SUN LIFE ASSURANCE COMPANY OF CANADA

Executive Office:
One Sun Life Executive Park
Wellesley Hills, MA 02481

(800) 247-6875
www.sunlife.com/us

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

Policy Number:	936024-005
Policy Effective Date:	January 1, 2020
Policyholder:	Coastal States Bank
Employer:	Coastal States Bank
Issue State:	South Carolina

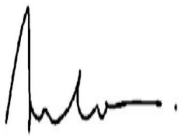
NOTICE TO BUYER. THIS IS A LIMITED BENEFIT CERTIFICATE. THIS CERTIFICATE PROVIDES ACCIDENT ONLY COVERAGE AND DOES NOT PAY BENEFITS FOR LOSS FROM SICKNESS.

PLEASE READ YOUR CERTIFICATE CAREFULLY.

This Certificate contains the terms of the Group Insurance Policy 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 Accident Insurance Certificate

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 date of employment

1. BENEFIT HIGHLIGHTS

Accident insurance for all Insureds you elect to enroll will be based on the following:

Benefit Coverage Type: 24-Hour Coverage

Covered Benefits

Unless otherwise specified, the following benefits will be payable only once for each Covered Accident as applicable. Refer to the Covered Accident Benefits section of this Certificate for additional benefit details.

Life and Dismemberment Losses	**Amount of Benefit**		
High Plan	**Employee**	**Spouse**	**Child**
Accidental Death	$25,000	$25,000	$12,500
Accidental Death Common Carrier	$100,000	$100,000	$50,000
Catastrophic Loss: Loss of Arm or Loss of Hand—both arms or both hands, Loss of Leg or Loss of Foot—both legs or both feet, Loss of Hand and Loss of Foot or Loss of Arm and Loss of Leg—one hand and one foot or one arm and one leg, Loss of an Eye—both eyes, irrecoverable Loss of Sight—both eyes, or any combination equaling two or more losses from: Loss of Arm, Loss of Hand, Loss of Leg, Loss of Foot or Loss of an Eye	$15,000	$15,000	$7,500
Accidental Dismemberment:			
Loss of Hand—one hand, Loss of Foot—one foot, Loss of Leg—one leg or Loss of Arm—one arm	$7,500	$7,500	$3,750
Loss of a Finger or Loss of a Toe—two or more fingers or toes	$1,500	$1,500	$750
Loss of a Finger or Loss of a Toe—one finger or one toe	$750	$750	$375
Loss of Sight or Loss of an Eye—one eye	$7,500	$7,500	$3,750

Dislocations Open Reduction	**High Plan**
Hip	$4,000
Knee, ankle or bones of the foot	$2,000
Elbow or wrist	$800
Shoulder	$1,000
Collarbone or bones of the hand	$1,600
Finger(s) or toe(s)	$200
Lower jaw	$800

Dislocations Closed Reduction	**High Plan**
Hip	$2,000
Knee	$1,000
Ankle or bones of the foot	$1,000

Elbow or wrist	$400
Shoulder	$500
Collarbone or bones of the hand	$800
Finger(s) or toe(s)	$100
Lower jaw	$400
Incomplete Dislocation or a Dislocation that requires reduction without Anesthesia	100% of the applicable Closed Reduction

Fractures Open Reduction	**High Plan**
Hip or thigh	$4,000
Skull-depressed	$6,000
Skull-simple	$3,000
Vertebral processes	$700
Bones of face	$700
Bones of nose	$700
Leg (tibia or fibula)	$2,000
Vertebrae (body of) or sternum	$1,600
Pelvis (excluding coccyx)	$1,600
Upper jaw or upper arm	$750
Lower jaw	$650
Knee cap	$650
Ankle	$650
Foot	$650
Collarbone	$650
Shoulder	$650
Forearm	$650
Hand	$650
Wrist	$650
Elbow	$650
Heel	$650
Rib	$350
Finger	$350
Toe	$350
Coccyx	$350
Multiple ribs	$1,000

Fractures Closed Reduction	**High Plan**
Hip or thigh	$2,000
Skull-depressed	$3,000
Skull-simple	$1,500
Vertebral processes	$350
Bones of face	$350
Bones of nose	$350
Leg (tibia or fibula)	$1,000
Vertebrae (body of) or sternum	$800
Pelvis (excluding coccyx)	$800
Upper jaw or upper arm	$375

Lower jaw	$325
Knee cap	$325
Ankle	$325
Foot	$325
Collarbone	$325
Shoulder	$325
Forearm	$325
Hand	$325
Wrist	$325
Elbow	$325
Heel	$325
Rib	$175
Finger	$175
Toe	$175
Coccyx	$175
Multiple ribs	$500
Chip Fractures and other Fractures not reduced by Open or Closed Reduction	25% of the applicable Closed Reduction

Additional Injuries	**High Plan**
Eye - surgery	$250
Eye - object remove	$250
Gunshot wound	$500
Paralysis - paraplegia	$25,000
Paralysis - quadriplegia	$50,000
Coma	$10,000
Concussion	$100

Lacerations	**High Plan**
Laceration(s) with no sutures and treated by Physician	$35
Single laceration under 5 centimeters with sutures	$65
Lacerations 5 - 15 centimeters with sutures (total of all lacerations)	$250
Lacerations greater than 15 centimeters with sutures (total of all lacerations)	$500

Burns	**High Plan**
21 - 40 square centimeters 2nd degree	$400
21 - 40 square centimeters 3rd degree	$1,000
41 - 65 square centimeters 2nd degree	$800
41 - 65 square centimeters 3rd degree	$2,000
66 - 160 square centimeters 2nd degree	$1,200
66 - 160 square centimeters 3rd degree	$6,000
161 - 225 square centimeters 2nd degree	$1,600
161 - 225 square centimeters 3rd degree	$14,000

