

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:	974104-003
Policy Effective Date:	January 1, 2025
Policyholder:	Great Plains Plumbing
Employer:	Great Plains Plumbing
Issue State:	Kansas

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.



Kevin Strain
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 30 hours per week.
Eligibility Waiting Period:	Until the first of the month following date 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: None

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
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: None

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	\$2,000 per day
Hospital Confinement: Limited to 30 day(s) per Benefit Year	\$200 per day
Intensive Care Unit (ICU) Confinement: Limited to 10 day(s) per Benefit Year	\$200 per day
Additional and Enhanced Benefit(s) (All benefits are payable per Benefit Year per Insured.)	
Extended Hospitalization:	\$200 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.

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 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.

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.

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

2. DEFINITIONS

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 is a full-time student attending school outside of the United States.

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.

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).

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.

2. DEFINITIONS

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

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.

Hospice Facility means an appropriately licensed healthcare facility or other institution 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.

2. DEFINITIONS

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.

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. 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.

2. DEFINITIONS

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.

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.

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.

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;

2. DEFINITIONS

- 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 and Complications of Pregnancy.

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.

2. DEFINITIONS

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:

- January 1, 2025;
- the first day of the month following your date of employment; 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 Pre-Existing Conditions limitation. A Pre-Existing Condition limitation will be considered to have occurred in relation to the effective date of the change, not the original effective date of your coverage.

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 on the January 1st following the date of change, 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 January 1st following 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

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF EMPLOYEE INSURANCE

- 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.

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 Pre-existing Condition limitation 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(s) provided.

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF EMPLOYEE INSURANCE

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.

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 Pre-Existing Condition Limitation period.

Any increase in coverage or the addition of coverage at the time of reinstatement for any Insured is subject to the Pre-Existing Conditions limitation.

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:

- January 1, 2025;
- 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 Pre-Existing Conditions limitation. A Pre-existing Condition limitation will be considered to have occurred in relation to the effective date of the change, not the original effective date of your coverage.

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 on the January 1st following the date of change, 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.

4. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE

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, for reasons other than a Family Status Change, will start on the January 1st following 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, you are initially eligible for Dependent Children Hospital Indemnity Insurance on the latest of:

- January 1, 2025;
- 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 Pre-Existing Conditions limitation. A Pre-existing Condition limitation will be considered to have occurred in relation to the effective date of the change, not the original effective date of your coverage.

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 on the January 1st following the date of change, 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 January 1st following 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

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

- the date your Dependent Child dies.

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.

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.

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.

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.

Do any limitations apply to Pre-Existing Conditions?

In addition to the limitations stated in the Covered Hospital Indemnity Benefits section of this Certificate, we will not pay any benefit for any Sickness that is diagnosed or treated in the first 12 months following the effective date of any Insured's insurance or the effective date of any Insured's increase in insurance and results from or is caused or contributed to by a Pre-Existing Condition.

Pre-Existing Condition means during the 12 months prior to any Insured's effective date of insurance or the effective date of an increase in any Insured's amount of insurance, any condition for which any Insured:

- sought medical Treatment, consultation, advice, care or services, including diagnostic measures for the condition, or symptoms related to the condition, regardless of whether the condition was diagnosed or suspected at that time; or
- took prescribed drugs or medicines for the condition.

When newborn children, newly placed foster children or newly adopted children are added to your Dependent Children Insurance within 31 days of the birth, placement or adoption, the Pre-Existing Condition limitation does not apply.

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 immediately 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 90 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; and
- your right to bring a civil action under ERISA, §502(a), if applicable, following an adverse determination on review.

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; and
- the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Insurance regulatory agency."

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.

8. CLAIM PROVISIONS

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 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. 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.

11. 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.

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 5 years after the time Proof of claim is required.

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.

11. GENERAL PROVISIONS

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



Great Plains Plumbing Employee Benefit Plan (The Plan) has been established to provide welfare benefits for its eligible employees and their eligible dependents.

The Employee Retirement Income Security Act of 1974 (ERISA) requires that the Plan Administrator provide you with a Summary Plan Description which discloses required information about the employee benefit plan. The following section entitled "Summary Plan Description" is not part of the Group Insurance Policy. The information in the Summary Plan Description is provided by the Plan Administrator who is the Policyholder and is included in this Certificate for your convenience. This Summary Plan Description applies only to the benefits under the Plan to the extent they are funded by the Group Insurance Policy issued by Sun Life Assurance Company of Canada. Sun Life Assurance Company of Canada assumes no responsibility for the accuracy or sufficiency of the information in the Summary Plan Description.

SUMMARY PLAN DESCRIPTION

Plan Sponsor: Great Plains Plumbing
9125 Barton St
Overland Park, KS 66214

Plan Administrator: Great Plains Plumbing
9125 Barton St
Overland Park, KS 66214

The Plan Administrator has authority to control and manage the operation and administration of the Plan, except that Sun Life Assurance Company of Canada makes all benefit claim determinations under the Group Insurance Policy.

Agent for Service of Legal Process: Great Plains Plumbing
9125 Barton St
Overland Park, KS 66214

Service of Legal Process for Sun Life:
General Counsel
1 Sun Life Executive Park
Wellesley Hills, MA 02481

Employer Identification Number (EIN): 92-1199798

Plan Number: 501

End of Plan Year: December 31st

Type of Administration: The Plan is administered by the Plan Administrator. The benefits provided by the Group Insurance Policy issued by Sun Life Assurance Company of Canada are included in the Plan. Sun Life Assurance Company of Canada is the claims administrator for those benefits and has full authority to make all benefit claim determinations.

Participants: The insured employees described in the Sun Life Assurance Company of Canada Certificate.

Plan Changes and Termination: The Plan Administrator may amend, modify or terminate the Plan.

Contributions: The cost of the insurance premiums are paid for by you.

Funding: The benefits under the Plan are funded, at least in part, by the Group Insurance Policy issued by Sun Life Assurance Company of Canada. Those insurance benefits are described in your Certificate.

Claims Procedure: When you or your beneficiary wish to file a claim under the Plan, you should contact your personnel office for claim forms and instructions for filing. Your Certificate explains the procedure for filing a claim under the Group Insurance Policy.

If your claim for benefits is denied in whole or in part, you will receive a written notice within the time required by ERISA from the date you filed your claim, stating the reasons why your claim was denied. You will then have the right, upon written notice from you or your authorized representative, to review that claim denial. The claim denial notice will include the name and address of the person you may ask for such a review. Additional information about claims submitted and review procedures may be obtained by contacting your Plan Administrator.

Your Rights under ERISA:

As a participant in the 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 Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report, if required by ERISA. 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 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 benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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 Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part and if you have exhausted the claims and appeal procedures described in the Certificate, you may file suit in a state or 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 of 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 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, DC 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.