurance start?

If you are Actively at Work, any increase in Employee Hospital Indemnity Insurance or benefits, for reasons other than a Family Status Change, will start none, when you apply for a different coverage option and you agree to make any required contribution toward the cost of insurance.

If you are not Actively at Work on that date, any increase in insurance or benefits will not start until you resume being Actively at Work.

Whether or not you are Actively at Work, any reduction in Employee Hospital Indemnity Insurance or benefits, for reasons other than a Family Status Change, will start on the date of change, when you reduce coverage.

If you are Actively at Work, any increase in Employee Hospital Indemnity Insurance or benefits due to a Family Status Change will start on the later of:

- the date you apply for such change in Employee Hospital Indemnity Insurance, if you apply within 31 days of the Family Status Change and you agree to make any required contribution toward the cost of insurance; or
- the date of your Family Status Change.

If you are not Actively at Work on that date, any increase in insurance or benefits will not start until you resume being Actively at Work.

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF EMPLOYEE INSURANCE

Whether or not you are Actively at Work, any reduction in Employee Hospital Indemnity Insurance or benefits due to a Family Status Change will start on the date of your Family Status Change.

Any change in Employee Hospital Indemnity Insurance will only affect benefits for a Covered Accident or Covered Sickness that occurs after the effective date of the change.

What happens if you are rehired by your Employer?

If you are rehired by your Employer within 6 months of the date your employment ends, your insurance may be reactivated. Your reactivated insurance will:

- be the same insurance for which you were insured prior to termination of employment; and
- be subject to all the terms and provisions of the Policy.

You will be subject to a new Pregnancy Waiting Period as of the date you are rehired. You will be given credit for the time you were insured prior to your termination of employment.

If you had partially satisfied your Eligibility Waiting Period prior to your termination of employment, your previous time employed with your Employer will count towards completion of your Eligibility Waiting Period. Your Eligibility Date will be the later of the date you are rehired or the day after you complete the Eligibility Waiting Period.

If you are rehired by your Employer 6 months or later after the date your employment terminates, your coverage will not be reactivated. You will be eligible for insurance on the day after you complete a new Eligibility Waiting Period.

You must re-enroll within 31 days of your rehire date.

Coverage will not be reactivated for any amount of insurance which you continued under the Portability Provision, unless you cancel such coverage.

When does Employee Hospital Indemnity Insurance end?

Your Employee Hospital Indemnity Insurance under the Policy will end on the earliest of the following to occur:

- the date the Policy terminates;
- the last day of the period for which any required premium has been paid for your Employee Hospital Indemnity Insurance or any part of your insurance;
- the date you notify us in Writing to cancel your Employee Hospital Indemnity Insurance; or
- the date you die.

Your Employee Hospital Indemnity Insurance will also end when any of the following occur, but coverage may be extended subject to any allowed continuation as specified in the Insurance Continuation section:

- the date you are no longer in an Eligible Class;
- the date you enter active duty in any armed service;
- the date you retire;
- the date your class is no longer included for insurance; or
- the last day you are Actively at Work, subject to any applicable Portability provision provided.

If your coverage has ended, can it be reinstated?

If your insurance ends for any reason other than you have voluntarily terminated your insurance, then your insurance may be reinstated within 12 months from when your insurance ended. To reinstate your insurance, you must submit a Written request within 31 days after you return to being Actively at Work in an Eligible Class. Reinstatement will be effective on the later date when both of the following have occurred:

- you agree to make any required contribution toward the cost of your insurance; and
- you return to being Actively at Work.

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF EMPLOYEE INSURANCE

Any Accident or Sickness occurring between your termination date and your reinstatement effective date will not be considered a Covered Hospital Indemnity Benefit.

A new Eligibility Waiting Period will not apply.

We will credit any time the Insured was previously covered under the Policy toward the satisfaction of the Pregnancy Waiting Period.

Any increase in coverage or the addition of coverage at the time of reinstatement for any Insured is subject to the Pregnancy Waiting Period.

Your reinstated insurance will be subject to all the terms and provisions of the Policy.

Coverage will not be reinstated for any amount of insurance which you continued under the Portability provision, unless you cancel such coverage.

4. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE

When are you eligible for Spouse Hospital Indemnity Insurance?

If you are in an Eligible Class, you are initially eligible for Spouse Hospital Indemnity Insurance on the latest of:

- July 1, 2021;
- the date you are eligible for Employee Hospital Indemnity Insurance; or
- the date you acquire a Spouse.

You are also eligible for Spouse Hospital Indemnity Insurance during any Enrollment Period or as a result of a Family Status Change, provided you are in an Eligible Class and have a Spouse.

When must you enroll for Spouse Hospital Indemnity Insurance?

You must enroll within 90 days of the date you are initially eligible for Spouse Hospital Indemnity Insurance.

If you refuse your Spouse insurance or do not enroll when you are eligible, then you will not be allowed to enroll your Spouse until the next Enrollment Period or within 31 days of the date of a Family Status Change.

When does Spouse Hospital Indemnity Insurance start?

For Contributory Spouse Hospital Indemnity Insurance, your insurance starts on the latest of the date:

- you are eligible for Spouse Hospital Indemnity Insurance;
- you are insured under the Policy for Employee Hospital Indemnity Insurance;
- you enroll for Spouse Hospital Indemnity Insurance and you agree to make any required contribution toward the cost of insurance; and

you are Actively at Work on that date and your Spouse is not Confined on that date.

If you are not Actively at Work on that date, your Spouse Hospital Indemnity Insurance will not start until you resume being Actively at Work.

If your Spouse is Confined on the date your Spouse Hospital Indemnity Insurance would normally start, your Spouse Hospital Indemnity Insurance will not start until your Spouse is no longer Confined.

When can you make changes in Spouse Hospital Indemnity Insurance?

You may request a change in your Spouse Hospital Indemnity Insurance benefit options during any Enrollment Period while the Policy is in force.

You may also request a change in Spouse Hospital Indemnity Insurance at any time due to a Family Status Change. Such request must be made within 31 days of the date the Family Status Change occurred.

Any increase in Spouse Hospital Indemnity Insurance is subject to the Pregnancy Waiting Period.

When does a change in Spouse Hospital Indemnity Insurance start?