More than 225 square centimeters 2nd degree	$2,000
More than 225 square centimeters 3rd degree	$20,000
Skin graft	50% of the applicable Burn Benefit

Medical Services	**High Plan**
Diagnostic Exam:	
Arteriogram, angiogram, CT, CAT, EKG, EEG, or MRI (1 time per Benefit Year)	$200
X-ray (1 time per Covered Accident)	$30
Accident Emergency Treatment (non-Emergency Room) (1 time per Covered Accident)	$50
Physician's follow-up Treatment office visit (per visit, up to 6 times per Covered Accident	$25
Physical and occupational therapy (per visit up to 10 visits per Covered Accident)	$25
Medical Devices	$125
Epidural Pain Management (up to 2 times per Covered Accident)	$50
Prescription drug	$25
Prosthesis (one)	$500
Prosthesis (two)	$1,000
Blood, plasma or platelet transfusion	$200

Hospital	**High Plan**
Hospital admission (once per Benefit Year)	$1,000
Hospital Confinement (per day up to 365 days per Covered Accident)	$250
Intensive Care Unit admission (once per Benefit Year; payable instead of Hospital admission benefit if Confined immediately to ICU)	$1,500
Intensive Care Unit Confinement (per day up to 15 days per Covered Accident; payable in addition to any Hospital Confinement benefit)	$500
Ambulance (Ground)	$200
Ambulance (Air)	$1,500
Emergency Room admission	$150
Family lodging	
Maximum Lodging Night Stays: 1 benefit per day, 30 days per Benefit Year	$100
Transportation (100 or more miles up to 3 times per Covered Accident)	$500
Rehabilitation Unit (per day up to 30 days per Covered Accident)	$100

Surgery	**High Plan**
Miscellaneous Surgery requiring general anesthesia that is not otherwise listed (once	$300

per 24 hour period even though multiple surgical procedures may be performed)	
Open Surgery	$1,250
Exploratory Surgery or debridement	$250
Tendon/Ligament/Rotator cuff tear	$625
Torn Knee Cartilage	$625
Ruptured / herniated disc	$625

Emergency Dental	**High Plan**
Emergency dental extraction	$65
Emergency dental crown	$200

Wellness Screening Benefit	**High Plan**
(once per Benefit Year)	$50

Contributions: The cost of your insurance is paid for entirely by you. This is your Contributory insurance.

2. DEFINITIONS

24-Hour Coverage 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;
- is independent of any illness, disease or other bodily malfunction; and
- occurs while coverage is in force under the Policy for the Insured.

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 local anesthetic or peripheral nerve blocks.

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

Chip Fracture means a bone Fracture diagnosed by a Physician interpreting an x-ray or other imaging test showing that part of the bone close to a joint has broken-off at a ligament attachment point.

Coma means that while insured under the Policy, an Insured has been diagnosed by a Physician with a condition from which the Insured cannot be aroused and which requires an external life support system, both of which have persisted continuously for at least 7 days. Coma does not include: (1) a medically induced coma; or (2) a coma that results from any alcohol or drug use.

Common Carrier means commercial airplanes, trains, buses, trolleys, subways, ferries and boats that operate on a regularly scheduled basis between predetermined points or cities. Privately chartered vehicles and taxis are not Common Carriers.

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 24 continuous hours. There must be a charge for room and board.

Contributory means you pay all or part of the premium.

Covered Accident means an Accident that:

- occurs while the Policy and the Insured's coverage is in force;
- occurs on or after the effective date of insurance; and
- 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.

2. DEFINITIONS

Dependent Child includes:
- your step-child;
- your grandchild who is a dependent for federal income tax purposes at the time application for coverage for such child is made;
- a foster child placed with you by a licensed agency;
- 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.

Dislocation means a completely separated joint.
- Open Reduction of Dislocation means a surgical procedure.
- Closed Reduction of Dislocation means a non-surgical procedure.

The joint Dislocations covered under the Policy are shown in the Benefit Highlights.

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. 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;
- 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, change or cancel 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.

Exploratory Surgery means an operation performed for diagnostic purposes.

Family Member means: (a) your Spouse, civil union partner or domestic partner and (b) the following relatives of you or your Spouse, civil union partner or domestic partner: (1) parent; (2) grandparent; (3) child; (4) grandchild; (5) brother; (6) sister; (7) aunt; (8) uncle; (9) first cousin; (10) 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;
- the commencement or termination of employment of your Spouse.

Fracture means a broken bone which can be seen by x-ray.
- Open Reduction of Fracture means a surgical procedure.
- Closed Reduction of Fracture means a non-surgical procedure.

The bone Fractures covered under the Policy are shown in the Benefit Highlights.

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: (1) a rest home; (2) a skilled nursing facility; (3) an extended care facility; (4) a place of convalescence; (5) rehabilitative care; (6) custodial care; or (7) a place primarily for the Treatment of drug addiction or alcoholism.

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;
- separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement;
- permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- 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.

Incomplete Dislocation means a dislocation in which the joint is not completely separated.

Injury means accidental body injury that is the direct result of a Covered Accident. Injuries must be independent of Sickness, disease, bodily infirmity and other causes.

2. DEFINITIONS

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.

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, but is not limited to, automobiles, motorcycles, boats and snowmobiles.

Laceration means a cut.

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.