If you are Actively at Work, any increase in Spouse Hospital Indemnity Insurance or benefits, for reasons other than a Family Status Change, will start none, when you apply for a different coverage option and you agree to make any required contribution toward the cost of insurance.

Your Spouse must not be Confined on the date of the increase in benefits.

If you are not Actively at Work on that date, any increase in Spouse Hospital Indemnity Insurance or benefits will not start until you resume being Actively at Work.

If your Spouse is Confined on that date, your increase in Spouse Hospital Indemnity Insurance or benefits will not start until your Spouse is no longer Confined.

4. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE

Whether or not you are Actively at Work, any reduction in Spouse Hospital Indemnity Insurance or benefits, for reasons other than a Family Status Change, will start on the date of change, when you reduce coverage.

If you are Actively at Work, any increase in Spouse Hospital Indemnity Insurance or benefits due to a Family Status Change will start on the later of:

- the date you apply for such change in Spouse Hospital Indemnity Insurance, if you apply within 31 days of the Family Status Change and you agree to make any required contribution toward the cost of insurance; or
- the date of your Family Status Change.

Your Spouse must not be Confined on the date of the increase in benefits.

If you are not Actively at Work on that date, any increase in Spouse Hospital Indemnity Insurance or benefits will not start until you resume being Actively at Work.

If your Spouse is Confined on that date, your increase in Spouse Hospital Indemnity Insurance or benefits will not start until your Spouse is no longer Confined.

Whether or not you are Actively at Work, any reduction in Spouse Hospital Indemnity Insurance or benefits due to a Family Status Change will start on the date of your Family Status Change.

Any change in Spouse Hospital Indemnity Insurance will only affect benefits for a Covered Accident or Covered Sickness that occurs after the effective date of the change.

When does Spouse Hospital Indemnity Insurance end?

Spouse Hospital Indemnity Insurance under the Policy will end on the earliest of the following to occur:

- the date the Policy terminates;
- the last day of the period for which any required premium has been paid for your insurance or your Spouse Hospital Indemnity Insurance or any part of your insurance or your Spouse Hospital Indemnity Insurance;
- the date you notify us in Writing to cancel your Spouse Hospital Indemnity Insurance;
- the date you die; or
- the date your Spouse dies.

Your Spouse Hospital Indemnity Insurance will also end when any of the following occur, but coverage may be extended subject to any allowed continuation as specified in the Insurance Continuation section:

- the date you are no longer in an Eligible Class;
- the date you are no longer insured under the Policy;
- the date your Spouse no longer meets the definition of Spouse as described in this Certificate;
- the date your Spouse enters active duty in any armed service;
- the date you retire;
- the date your class is no longer included for insurance; or
- the last day you are Actively at Work, subject to any Portability provision provided.

5. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF DEPENDENT CHILDREN INSURANCE

When are you eligible for Dependent Children Hospital Indemnity Insurance?

If you are in an Eligible Class, then you are initially eligible for Dependent Children Hospital Indemnity Insurance on the latest of:

- July 1, 2021;
- the date you are eligible for Employee Hospital Indemnity Insurance; or
- the date you acquire your Dependent Children.

You are also eligible for Dependent Children Hospital Indemnity Insurance during any Enrollment Period or as a result of a Family Status Change, provided you are in an Eligible Class and have one or more Dependent Children.

When must you enroll for Dependent Children Hospital Indemnity Insurance?

You must enroll within 90 days of the date you are initially eligible for Dependent Children Hospital Indemnity Insurance otherwise you will not be allowed to enroll until the next Enrollment Period or until a Family Status Change.

When does Dependent Children Hospital Indemnity Insurance start?

For Contributory Dependent Children Hospital Indemnity Insurance, your insurance starts on the latest of the date:

- you are eligible for Dependent Children Hospital Indemnity Insurance;
- you are insured under the Policy for Employee Hospital Indemnity Insurance;
- you enroll for Dependent Children Hospital Indemnity Insurance and you agree to make any required contribution toward the cost of insurance; and

you are Actively at Work on that date and your Dependent Child is not Confined on that date.

If you are not Actively at Work on that date, your Dependent Children Hospital Indemnity Insurance will not start until you resume being Actively at Work.

If your Dependent Child is Confined on the date your Dependent Children Hospital Indemnity Insurance would normally start, your Dependent Children Hospital Indemnity Insurance for that Child will not start until your Child is no longer Confined. Confinement does not apply to a newborn child, newly placed foster child or a newly adopted child.

When can you make changes in Dependent Children Hospital Indemnity Insurance?

You may request a change in your Dependent Children Hospital Indemnity Insurance benefit options during any Enrollment Period while the Policy is in force.

You may also request a change in Dependent Children Hospital Indemnity Insurance at any time due to a Family Status Change. Such request must be made within 31 days of the date the Family Status Change occurred.

Any increase in Dependent Children Hospital Indemnity Insurance is subject to the Pregnancy Waiting Period.

When does a change in Dependent Children Hospital Indemnity Insurance start?

If you are Actively at Work, any increase in Dependent Children Hospital Indemnity Insurance or benefits, for reasons other than a Family Status Change, will start none, when you apply for a different coverage option and you agree to make any required contribution toward the cost of insurance.

Your Dependent Child must not be Confined on the date of the increase in benefits.

If you are not Actively at Work on that date, any increase in Dependent Children Hospital Indemnity Insurance or benefits will not start until you resume being Actively at Work.

5. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF DEPENDENT CHILDREN INSURANCE

If your Dependent Child is Confined on that date, your increase in Dependent Children Hospital Indemnity Insurance or benefits will not start until your Dependent Child is no longer Confined.

Whether or not you are Actively at Work, any reduction in Dependent Children Hospital Indemnity Insurance or benefits, for reasons other than a Family Status Change, will start on the date of change, when you reduce coverage.

If you are Actively at Work, any increase in Dependent Children Hospital Indemnity Insurance or benefits due to a Family Status Change will start on the later of:

- the date you apply for such change in Dependent Children Hospital Indemnity Insurance, if you apply within 31 days of the Family Status Change and you agree to make any required contribution toward the cost of insurance; or
- the date of your Family Status Change.

Your Dependent Child must not be Confined on the date of the increase in benefits.

If you are not Actively at Work on that date, any increase in Dependent Children Hospital Indemnity Insurance or benefits will not start until you resume being Actively at Work.

If your Dependent Child is Confined on that date, your increase in Dependent Children Hospital Indemnity Insurance or benefits will not start until your Dependent Child is no longer Confined.

Whether or not you are Actively at Work, any reduction in Dependent Children Hospital Indemnity Insurance or benefits due to a Family Status Change will start on the date of your Family Status Change.

Any change in Dependent Children Hospital Indemnity Insurance will only affect benefits for a Covered Accident or Covered Sickness that occurs after the effective date of the change.

How can you add a child or children to your Dependent Children Hospital Indemnity Insurance?

After you and a Dependent Child are covered under the Policy, and you are Actively at Work, any child who becomes one of your Dependent Children will automatically be covered.

How does Dependent Children Hospital Indemnity Insurance apply to newborn children, newly placed foster children or newly adopted children?

If you are insured under the Policy but do not have Dependent Children Hospital Indemnity Insurance when a newborn child, newly placed foster child or newly adopted child becomes one of your Dependent Children, then such child will automatically be covered for 31 days from the date he or she becomes your Dependent Child. To continue coverage beyond 31 days, you must:

- enroll for Dependent Children Hospital Indemnity Insurance within 31 days from the date the newborn child, newly placed foster child or newly adopted child becomes your Dependent Child; and
- pay the required premium to continue your Dependent Children Hospital Indemnity Insurance.

If you are covered under the Policy and have Dependent Children Hospital Indemnity Insurance when a newborn child, newly placed foster child or newly adopted child becomes one of your Dependent Children, then such child will automatically be covered.

When does Dependent Children Hospital Indemnity Insurance end?

Dependent Children Hospital Indemnity Insurance under the Policy will end on the earliest of the following to occur:

- the date the Policy terminates;
- the last day of the period for which any required premium has been paid for your insurance or your Dependent Children Hospital Indemnity Insurance, or any part of the insurance;
- the date you request in Writing to cancel your Dependent Children Hospital Indemnity Insurance;
- the date you die; or
- the date your Dependent Child dies.

5. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF DEPENDENT CHILDREN INSURANCE

Your Dependent Children Hospital Indemnity Insurance will also end when any of the following occur, but coverage may be extended subject to any allowed continuation as specified in the Insurance Continuation section:

- the date you are no longer in an Eligible Class;
- the date you are no longer insured under the Policy;
- the date your Dependent Child no longer meets the definition of Dependent Child as described in this Certificate, but only with respect to that person;
- the date your Dependent Child enters active duty in any armed service;
- the date you retire;
- the date your class is no longer included for insurance; or
- the last day you are Actively at Work, subject to any Portability provision provided.

6. COVERED HOSPITAL INDEMNITY BENEFITS

Benefit Plan: LOW

What benefits are payable under the Policy?

We will pay the Benefit Amount shown in the Benefit Highlights when an Insured is Confined or receives Treatment for a Covered Accident or Covered Sickness. The Confinement or Treatment must occur on or after the effective date of insurance. Any required premiums must continue to be paid, either under the Policy or under the group portability policy, if eligible, for benefits to be paid.

Any benefits are subject to the provisions of the Policy.

Confinement Benefits

First Day Hospital Confinement

We will pay the First Day Hospital Confinement amount on the first day an Insured is Confined to a Hospital as a result of a Covered Accident or Covered Sickness. This benefit is payable only once per continuous Confinement per Insured. We will not pay this benefit for Outpatient Treatment, Emergency Room Treatment or a stay in an Observation Unit.

The Confinement must begin within 365 days after the Covered Accident occurs. This benefit is payable once per Covered Accident or Covered Sickness, and is only payable once per day, even if the Confinement is the result of more than one Covered Accident or Covered Sickness.

Hospital Confinement

We will pay the Hospital Confinement amount for each day during a period of Confinement in which an Insured is Confined as an Inpatient for the Treatment of a Covered Accident or Covered Sickness. We will not pay this benefit for Outpatient Treatment, Emergency Room Treatment or a stay of 19 hours or less in an Observation Unit. We will pay this benefit on the same day as the First Day Hospital Confinement benefit is paid.

The Confinement must begin within 365 days after the Covered Accident occurs. This benefit is payable once per day, even if the Confinement is the result of more than one Covered Accident or Covered Sickness.

Intensive Care Unit (ICU) Confinement

We will pay the Intensive Care Unit (ICU) Confinement amount for each day during a period of Confinement in which an Insured is Confined to a Hospital Intensive Care Unit (ICU) as a result of a Covered Accident or Covered Sickness. We will pay this benefit in addition to the Hospital Confinement amount. We will pay this benefit on the same day as the First Day Hospital Confinement benefit is paid.

The Confinement must begin within 365 days after the Covered Accident occurs. This benefit is only payable once per day, even if the Confinement is the result of more than one Covered Accident or Covered Sickness.

Additional and Enhanced Benefit(s)

Extended Hospitalization

After the Insured has been Confined in a Hospital or Intensive Care Unit for at least 10 consecutive days, we will pay the Extended Hospitalization amount shown in the Benefit Highlights. This benefit is payable for each day of Hospital or Intensive Care Unit Confinement beginning with the first day of Confinement.

This benefit is payable in addition to the Hospital Confinement or Intensive Care Unit (ICU) Confinement benefit.

6. COVERED HOSPITAL INDEMNITY BENEFITS

Family Care Benefit(s)

Wellness Screening

A Wellness Screening benefit is payable for each Insured who has any one of the following wellness screening tests performed:

- annual physical examination
- abdominal and aortic aneurysm ultrasonography
- biopsies for cancer
- bone density screening
- bone marrow testing
- BRCA (cancer genetic mutation test)
- breast cancer screening (clinical breast exam, mammography, MRI, thermography, ultrasound)
- CA15-3 (blood test for breast cancer)
- CA125 (blood test for ovarian cancer)
- cardiac exercise stress test
- carotid doppler
- CEA (blood test for colon cancer)
- chest x-ray
- colorectal cancer screening (fecal occult blood test, colonoscopy, sigmoidoscopy)
- CT angiography
- diabetes tests (fasting blood glucose test, hemoglobin A1c)
- double contrast barium enema
- echocardiogram
- electrocardiogram (ECG)-resting or stress
- flexible Sigmoidoscopy
- hemocult Stool Analysis
- immunizations
- interscholastic sports physical exam
- lymphocyte genome sensitivity test (LGS) (universal blood test for cancer)
- lipid panel (total cholesterol including serum cholesterol test, triglycerides, HDL, LDL)
- pap smear (including ThinPrep)
- prostate Cancer Screening (digital rectal exam, PSA blood test)
- serum Protein Electrophoresis (blood test for myeloma)
- skin cancer screening
- testicular ultrasound
- smoking cessation program
- weight reduction program
- dental examination
- vision examination

To receive this benefit, you must notify us of which wellness screening test was performed.