Loss of Arm, Eye, Finger, Foot, Hand, Leg, Toe, Sight

- Loss of Arm means that the arm is completely cut off at or above the elbow.
- Loss of an Eye means the permanent removal of the eyeball.
- Loss of a Finger means that the finger is completely cut off at the joint proximate to the first interphalangeal joint where it is attached to the hand.
- Loss of Foot means the loss of at least four toes of the same foot or that the foot is completely cut off at or above the ankle joint or the use of the foot is permanently lost.
- Loss of Hand means the loss of at least two fingers and a thumb of the same hand or the permanent and irrecoverable loss of use of the hand.
- Loss of Leg means that the leg is completely cut off at or above the knee.
- Loss of a Toe means that the toe is completely cut off at the joint proximate to the first interphalangeal joint where it is attached to the foot.
- Loss of Sight of an eye means best corrected vision of the eye is 20/200 or worse, or a visual field of 20 degrees or less. The degree of visual loss must be permanent with no realistic expectation of improvement.

Observation Unit means a specified area within a Hospital, apart from the Emergency Room, where a patient can be monitored following outpatient surgery or Treatment in the Emergency Room 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.

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 licensed ambulatory care facility and there is no charge for room and board.

Paralysis means the Insured has been diagnosed by a Physician with total and irreversible loss of voluntary movement in muscles due to Injury of associated nerves that is consecutively present for 30 days, but shall not include any paralysis caused by a stroke.

- Monoplegia is the complete and irreversible Paralysis of one arm or one leg.
- Hemiplegia is the complete and irreversible Paralysis of one arm and one leg on the same side.
- Diplegia is the complete and irreversible Paralysis of both arms.

- Paraplegia is the complete and irreversible Paralysis of both legs.
- Quadriplegia is the complete and irreversible Paralysis of both arms and both legs.

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.

Physical or Occupational Therapist means a person who:
- is licensed by the state or province to practice physical or occupational therapy;
- performs services which are allowed by their license; and
- performs services for which benefits are provided under the Policy; and
- practices according to the Code of Ethics of the American Physical Therapy Association.

The Physical or Occupational Therapist cannot be you, a business associate or any Family Member.

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.

Prosthesis means the replacement of a missing part by an artificial substitute, such as an artificial extremity, an artificial organ or part but does not include cosmetic prosthesis.

Rehabilitation Unit means an appropriately licensed facility that provides rehabilitation care services on an inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational and vocational services to enable patients disabled by accidental Injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Physicians. The rehabilitation unit may be part of a Hospital or a freestanding facility.
A rehabilitation unit is not:
- a nursing home;
- an extended care facility;
- a skilled nursing facility;
- a rest home or home for the aged;
- a hospice care facility;
- a place for alcoholics or drug addicts; or
- an assisted living facility.

Sickness means disease or illness, mental illness, drug illness, abuse or addiction, and alcohol illness, abuse or addiction, or 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.

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; or
- is a domestic partner as defined by the Policyholder.

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.

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 Accident Insurance?
You are initially eligible for Employee Accident Insurance on the latest of:

- January 1, 2020;
- 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 Accident 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 Accident Insurance?
You must enroll within 90 days of the date you are initially eligible for Employee Accident Insurance or within 31 days of the date of a Family Status Change or during any Enrollment Period.

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.

When does your Employee Accident Insurance start?
For Contributory Employee Accident Insurance, your insurance starts on the latest of the date:

- you are eligible;
- you enroll; and
- you agree to make any required contribution toward the cost of insurance;

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

You may also request a change in Employee Accident 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.

When does a change in your Employee Accident Insurance start?
If you are Actively at Work, any increase in Employee Accident Insurance or benefits, for reasons other than a Family Status Change, will start on the date of the Policy change.

If you are not Actively at Work on that date, any increase in Employee Accident Insurance will not start until you resume being Actively at Work.

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

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

- the date you apply for such change in Employee Accident Insurance and you agree to make any required contribution toward the cost of the insurance; or
- the date of your Family Status Change.

If you are not Actively at Work on that date, any increase due to a Family Status Change in Employee Accident 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 Accident Insurance or benefits due to a Family Status Change will start on the date of your Family Status Change.

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF EMPLOYEE INSURANCE

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

When does your Employee Accident Insurance end?
Your Employee Accident 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 Accident Insurance or any part of your insurance;
- the date you notify us in Writing to cancel your Employee Accident Insurance; or
- the date you die.

Your Employee Accident 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.

Any Accident occurring between your termination date and your reinstatement effective date will not be considered a Covered Accident.

A new Eligibility Waiting Period will not apply.

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

- January 1, 2020;
- the date you are eligible for Employee Accident Insurance; or
- the date you acquire a Spouse.

You are also eligible for Spouse Accident 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 Accident Insurance?
You must enroll within 90 days of the date you are initially eligible for Spouse Accident Insurance or within 31 days of the date of a Family Status Change or during any Enrollment Period.

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.

When does Spouse Accident Insurance start?
For Contributory Spouse Accident Insurance, your insurance starts on the latest of the date:

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

if you are Actively at Work on that date.

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

When can you make changes in your Spouse Accident Insurance?
You may request a change in your Accident Insurance benefit options during any Enrollment Period while the Policy is in force.

You may also request a change in Spouse Accident 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.

When does a change in your Spouse Accident Insurance start?
If you are Actively at Work, any increase in Spouse Accident Insurance or benefits, for reasons other than a Family Status Change, will start on the date of the Policy change.

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

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

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

- the date you apply for such change in Spouse Accident Insurance and you agree to make any required contribution toward the cost of the insurance; or
- the date of your Family Status Change.

If you are not Actively at Work on that date, any increase due to a Family Status Change in Spouse Accident Insurance or benefits will not start until you resume being Actively at Work.