6. COVERED HOSPITAL INDEMNITY BENEFITS

Benefit Plan: HIGH

What benefits are payable under the Policy?

We will pay the Benefit Amount shown in the Benefit Highlights when an Insured is Confined or receives Treatment for a Covered Accident or Covered Sickness. The Confinement or Treatment must occur on or after the effective date of insurance. Any required premiums must continue to be paid, either under the Policy or under the group portability policy, if eligible, for benefits to be paid.

Any benefits are subject to the provisions of the Policy.

Confinement Benefits

First Day Hospital Confinement

We will pay the First Day Hospital Confinement amount on the first day an Insured is Confined to a Hospital as a result of a Covered Accident or Covered Sickness. This benefit is payable only once per continuous Confinement per Insured. We will not pay this benefit for Outpatient Treatment, Emergency Room Treatment or a stay in an Observation Unit, or for Confinement that is covered under the Rehabilitation Unit benefit.

The Confinement must begin within 365 days after the Covered Accident occurs. This benefit is payable once per Covered Accident or Covered Sickness, and is only payable once per day, even if the Confinement is the result of more than one Covered Accident or Covered Sickness.

Successive Confinements under this benefit will be considered as one Confinement if they are due to the same or related Covered Accident or Covered Sickness and are separated by less than 30 days

Hospital Confinement

We will pay the Hospital Confinement amount for each day during a period of Confinement in which an Insured is Confined as an Inpatient for the Treatment of a Covered Accident or Covered Sickness. We will not pay this benefit for Outpatient Treatment or Emergency Room Treatment or a stay of 19 hours or less in an Observation Unit. We will pay this benefit on the same day as the First Day Hospital Confinement or First Day Intensive Care Unit (ICU) Confinement benefits are paid.

The Confinement must begin within 365 days after the Covered Accident occurs. This benefit is payable once per day, even if the Confinement is the result of more than one Covered Accident or Covered Sickness.

First Day Intensive Care Unit (ICU) Confinement

We will pay the First Day Intensive Care Unit (ICU) Confinement amount on the first day an Insured is Confined to a Hospital Intensive Care Unit (ICU) as a result of a Covered Accident or Covered Sickness. This benefit is payable only once per continuous Confinement per Insured. We will pay this benefit in addition to the First Day Hospital Confinement benefit.

The Confinement must begin within 365 days after the Covered Accident occurs. This benefit is payable once per Covered Accident or Covered Sickness, and is only payable once per day, even if the Confinement is the result of more than one Covered Accident or Covered Sickness.

Intensive Care Unit (ICU) Confinement

We will pay the Intensive Care Unit (ICU) Confinement amount for each day during a period of Confinement in which an Insured is Confined to a Hospital Intensive Care Unit (ICU) as a result of a Covered Accident or Covered Sickness. We will pay this benefit in addition to the Hospital Confinement amount. We will pay this benefit on the same day as the First Day Hospital Confinement or First Day Intensive Care Unit Confinement benefits are paid.

6. COVERED HOSPITAL INDEMNITY BENEFITS

The Confinement must begin within 365 days after the Covered Accident occurs. This benefit is only payable once per day, even if the Confinement is the result of more than one Covered Accident or Covered Sickness.

Intermediate Step-Down Unit Confinement

We will pay the Intermediate Step-Down Unit Confinement amount shown in the Benefit Highlights for each day during a period of Confinement in which an Insured is Confined to a Hospital Intermediate Step-Down Unit as a result of a Covered Accident or Covered Sickness. We will pay this benefit on the same day the First Day Hospital Confinement benefit is paid. We will pay this benefit in addition to the Hospital Confinement amount shown in the Benefit Highlights.

The Confinement must begin within 365 days after the Covered Accident occurs. This benefit is only payable once per day, even if the Confinement is the result of more than one Covered Accident or Covered Sickness.

Newborn Nursery Confinement

We will pay the Newborn Nursery Confinement amount shown in the Benefit Highlights for a newborn baby who is under Newborn Nursery Care and is not Confined for Treatment of a physical illness, infirmity, disease or Injury. We will pay this benefit for each day the newborn is Confined, up to the number of days shown in the Benefit Highlights. If a newborn baby is Confined for Treatment of a physical illness, infirmity, disease or Injury, we will pay the higher of the Hospital Confinement benefit or Intensive Care Unit (ICU) Confinement Benefit instead of the Newborn Nursery Confinement benefit. We will pay this benefit in addition to the First Day Hospital Confinement benefit.

Rehabilitation Unit

We will pay the Rehabilitation Unit amount shown in the Benefit Highlights for each day during a period of Confinement in which an Insured is Confined to a Rehabilitation Unit as an Inpatient for Treatment of a Covered Accident or Covered Sickness. Confinement to a Rehabilitation Unit must begin within 30 days of a related Confinement. We will pay this benefit in addition to the Hospital Confinement benefit.

This benefit is only payable once per day, even if the Confinement is the result of more than one Covered Accident or Covered Sickness.

Inpatient Surgery

We will pay the Inpatient Surgery amount shown in the Benefit Highlights for each day during a period of Confinement in which an Insured is Confined to a Hospital as an Inpatient due to undergoing invasive or Open Surgery as a result of a Covered Accident or Covered Sickness.

The surgery must be performed within 365 days after the Covered Accident occurs. This benefit is paid once per day, even if more than one surgery is performed in one day.

Additional and Enhanced Benefit(s)

Annual Benefit Increase

Each year, up to the maximum number of years shown in the Benefit Highlights, we will increase the First Day Hospital Confinement benefit amount.

The listed benefits will be increased by the Annual Benefit Increase amount on the Policy anniversary.