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

4. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE

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

When does Spouse Accident Insurance end?
Spouse Accident 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 Accident Insurance or any part of your insurance or your Spouse Accident Insurance;
- the date you notify us in Writing to cancel your Spouse Accident Insurance;
- the date you die; or
- the date your Spouse dies.

Your Spouse Accident 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 Accident Insurance?
If you are in an Eligible Class, then you are initially eligible for Dependent Children Accident Insurance on the latest of:

- January 1, 2020;
- the date you are eligible for Employee Accident Insurance; or
- the date you acquire your Dependent Children.

You are also eligible for Dependent Children Accident 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 Accident Insurance?
You must enroll within 90 days of the date you are initially eligible for Dependent Children Accident Insurance or within 31 days of the date of a Family Status Change or during any Enrollment Period.

When does Dependent Children Accident Insurance start?
For Contributory Dependent Children Accident Insurance, your insurance starts on the latest of the date:

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

if you are Actively at Work on that date.

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

When can you make changes in Dependent Children Accident Insurance?
You may request a change in your Dependent Children Accident Insurance benefit options during any Enrollment Period while the Policy is in force.

You may also request a change in Dependent Children Accident 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.

When does a change in your Dependent Children Accident Insurance start?
If you are Actively at Work, any increase in Dependent Children Accident Insurance or benefits, for reasons other than a Family Status Change, will start on the date of the Policy change.

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

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

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

- the date you apply for such change in Dependent Children Accident Insurance and you agree to make any required contribution toward the cost of the insurance; or
- the date of your Family Status Change.

If you are not Actively at Work on that date, any increase due to a Family Status Change in Dependent Children Accident Insurance or benefits will not start until you resume being Actively at Work.

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

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

Any change in insurance for your Dependent Children will only affect benefits for a Covered Accident that occurs after the effective date of the change.

How can you add a child or children to your Dependent Children Accident 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 Accident 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 Accident 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 Accident 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 Accident Insurance.

If you are covered under the Policy and have Dependent Children Accident Insurance when a newborn, 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 Accident Insurance end?
Dependent Children Accident 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 Accident Insurance, or any part of the insurance;
- the date you notify us in Writing to cancel your Dependent Children Accident Insurance;
- the date you die; or
- the date your Dependent Child dies.

Your Dependent Children Accident 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 ACCIDENT BENEFITS

What benefits are payable under the Policy?
The following are the Covered Accident Benefits covered under the Policy. Eligible benefit payments for a Covered Accident Benefit will be payable in a lump sum as shown in the Benefit Highlights. Each Covered Accident Benefit can be claimed only once for each Covered Accident, unless otherwise specified. We will pay benefits for multiple Injuries sustained in the same Covered Accident up to the benefit amount shown in the Benefit Highlights for such Injuries. Diagnosis and Treatment for Injuries sustained by Covered Accidents must be made within 12 months to qualify for benefits under the Policy unless otherwise specified.

Accident Emergency Treatment (non-Emergency Room) Benefit
The Accident Emergency Treatment (non-Emergency Room) Benefit is payable for each Insured who receives Treatment from a Physician as the result of Injuries received in a Covered Accident, provided the Treatment is received within 15 days after the date of the Covered Accident. This benefit is payable only once per Insured for each Covered Accident and not more than once per 24 hour period. If the Insured receives Treatment for the same Injuries in an Emergency Room within the same 15 days period, we will pay only the Emergency Room Treatment Benefit.

Accidental Death Benefit
An Accidental Death Benefit is payable if an Insured dies within 365 days of the date of the Covered Accident as a result of Injuries received from that Accident. If we pay this benefit for an Insured, we will not pay the Accidental Death Common Carrier Benefit for the same Insured.

Accidental Death Common Carrier Benefit
An Accidental Death Common Carrier Benefit is payable if an Insured dies within 365 days of the date of the Covered Accident as a result of Injuries received from that Covered Accident, while a fare paying passenger on a Common Carrier. If we pay this benefit for an Insured, we will not pay the Accidental Death Benefit for the same Insured.

Accidental Dismemberment Benefit
An Accidental Dismemberment Benefit is payable if an Insured sustains the following:
- Loss of Hand—one hand;
- Loss of Foot—one foot;
- Loss of Leg—one leg;
- Loss of Arm—one arm;
- Loss of a Finger or Loss of a Toe—one or more fingers or toes;
- Loss of an Eye—one eye; or
- irrecoverable Loss of Sight—one eye;

due to Injuries received in a Covered Accident, and the loss occurs within 365 days after the date of the Covered Accident.

If the Insured loses a finger or a toe and later loses a hand, foot, arm or leg on the same side of the body within 365 days after the date of the Covered Accident as the result of the same Covered Accident, we will subtract the amount we paid for the loss of the finger or toe from the benefit we pay for the loss of the hand, foot, arm or leg.

For multiple Dismemberments resulting from the same Covered Accident that occur within 365 days after the date of the Covered Accident, we will pay 100% of each benefit amount listed in the Benefit Highlights for the applicable dismembered body part. If the Insured loses one arm or one leg and later loses the other arm or leg within 365 days of the Covered Accident as the result of the same Covered Accident, we will subtract the amount we paid for that loss of an arm or leg from the benefit we pay for the Catastrophic Accident Benefit. If the Insured loses one arm and one leg or one hand and one foot within 365 days of the Covered Accident as the result of the same Covered Accident, we will pay for the Catastrophic Accident Benefit. No Accidental Dismemberment Benefit will be paid in addition to the Catastrophic Accident Benefit.