Annual Wellness Increase

Each year, up to the maximum number of years shown in the Benefit Highlights, we will increase the Wellness Screening benefit amount. The Wellness Screening benefit will be increased by the Wellness Annual Increase amount on the Policy anniversary.

6. COVERED HOSPITAL INDEMNITY BENEFITS

Emergency Room (ER) Treatment – Accident Only

We will pay the Emergency Room (ER) Treatment - Accident Only amount shown in the Benefit Highlights for each day an Insured received Treatment in an Emergency Room as a result of a Covered Accident.

Treatment in the Emergency Room must occur within 30 days after the Covered Accident occurs. This benefit is paid once per day, even if the Insured has multiple Emergency Room visits or receives Treatment for more than one Covered Accident.

Employer Facility

We will pay the additional amount for the benefits indicated in the Benefit Highlights, for each day an Insured receives Treatment in an Employer Facility as a result of a Covered Accident or Covered Sickness.

Extended Hospitalization

After the Insured has been Confined in a Hospital, Intensive Care Unit or Intermediate Step-Down Unit for at least 10 consecutive days, we will pay the Extended Hospitalization amount shown in the Benefit Highlights. This benefit is payable for each day of Hospital, Intensive Care Unit or Intermediate Step-Down Unit Confinement, beginning with the first day of Confinement.

This benefit is payable in addition to the Hospital Confinement, Intensive Care Unit (ICU) Confinement or Intermediate Step-Down Unit Confinement benefit.

Observation Unit Stay

We will pay the Observation Unit Stay amount shown in the Benefit Highlights for each day in which an Insured receives Treatment in an Observation Unit as a result of a Covered Accident or Covered Sickness. We will not pay this benefit on the same day as the Hospital Confinement benefits are paid.

Treatment must begin within 365 days after the Covered Accident occurs. This benefit is only payable once per day, even if the Treatment is the result of more than one Covered Accident or Covered Sickness.

An observation stay lasting more than 19 hours is treated as a Hospital Confinement.

Family Care Benefit(s)

Family Care

We will pay the amount shown in the Benefit Highlights for each day that you or your Spouse incur an expense for the care of a Dependent Family Member as a result of you or your Spouse receiving one of the following benefits under this Policy:

- First Day Hospital Confinement
- Hospital Confinement
- First Day Intensive Care Unit (ICU) Confinement
- Intensive Care Unit (ICU) Confinement
- Intermediate Step-Down Unit Confinement
- Rehabilitation Unit

This benefit is only payable once per day, even if the paid benefit is the result of more than one Covered Accident or Covered Sickness or more than one Dependent Family Member requires care.

This benefit is not payable if the care is provided by a Family Member.

The Dependent Family Member does not have to be insured under the Policy for this benefit to be payable.

6. COVERED HOSPITAL INDEMNITY BENEFITS

Lodging

We will pay the Lodging amount shown in the Benefit Highlights for each day an expense is incurred for lodging by an Insured or an adult Family Member, or adult companion, accompanying an Insured who is Confined more than 100 miles away from the Insured's primary residence for Treatment that is the result of a Covered Accident or Covered Sickness. Lodging must be incurred within 365 days after the Covered Accident occurs.

This benefit is only payable:

- if the adult Family Member or adult companion is providing care for the Insured or is acting as an advocate on the behalf of an Insured while the Insured is Confined; and
- for a Confinement for which a benefit is payable for an Insured under the Policy.

Proof of the expense incurred for lodging must be submitted with the claim. Mileage is measured as the distance from the Insured's primary residence to the facility at which the Confinement occurs.

This benefit is only payable once per day.

Transportation

We will pay the Transportation amount shown in the Benefit Highlights for each day an Insured must travel to or from a Hospital more than 100 miles away from his or her primary residence for Confinement that is the result of a Covered Accident or Covered Sickness.

The Confinement for which travel is required must be prescribed by a Physician. Travel must occur within 365 days after the Covered Accident occurs.

Proof of the expense incurred for transportation must be submitted with the claim. Mileage is measured as the distance from the Insured's primary residence to the facility at which the Confinement occurs.

This benefit is only payable once per day.

Wellness Screening

A Wellness Screening benefit is payable for each Insured who has any one of the following wellness screening tests performed:

- annual physical examination
- abdominal and aortic aneurysm ultrasonography
- biopsies for cancer
- bone density screening
- bone marrow testing
- BRCA (cancer genetic mutation test)
- breast cancer screening (clinical breast exam, mammography, MRI, thermography, ultrasound)
- CA15-3 (blood test for breast cancer)
- CA125 (blood test for ovarian cancer)
- cardiac exercise stress test
- carotid doppler
- CEA (blood test for colon cancer)
- chest x-ray
- colorectal cancer screening (fecal occult blood test, colonoscopy, sigmoidoscopy)
- CT angiography
- diabetes tests (fasting blood glucose test, hemoglobin A1c)
- double contrast barium enema
- echocardiogram
- electrocardiogram (ECG)-resting or stress
- flexible Sigmoidoscopy
- hemocult Stool Analysis

6. COVERED HOSPITAL INDEMNITY BENEFITS

- immunizations
- interscholastic sports physical exam
- lymphocyte genome sensitivity test (LGS) (universal blood test for cancer)
- lipid panel (total cholesterol including serum cholesterol test, triglycerides, HDL, LDL)
- pap smear (including ThinPrep)
- prostate Cancer Screening (digital rectal exam, PSA blood test)
- serum Protein Electrophoresis (blood test for myeloma)
- skin cancer screening
- testicular ultrasound
- smoking cessation program
- weight reduction program
- dental examination
- vision examination

To receive this benefit, you must notify us of which wellness screening test was performed.

7. EXCLUSIONS AND LIMITATIONS

What exclusions apply to the benefits payable?

No benefits will be payable for any loss that is caused or contributed to by:

- war or any act of war or your active duty in any armed service during a time of war (this does not include acts of terrorism);
- active military duty;
- riding in or driving any motor-driven vehicle in a race, stunt show, speed test or driving while Intoxicated;
- committing of or attempting to commit an assault, felony or other criminal act;
- active Participation in a Riot, Rebellion or Insurrection;
- committing or attempting to commit suicide, whether sane or insane, or injuring oneself intentionally;
- incarceration in a penal institution of any kind;
- elective abortion or complications thereof;
- elective or cosmetic surgery or procedures, except for reconstructive surgery or unless due to congenital anomaly or disease of a Dependent Child which has resulted in a defect;
- artificial insemination, in vitro fertilization, test tube fertilization; or
- sterilization, tubal ligation or vasectomy, and reversal thereof, unless recommended by a Physician.

No benefits will be payable relating to or resulting from services or Treatment rendered or Confinement outside the United States or Canada.

What limitations apply to pregnancy?

An Insured must complete the Pregnancy Waiting Period as shown in the Benefit Schedule before becoming eligible for benefits for normal pregnancy or childbirth under the Policy. If the Insured receives Treatment for pregnancy or childbirth during this Pregnancy Waiting Period, benefits are not payable.

If the Insured becomes Confined as the result of pregnancy or childbirth prior to completing the Pregnancy Waiting Period, benefits will only be payable for any day of Confinement that extends after the end of the Pregnancy Waiting Period.

This limitation does not apply to Complications of Pregnancy.

8. CLAIM PROVISIONS

How is a claim submitted?

To submit a claim, you or someone on your behalf must send us Written notice and Proof of claim on our form within the time limits specified. Your Employer has the notice and Proof of claim forms.

NOTICE OF CLAIM

When does Written notice of claim have to be submitted?

Written notice of claim must be given to us no later than 90 days after the Insured's date of loss.

If notice cannot be given within the applicable time period, we must be notified as soon as it is reasonably possible.

When we receive Written notice of claim, we will send the forms for Proof of claim. If the forms are not received within 15 days after Written notice of claim is sent, Proof of claim may be sent to us without waiting to receive the Proof of claim forms.

PROOF OF CLAIM

When does Written Proof of claim have to be submitted?

Written Proof of claim must be given to us no later than 180 days after the Insured's date of loss.

If Proof cannot be given within the time limit, Proof must be given as soon as reasonably possible. Proof of claim may not be given later than one year after the time Proof is otherwise required unless you are legally incompetent.

What is considered Proof of claim?

Proof of claim must consist of at least the following information:

- for any Hospital Confinement, Proof that a Hospital room and board charge is incurred;
- a description of the loss;
- the date the loss occurred;
- the cause of the loss;
- hospital records, physician records, x-rays, narrative reports, or lab, toxicology or other diagnostic testing materials as appropriate for the Treatment of the Accident or Sickness;
- police accident reports; and
- any other information we may require to make a claim determination.

We may require as part of the Proof, authorizations to obtain medical and non-medical information. Proof must be satisfactory to us.

PAYMENT OF BENEFITS

When are benefits payable?

Benefits are payable upon our receipt of satisfactory Proof of claim that establishes benefit eligibility according to the provisions of the Policy.

When will a decision on your claim be made?

We will send you a Written notice of our decision on your claim within a reasonable time after we receive the claim but not later than 90 days after receipt of the claim. If we cannot make a decision within 90 days after receiving your claim, we will request a 30 day extension as permitted by U.S. Department of Labor regulations. Any request for extension will specifically explain:

- the standards on which entitlement to benefits is based;
- the unresolved issues that prevent a decision on the claim; and
- the additional information needed to resolve those issues.

8. CLAIM PROVISIONS

If a period of time is extended because you failed to provide necessary information, the period for making the benefit determination is tolled from the date we send notice of the extension to you until the date on which you respond and provide the requested information. You will have 45 days to provide the specified information.

What if your claim is denied?

If we deny all or any part of your claim, you will receive a Written notice of denial stating:

- the specific reason(s) for the denial;
- the specific Policy provision(s) on which the denial is based;
- your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
- a description of any additional material or information needed to prove entitlement to benefits and an explanation of why such material or information is necessary;
- a description of the appeal procedures and time limits;
- your right to bring a civil action under ERISA, §502(a), if applicable, following an adverse determination on review; and

Can you request a review of a claim denial?

If all or part of your claim is denied, you may request in Writing a review of the denial within 60 days after receiving notice of denial.

You may submit Written comments, documents, records or other information relating to your claim for benefits, and may request free of charge copies of all documents, records, and other information relevant to your claim for benefits.

We will review the claim on receipt of the Written request for review, and will notify you of our decision within a reasonable time but not later than 60 days after the request has been received. If an extension of time is required to process the claim, we will notify you in Writing of the special circumstances requiring the extension and the date by which we expect to make a determination on review. The extension cannot exceed a period of 60 days from the end of the initial period.

If a period of time is extended because you failed to provide information necessary to decide your claim, the period for making the decision on review is tolled from the date we send notice of the extension to you until the date on which you respond to the request for additional information. You will have at least 45 days to provide the specified information.

What if your claim is denied on review?

If we deny all or any part of your claim on review, you will receive a Written notice of denial stating:

- the specific reasons for the denial;
- the specific Policy provisions on which the denial is based;
- your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
- your right to bring a civil action under ERISA, §502(a), if applicable;

To whom are benefits payable?

We will pay you if your Proof of claim is satisfactory to us, except in the following situations:

- you are a minor. In such case, claim may be made by your duly appointed guardian, conservator or committee and we will pay to such person or persons;
- due to physical or mental incapacity, you cannot, in our judgment, give us a valid receipt for payments. In such case, claim may be made as described above; or
- you die before we pay you. In such case, claim may be made by your executor or the administrator of your estate and we will pay to such person or persons.

If we do not pay you and claim is not made by the appropriate person designated above, we may, at our option, make payments under either or both Methods A or B below. Any decision to pay any benefits, prior to the appointment of the appropriate person designated (as shown above), is solely at our

8. CLAIM PROVISIONS

discretion, and we may choose to pay no amounts under any circumstances until such appropriate person is formally appointed.

Method A: We may pay up to the sum of \$5,000 to any individual or entity we determine has incurred or paid expenses as a result of funeral services provided to or on your behalf. If we pay such a benefit, we will not have to pay that benefit amount again and the total benefit due under the Policy shall be reduced by the amount paid under this provision.

Method B: We may pay the whole or any part of such benefit:

- to your Spouse, up to a cumulative amount of \$5,000; or
- if you have no Spouse, up to a cumulative amount of \$5,000 to any one or more of the following relatives in the following order of priority:
 - first, your child or children;
 - then, your mother or father.