6. COVERED ACCIDENT BENEFITS

Ambulance Benefit (Air)
An Ambulance Benefit is payable for a licensed professional air ambulance company to transport an Insured to or from a Hospital, or between medical facilities for Treatment of Injuries received in a Covered Accident. The air ambulance must provide the transportation services to the Insured within 3 days after the date of the Covered Accident.

Ambulance Benefit (Ground)
An Ambulance Benefit is payable for a licensed professional ambulance company to transport an Insured by ground, to or from a Hospital or between medical facilities for Treatment of Injuries received in a Covered Accident. The ambulance must provide transportation services to the Insured within 3 days after the date of the Covered Accident.

Blood/Plasma/Platelet Transfusion Benefit
A Blood/Plasma/Platelet Transfusion Benefit is payable for each Insured who requires a transfusion, administration, cross matching, typing and processing of blood, plasma or platelet as a result of Injuries received in a Covered Accident. The blood, plasma or platelet transfusion must be administered within 90 days after the date of the Covered Accident.

Burn Benefit
A Burn Benefit is payable for each Insured who sustains covered burns shown in the Benefit Highlights as the result of Injuries received in a Covered Accident. The Insured must be treated by a Physician within 3 days after the date of the Covered Accident. If the Insured meets more than one of the burn classifications, we will pay only the greater benefit amount as shown in the Benefit Highlights.

Catastrophic Accident Benefit
A Catastrophic Accident Benefit is payable if an Insured sustains the following:

- Loss of Hand—both hands;
- Loss of Foot—both feet;
- Loss of Arm or Loss of Leg—both arms or both legs;
- Loss of Hand and Loss of Foot—one hand and one foot;
- Loss of Arm and Loss of Leg—one arm and one leg;
- Loss of an Eye—both eyes;
- irrecoverable Loss of Sight—both eyes; or
- any combination equaling two or more losses from: Loss of Arm, Loss of Hand, Loss of Leg, Loss of Foot, or Loss of an Eye;

due to Injuries received in a Covered Accident and occurs within 365 days after the date of the Covered Accident. Loss of Arm and Loss of Hand or Loss of Leg and Loss of Foot on the same side of the body are counted as one loss. If the insured loses one arm or one leg and later loses the other arm or leg within 365 days of the Covered Accident as the result of the same Covered Accident, we will subtract the amount we paid for that loss of an arm or leg from the benefit we pay for the Catastrophic Accident Benefit. If the Injury is diagnosed as temporary blindness and then results in permanent irrecoverable Loss of Sight of both eyes within 365 days of the Covered Accident as a result of the same Covered Accident, we will subtract from the Catastrophic Accident Benefit the amount we paid for the Brain Injury Benefit if the sole reason for paying the Brain Injury Benefit was due to blindness.

Coma Benefit
A Coma Benefit is payable for each Insured who is in a Coma as the result of Injuries received in a Covered Accident.

Concussion Benefit
A Concussion Benefit is payable for each Insured who sustains a concussion as the result of a Covered Accident. The concussion must be diagnosed by a Physician within 3 days of the Covered Accident.

Diagnostic Exam Benefit
A Diagnostic Exam Benefit is payable for each Insured who requires a diagnostic examination to determine the extent of Injuries received in a Covered Accident. The Insured must schedule an examination and the examination must be performed within 30 days after the date of the Covered

Accident. Diagnostic exams include arteriogram, angiogram, Computed Tomographies (CT Scan), Computerized Axial Tomography (CAT), Electrocardiography (EKG), Electroencephalogram (EEG), Magnetic Resonance Imagings (MRIs) and x-rays. This benefit is payable only once per Benefit Year for each Insured except for x-rays.

Dislocation Benefit
A Dislocation Benefit is payable for each Insured who sustains a Dislocation as the result of Injuries received in a Covered Accident. The Dislocation must be diagnosed by a Physician within 90 days after the date of the Covered Accident. It can be corrected by open (surgical) reduction or closed (non-surgical) reduction, and it must be a complete Dislocation.

If the Dislocation requires reduction without Anesthesia by a Physician or a Physician diagnoses the dislocation as an Incomplete Dislocation, we will pay 100% of the applicable benefit amount shown in the Benefit Highlights for a Closed Reduction of the joint involved.

Benefits will only be payable for the first Dislocation of a joint sustained in a Covered Accident. Subsequent Dislocations of the same joint are not payable for the same Covered Accident.

If the Insured sustains more than one Dislocation in a Covered Accident that requires open or closed reduction, we will pay for no more than two Dislocations with the benefit paid being the two highest applicable benefit amounts as shown in the Benefit Highlights.

Emergency Dental Benefit
An Emergency Dental Benefit is payable for each Insured who requires dental work as the result of Injuries received in a Covered Accident. The dental work must occur within 90 days after the date of the Covered Accident. This benefit is only payable for broken teeth repaired with crown(s) or broken teeth requiring extraction, regardless of the number of teeth involved.

Emergency Room Treatment Benefit
An Emergency Room Treatment Benefit is payable for each Insured who requires examination and Treatment by a Physician in an Emergency Room as the result of Injuries received in a Covered Accident. The Emergency Room examination and Treatment must occur within 3 days after the date of the Covered Accident.

Epidural Pain Management Benefit
An Epidural Pain Management Benefit is payable for each Insured who receives an Epidural Injection administered for pain management for Injuries received in a Covered Accident. Epidural Injection means injection of drugs through a catheter placed into the epidural space. The epidural must be prescribed by a Physician and administered in a Hospital or Physician's office within 90 days after the date of the Covered Accident. This benefit is payable up to 2 times per Insured per Covered Accident. This benefit is not payable for an Epidural Injection administered during a surgical procedure and does not include epidural steroid injections.

Eye Injury Benefit
An Eye Injury Benefit is payable for each Insured who incurs an eye Injury as a result of a Covered Accident. The eye Injury must require surgery or the removal of a foreign object by a Physician and must be performed within 90 days of the Covered Accident. Only one Eye Injury Benefit is payable for all eye Injuries sustained in the same Covered Accident.

6. COVERED ACCIDENT BENEFITS

Family Lodging Benefit
A Family Lodging Benefit is payable for one companion to accompany the Insured who is Confined in a Hospital as a result of Injuries received in a Covered Accident. The Hospital must be more than 100 miles from the residence of the Insured. The place of lodging must be a motel or hotel room. The expenses for such lodging must occur within 30 days of the Covered Accident. Subject to the Maximum Lodging Night Stays shown in the Benefit Highlights, benefits will be paid as long as:

- the companion accompanies the Insured; and
- the Insured remains Confined.

Fracture Benefit
A Fracture Benefit is payable for each Insured who sustains Fractures as the result of Injuries received in a Covered Accident. The Fracture must:

- be a Fracture covered under the Policy as shown in the Benefit Highlights;
- be diagnosed by a Physician within 90 days after the date of the Covered Accident; and
- require open (surgical) reduction or closed (non-surgical) reduction by a Physician.

A partial benefit is payable for each Insured who sustains a Chip Fracture or other Fractures not reduced by open or closed reduction.

If an Insured sustains more than one Fracture in a Covered Accident which requires open or closed reduction, we will pay for no more than two Fractures with the benefit paid being the two highest applicable benefit amounts as shown in the Benefit Highlights.

Gunshot Wound Benefit
A Gunshot Wound Benefit is payable for each Insured who sustains a gunshot wound as a result of a Covered Accident. The gunshot wound must be caused by:

- a bullet; or
- other object fired by rifle or pistol using gunpowder.

The gunshot wound must be treated by a Physician at a Hospital within 24 hours of the shooting. Only one Gunshot Wound Benefit is payable for all gunshot Injuries sustained in the same Covered Accident.

Hospital Admission Benefit
A Hospital Admission Benefit is payable for each Insured admitted to a Hospital as a result of Injuries received in a Covered Accident. Admission to the Hospital must occur within 30 days after the date of the Covered Accident. If the Insured is Confined immediately to the Intensive Care Unit, we will pay only the Hospital Intensive Care Unit Admission Benefit and not the Hospital Admission Benefit. This benefit is payable only once per Benefit Year for each Insured.

This benefit will not be paid for:

- Emergency Room Treatment;
- Outpatient Treatment; or
- a stay of less than 24 hours in an Observation Unit.

Hospital Confinement Benefit
A Hospital Confinement Benefit is payable for each Insured Confined in a Hospital as a result of Injuries received in a Covered Accident. The Hospital Confinement must begin within 90 days after the date of the Covered Accident.

We will pay benefits for only one period of Confinement at a time even if it is caused by more than one Covered Accident. If the Insured is Confined in a Hospital, and is Confined once again within 90 days for Injuries received in the same Covered Accident or by a related condition, we will treat that Confinement as a continuation of the prior Confinement. If more than 90 days have passed between the periods of Hospital Confinement, we will treat the Confinement as a new Confinement.

The maximum benefit paid will not exceed number of days for the Hospital Confinement Benefit as shown in the Benefit Highlights.

This benefit will not be paid for:
- Emergency Room Treatment;
- Outpatient Treatment; or
- Confinement of less than 24 hours to an Observation Unit.

Hospital Intensive Care Unit Admission Benefit
A Hospital Intensive Care Unit Admission Benefit is payable for each Insured who is admitted to the Hospital's Intensive Care Unit due to Injuries sustained in a Covered Accident. Admission to the Hospital's Intensive Care Unit must occur within 30 days after the date of the Covered Accident. This benefit is payable only once per Benefit Year for each Insured.

Hospital Intensive Care Unit Confinement Benefit
A Hospital Intensive Care Unit Confinement Benefit is payable for each Insured Confined in an Intensive Care Unit as a result of Injuries received in a Covered Accident. Confinement in a Hospital Intensive Care Unit must begin within 14 days after the date of the Covered Accident.

If the Insured is Confined in a Hospital Intensive Care Unit, and is Confined once again within 90 days for Injuries received in the same Covered Accident or by a related condition, we will treat this Confinement as a continuation of the prior Confinement. If more than 90 days have passed between the periods of Confinement in a Hospital Intensive Care Unit, we will treat the Confinement as a new Confinement.

If the Insured is Confined to a hospital intensive care unit that does not meet the definition of a Hospital Intensive Care Unit, we will pay the Hospital Confinement Benefit. The Hospital Intensive Care Unit Confinement Benefit is paid in addition to the Hospital Confinement Benefit for the first 15 days of Confinement in the Hospital Intensive Care Unit. If the Insured is Confined in a Hospital Intensive Care Unit for more than 15 days, benefits will continue to be paid under the Hospital Confinement Benefit beginning on the 16th day. The maximum benefits paid will not exceed the number of days for the Hospital Confinement Benefit and the number of days for the Hospital Intensive Care Unit Confinement Benefit as shown in the Benefit Highlights.

Laceration Benefit
A Laceration Benefit is payable for each Insured who sustains Lacerations as the result of Injuries received in a Covered Accident. The Laceration must be repaired by a Physician within 3 days after the date of the Covered Accident. The benefit payable will be based on the total length of all Lacerations received in any one Covered Accident which requires repair. This benefit is payable only once for each Covered Accident.