9. INSURANCE CONTINUATION

Are there any conditions under which your Employer can continue your insurance?

While the Policy is in force and subject to the conditions stated in the Policy, your Employer may continue your insurance that was in force on the date immediately before the date you ceased to be Actively at Work by paying the required premium to us for any of the following reasons and durations:

- Sickness or Injury – up to 12 months
- Layoff – up to 3 months
- Leave of Absence – up to 3 months including Family and Medical Leave of Absences
- Vacation – based on your Employer's policy, not to exceed 3 months

You should contact your Employer for more details.

While the Policy is in force, you may be eligible to continue your insurance pursuant to the Family and Medical Leave Act of 1993, as amended or continue coverage pursuant to a state required continuation period (if any). You should contact your Employer for more details.

While the Policy is in force, you may be eligible to continue your insurance coverage pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA), as amended. You should contact your Employer for more details.

10. PORTABILITY

What is portable insurance and when are you eligible?

Portable insurance is an optional benefit that you may elect to continue your insurance for each Insured up to the later of the day before you attain age 70 or 12 months from the date your portable insurance started if:

- your insurance ends because you are no longer in an Eligible Class; or
- your insurance ends because your class is no longer included for insurance; or
- your insurance ends because you terminate employment; or
- a revision is made to the Policy to reduce your amount of insurance; or
- the Policy terminates; and
- you meet the following requirements:
 - you reside in the United States or Canada; and
 - you have not exercised your portable insurance right under a similar certificate issued by us; and
 - your insurance is not being continued under any Insurance Continuation provision.

You may not elect portable insurance for your Spouse or your Dependent Children if you have not elected portable insurance for yourself.

Your portable insurance will be provided under an insurance policy we make available for this purpose. Your portable insurance may not be identical to your current insurance under the Policy.

When must you apply for portable insurance?

You must complete an application for portable insurance and send it to us with payment of the first premium within 31 days of the date your insurance terminates. The application for portable insurance and applicable rates are available from your Employer.

What is the amount of portable insurance?

You may apply for portable insurance for the plan of insurance in force under the Policy on the date your insurance terminates. You may port to a lower plan of insurance, if available. Your portable insurance policy will not provide any benefits beyond those described in the section of this Certificate titled Covered Hospital Indemnity Benefits.

When does your portable insurance start?

Upon approval of your application and receipt of first premium, your portable insurance will become effective the day following your termination date.

When is portable insurance available to your Spouse and when is your Spouse eligible?

Portable insurance is available for your Spouse up to the later of the day before your Spouse attains age 70 or 12 months from the date your Spouse's portable insurance started if all of the following requirements are met:

- you die or divorce your Spouse and your Spouse was Insured under the Policy at that time; and
- your Spouse resides in the United States or Canada.

Your Spouse's portable insurance will be provided under an insurance policy we make available for this purpose. Their portable insurance may not be identical to your current insurance under the Policy.

When must your Spouse apply for portable insurance?

Your Spouse must complete an application for portable insurance and send it to us with payment of the first premium within 31 days of the date of your death or divorce. The application for portable insurance and applicable rates are available from your Employer.

What is the amount of your Spouse's portable insurance?

Your Spouse may apply for portable insurance for the plan in force under the Policy on the date of your death or divorce. Your Spouse may port to a lower plan of insurance, if available.

10. PORTABILITY

Your Spouse may not apply for portable insurance for a Dependent Child whose insurance has not terminated under the Policy due to divorce.

When does your Spouse's portable insurance start?

Upon approval of your Spouse's application and receipt of first premium, your Spouse's portable insurance will become effective the day following their termination date.

11. CONTINUITY OF COVERAGE

What happens if your Employer replaces other insurance with this Certificate and the Policy?

If your Employer replaces insurance provided by another insurance company ("Prior Policy") with the insurance provided by this Certificate and the Policy ("This Policy"), the Continuity of Coverage benefits set forth in this Section may be available to you. These benefits will be available if the insurance and level of benefits under the Prior Policy were substantially similar to the insurance provided by This Policy.

What if you are not Actively at Work when your Employer replaces the Prior Policy with This Policy?

You and your Spouse and your Dependent Children will be covered under This Policy if you are not Actively at Work on July 1, 2021 if:

- you were insured under the Prior Policy on the day before July 1, 2021;
- you are a member of an Eligible Class;
- your Employer continues to remit premiums for your coverage; and
- you are not receiving or eligible to receive benefits under your Employer's Prior Policy.

Any benefit payable will be the benefit payable under This Policy.

What if your Spouse or Dependent Child is Confined when your Employer's Prior Policy is replaced with This Policy and you are Actively at Work?

Your Spouse or your Dependent Children will be covered under This Policy if they are Confined on July 1, 2021 if:

- your Spouse or Dependent Child was insured under your Employer's Prior Policy on the day before July 1, 2021;
- you are a member of an Eligible Class for Spouse or Dependent Children coverage;
- your Employer continues to remit premiums for your Spouse or Dependent Children coverage; and
- your Spouse or Dependent Child are not receiving or eligible to receive Spouse or Dependent Child benefits under your Employer's Prior Policy.

Any Spouse or Dependent Child benefit payable will be the benefit payable under This Policy.

Does the Eligibility Waiting Period apply when your Employer's Prior Policy is replaced with This Policy?

We will apply any period of time satisfied under the Prior Policy to meet the requirements of the Eligibility Waiting Period toward the satisfaction of the period of time required by This Policy's Eligibility Waiting Period.

Does the Pregnancy Waiting Period apply when your Employer's Prior Policy is replaced with This Policy?

The Pregnancy Waiting Period will not apply if you or your Dependent were covered under your Employer's Prior Policy of hospital indemnity insurance on the day before July 1, 2021.

12. GENERAL PROVISIONS

AGENCY

Can the Policyholder, Employer, or third party administrator act as our agent?

For all purposes of the Policy, the Policyholder, Employer or third party administrator acts on its own behalf or as your agent. Under no circumstances will the Policyholder, Employer or third party administrator be deemed our agent.

ALTERATION

Who can alter the Policy?