Loss of Sight/Eye Benefit
A Loss of Sight Benefit is payable if an Insured sustains the irrecoverable Loss of Sight of one eye or both eyes or the Loss of an Eye or both eyes due to Injuries received in a Covered Accident, and the loss occurs within 365 days after the date of the Covered Accident.

Medical Device Benefit
A Medical Device Benefit is payable for the use of a medical device as an aid in personal locomotion or mobility. The medical device must be prescribed by a Physician for the Insured as a result of Injuries received in each Covered Accident. Medical devices include wheelchairs, crutches, walkers, back braces, leg braces, neck braces and walking boots. The use of a medical device must begin within 90 days after the date of the Covered Accident. This benefit is payable only once for each Covered Accident.

Paralysis Benefit
A Paralysis Benefit is payable for each Insured who becomes paralyzed as a result of Injuries received in a Covered Accident. The Paralysis must occur within 90 days of the Covered Accident. The Paralysis must be confirmed by a Physician and based on documented evidence that the Paralysis was caused by Injury. The duration of the Paralysis must be at least 30 days and expected to be permanent.

6. COVERED ACCIDENT BENEFITS

Physical and Occupational Therapy Benefit
A Physical and Occupational Therapy Benefit is payable for each Insured who requires physical or occupational therapy Treatment as the result of Injuries received in a Covered Accident. The therapy must begin within 90 days after:

- the date of the Covered Accident; or
- the date on which the Physician prescribes physical or occupational therapy following surgery or other medical Treatment required and provided for Treatment of the Injuries sustained in a Covered Accident.

The therapy must be rendered by a Physical or Occupational Therapist.

This benefit is limited to the maximum number of visits per Insured per Covered Accident as shown in the Benefit Highlights.

Physician Follow-Up Treatment Benefit
A Physician Follow-Up Treatment Benefit is payable for each Insured who receives follow-up Treatment for Injuries incurred from a Covered Accident when such follow-up Treatment is recommended or advised by a Physician. The follow-up Treatment must:

- be within 90 days after the date of the Covered Accident;
- be due to Injuries received as the result of a Covered Accident;
- occur after initial Treatment by a Physician; and
- not be for routine examinations or preventive testing.

This benefit includes follow-up Treatment provided by a licensed or certified chiropractor. This benefit is limited to the number of times per Insured per Covered Accident, as shown in the Benefit Highlights.

Prescription Drug Benefit
A Prescription Drug Benefit is payable 1 per Covered Accident for each Insured who requires medication to treat an Injury sustained as a direct result of a Covered Accident. The medication must be prescribed by a Physician within 30 days of the Covered Accident.

Prosthesis Benefit
A Prosthesis Benefit is payable for an Insured who sustains:

- Loss of Hand, Loss of Foot, Loss of Arm, Loss of Leg or Loss of an Eye as a result of Injuries received in a Covered Accident; and
- requires a prosthetic device, artificial limb or eye which is prescribed by a Physician.

The prosthetic device/artificial limb or eye must be received within 365 days after the date of the Covered Accident.

This benefit is not payable for joint replacement such as an artificial hip or knee.

Rehabilitation Unit Benefit
A Rehabilitation Unit Benefit provides a daily benefit if the Insured is Confined in a Rehabilitation Unit for physical, occupational or speech therapy Treatment of Injuries incurred from a Covered Accident. The rehabilitation unit confinement must begin within 30 days after the date of the Covered Accident and be preceded by Confinement in a Hospital. This benefit is limited to the maximum number of days per Insured per Covered Accident as shown in the Benefit Highlights. The Rehabilitation Unit benefit will not be paid if the Hospital Confinement Benefit is paid for the same day; only the highest eligible benefit will be paid.

Skin Graft Benefit
A Skin Graft Benefit is payable for each Insured who receives a skin graft within 90 days after the date of the Covered Accident for a burn for which a benefit was received under the Burn benefit. This benefit is payable once per Insured per Covered Accident.

Surgery Benefit
A Surgery Benefit is payable for each Insured who undergoes a surgical procedure listed in the Benefit Highlights for repair of internal Injuries received as the result of a Covered Accident. Treatment must be first provided by a Physician within 30 days and the Injury repaired through surgery within 180 days of the date of the Covered Accident. The surgery may be provided in a Hospital on an Inpatient or Outpatient basis or in a licensed ambulatory surgical facility. Benefits will be payable for Exploratory Surgery or other specified surgery without repair as shown in the Benefit Highlights.

Debridement Benefit
A Debridement Benefit is payable for each Insured who undergoes debridement as the result of an Injury received in a Covered Accident. Treatment must be first provided by a Physician within 30 days and the Injury must be repaired through surgery by a Physician within 180 days after the date of the Covered Accident.

Exploratory Surgery Benefit
An Exploratory Surgery Benefit is payable for each Insured who undergoes an operation performed for diagnostic purposes only as the result of an Injury received in a Covered Accident. Treatment must be first provided by a Physician within 30 days and the surgery must be performed by a Physician within 180 days after the date of the Covered Accident.

Miscellaneous Surgery Benefit
A Miscellaneous Surgery Benefit is payable for each Insured who undergoes a surgery requiring Anesthesia received as the result of a Covered Accident that is not covered by any other Injury benefit in the Benefit Highlights. Treatment must be first provided by a Physician within 30 days and the Injury must be repaired through surgery by a Physician within 180 days after the date of the Covered Accident. Only one Miscellaneous Surgery Benefit is payable per 24 hour period even though multiple surgical procedures may be performed.