The only persons with the authority to alter or modify the Policy or to waive any of its provisions are our president, actuary, secretary or one of our vice presidents and any such changes must be in Writing.

ASSIGNMENT

Can benefit payments be assigned?

An Insured cannot assign any of the group Hospital Indemnity insurance benefits.

CLERICAL ERROR

What happens when there is a clerical error in the administration of the Policy?

Clerical errors in the administration of the Policy or delays in keeping records for the Policy whether by us, the Policyholder, or the Employer:

- will not terminate insurance that would otherwise have been effective.
- will not continue insurance that would otherwise have ceased or should not have been in effect.

If appropriate, a fair adjustment of premium will be made to correct the error, subject to the "Limit of Premium Refunds" section.

This provision does not apply to benefit administration errors by the Policyholder or the Employer which results in an Employee:

- not enrolling for insurance within required time limits;
- failing to request increased amounts of insurance within required time limits; or
- failing to exercise any available Insurance Continuation or Portability option(s).

CONFORMITY WITH STATUTES

What is the effect of Conformity with Statutes?

If any provision of the Policy conflicts with any applicable law, the provision will be automatically amended to meet the minimum requirements of the law, except as otherwise pre-empted by federal law.

DISCHARGE OF OUR RESPONSIBILITY

What is the effect of payments under the Policy?

Payment made under the terms of the Policy will, to the extent of such payment, release us from all further obligations under the Policy. We will not be obligated to see to the application of such payment.

EXAMINATION

What are our examination rights?

We, at our expense, have the right to have any person with respect to whom a claim has been filed:

- examined by a Physician, other health professional or vocational expert of our choice; and/or
- interviewed by an authorized representative.

12. GENERAL PROVISIONS

This right may be used as often as we determine necessary. Unless authorized by the examining Physician, the examination may not be recorded nor may another person be present during the examination.

EXTENSION OF BENEFITS

What if an Insured is Hospital Confined on the date the Policy terminates?

If an Insured is Hospital Confined on the termination date of the Policy, unless termination is due to nonpayment of premiums, we will pay the same benefits for the duration of any Hospital Confinement or 90 days, whichever occurs first. No further premium payment is required to qualify for this extension of benefits.

INCONTESTABILITY

What is the Incontestability Provision?

Except for non-payment of premium, fraud or any claims incurred within two years of the effective date of an Insured's initial, increased, additional or reinstated insurance, no statement made by any Insured relating to insurability for such insurance will be used to contest the validity of that insurance after the insurance has been in force for a period of two years during that individual's lifetime. The statement must be contained in a form Signed by that individual.

This provision shall not preclude the assertion at any time of a defense to a claim based upon the Insured's eligibility for insurance.

INSURER'S AUTHORITY

What is our authority?

Sun Life has discretionary authority to make all final determinations regarding claims for benefits under the Policy. This discretionary authority includes, but is not limited to, the right to determine eligibility for benefits and the amount of any benefits due and to construe the terms of the Policy.

Any decision made by us in the exercise of this authority, including review of denials of benefit, is conclusive and binding on all parties. Any court reviewing such a decision shall uphold it unless the claimant proves that it was arbitrary and capricious.

LEGAL PROCEEDINGS

What are the time limits for legal proceedings?

No legal action may start:

- until 60 days after Proof of claim has been given; nor
- more than 3 years after the time Proof of claim is required.

The claimant must exhaust all internal appeal/administrative remedies prior to filing any legal proceeding. If the claimant fails to exhaust all administrative remedies prior to initiating any legal action, we shall be entitled to legal fees in defense of the action. For claims subject to ERISA, if a claimant files state law causes of action that are later determined by a court to be preempted by ERISA, we shall be entitled to legal fees in defense of those causes of action.

Any decision made by us, including review of denial of claims, is conclusive and binding on all parties. Any court reviewing our determination shall uphold such determination unless the claimant proves Sun Life's claim determination is without any rational basis. In any legal proceeding, the Court is limited in its review to the administrative record compiled by Sun Life prior to its final claim determination.

12. GENERAL PROVISIONS

LIMIT OF PREMIUM REFUNDS

Is there a limit on premium refunds?

Whether premiums were paid in error or otherwise, we will refund only that part of the excess premium that was paid during the 12-month period that preceded the date we learned of such overpayment.

MISSTATEMENT OF FACTS

What happens if there is a misstatement of facts in the administration of the Policy?

If relevant facts about the Employer or Employee relating to this insurance are determined not to be accurate:

- a fair adjustment of premium will be made, subject to the "Limit of Premium Refunds" section; and
- the actual facts will decide whether, and in what amount, and for what duration insurance is valid under the Policy.

NON-PARTICIPATING

Does the Policy participate in dividends?

The Policy is non-participating and will not share in any profits or surplus earnings of Sun Life Assurance Company of Canada, and, therefore, no dividends are payable.

PREMIUM PAYMENTS AS EVIDENCE OF INSURANCE

Does the payment of premiums guarantee coverage under the Policy?

The receipt of premiums by us is not a guarantee of insurance. Eligibility for benefits will be determined at the time of claim submission and in order to receive a benefit under the Policy, all Policy requirements must be satisfied.

If we determine that you, your Spouse or your Dependent Child are not eligible for coverage, you should contact your Employer regarding the refund of premiums due, if any.

REIMBURSEMENT

What if a benefit is underpaid or overpaid?

Reimbursement will be made to us for any overpayments that we may make due to any reason. You must repay us within 60 days unless we agree to a longer time period. Deductions may be made from future benefit payments to recover any such overpayments.

If we have underpaid a benefit for any reason, we will make a lump sum payment for that amount.

Interest does not accrue on any underpaid or overpaid benefit unless required under the applicable law.

STATEMENTS

Are statements warranties?

In the absence of fraud, all statements made in any application are considered representations and not warranties. No representation by you in enrolling for insurance under the Policy will be used to reduce or deny a claim unless a copy of your Written application for insurance is or has been given to you, your beneficiary, if any, or your estate representative.

TIME PERIODS

What time periods apply to this Certificate?

For the purpose of effective dates and termination dates under this Certificate, all days begin at 12:00 midnight and end at 11:59:59 PM at the Policyholder's location.

SUN LIFE ASSURANCE COMPANY OF CANADA

Group Hospital Indemnity Insurance Certificate

Non-Participating