Open Surgery Benefit
An Open Surgery Benefit is payable for each Insured who undergoes open abdominal, cranial or thoracic surgery to repair internal Injuries received as the result of a Covered Accident. However, an Open Surgery Benefit also includes exploratory laparotomy. Treatment must be first provided by a Physician within 30 days and the Injury must be repaired through surgery by a Physician within 180 days after the date of the Covered Accident. Benefits will be payable for Exploratory Surgery or other specified surgery without repair as shown in the Benefit Highlights. We will pay this benefit once per Covered Accident.

Ruptured/Herniated Disc Benefit
A Ruptured/Herniated Disc Benefit is payable for each Insured who sustains a ruptured or herniated disc in the spine as the result of Injuries received in a Covered Accident. Treatment must be first provided by a Physician within 30 days and the Injury repaired through surgery by a Physician within 180 days after the date of the Covered Accident.

Tendon/Ligament/Rotator Cuff Benefit

A Tendon/Ligament/Rotator Cuff Benefit is payable for each Insured who injures a tendon, ligament, or rotator cuff as the result of Injuries received in a Covered Accident. The tendon, ligament, or rotator cuff must be torn, ruptured or severed. Treatment must be first provided by a Physician within 30 days and the Injury repaired through surgery by a Physician within 180 days after the date of the Covered Accident. If exploratory arthroscopic surgery is performed and no repair is done, the applicable amount payable is shown in the Benefit Highlights.

Torn Knee Cartilage Benefit
A Torn Knee Cartilage Benefit is payable for each Insured who sustains a torn knee cartilage (meniscus) as the result of direct Injuries in a Covered Accident. Treatment must be first provided by a Physician within 30 days and the Injury repaired through surgery by a Physician within 180 days after the date of the Covered Accident. If exploratory arthroscopic surgery is performed and no repair is done, or if the cartilage is shaved (debridement), the applicable benefit payable is shown in the Benefit Highlights.

Transportation Benefit
A Transportation Benefit is payable for each Insured who is required to travel more than 100 miles one way from the Insured's residence to:

- receive special Treatment; or
- be Confined in a Hospital;

if prescribed by a Physician for the Treatment of Injuries resulting from a Covered Accident when such Treatment or confinement is not available locally. Such transportation must occur within 90 days of the date of the Covered Accident.

This benefit is not payable for transportation by ground ambulance or air ambulance.

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

- 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
- Fasting Blood Glucose Test
- Colorectal Cancer Screening (fecal occult blood test, colonoscopy, sigmoidoscopy)
- Hemocult Stool Analysis
- CEA (blood test for colon cancer)
- Chest x-ray
- Lipid panel (cholesterol, triglycerides, HDL, LDL)
- Pap smear
- Prostate Cancer Screening (digital rectal exam, PSA blood test)
- Serum Protein Electrophoresis
- Skin Cancer Screening
- Diabetes tests (fasting blood glucose test, hemoglobin A1c)
- Carotid Doppler
- Echocardiogram
- Electrocardiogram (ECG)-resting or stress
- Immunizations
- Interscholastic Sports Physical Exam

To receive this benefit, you must notify us of which wellness screening test was performed. The benefit is payable once per Insured per Benefit Year.

7. EXCLUSIONS

What exclusions apply to the benefits payable?
No benefits will be payable for any loss that is the result of a Covered Accident that is due to or results from:

- 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);
- Intoxication;
- operating, learning to operate, serving as a crew member of, jumping or falling from any aircraft, including those which are not motor-driven. This does not include:
    1. flying as a fare paying passenger in a scheduled or chartered flight operated by a commercial airline;
    2. flying as a passenger with no duties on board an aircraft operated by a private business to transport its personnel or guests;
    3. flying in your Employer's corporate aircraft as a passenger or crew member; or
    4. flying in a life-saving medevac or similar medical air transport service;
- operating a taxi or any other delivery service for any kind of compensation or profit;
- engaging in hang-gliding, bungee jumping, parachuting, sail gliding, parasailing, parakiting or mountaineering;
- participating in or practicing for any semi-professional or professional competitive athletic contest in which any compensation is received, including coaching or officiating;
- 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;
- voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless administered on the advice of a Physician and used as directed;
- improper or illegal use of inhalants or huffing;
- a Sickness or infection including physical or mental condition which is not caused solely by or as a direct result of a Covered Accident;
- incarceration in a penal institution of any kind.

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

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:

- 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 Injury;
- 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 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.

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?
Benefits payable for loss of life will be payable in accordance with the beneficiary designation. Unless you otherwise specify, if more than one beneficiary survives you, all surviving beneficiaries will share equally. The beneficiary designation must be in Writing, Signed by you and in a form acceptable to us. If no beneficiary is alive on the date of your death or you do not elect a beneficiary, we, at our option, may make payments as follows:

- to your spouse, if living; or
- if there is no surviving spouse, to your surviving children in equal shares; or
- if there is no surviving spouse or children, to your surviving parents in equal shares; or
- if there is no surviving spouse, children or parents, to your surviving brothers and sisters in equal shares; or

- if none of the above, to your estate.

Benefits payable for loss of life of your Spouse or a Dependent Child will be payable to you. If you are not living or are disqualified by operation of law, we will pay the deceased Dependent's estate.

For other benefits, 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 your beneficiary is a minor or is not competent, we have the right to pay up to $1,000 to the person or institution that appears to have assumed custody and main support for the minor, until the appointed legal representative makes a formal claim. If we pay benefits in good faith to a person or institution, we will not have to pay those benefits again.

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;
- 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; 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 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 in an amount up to 100% of each Insured's amount of insurance in force under the Policy on the date your insurance terminates.

When does your portable insurance start?
After your insurance terminates, your portable insurance will start on the later of the following:

- the date we approve your application for portable insurance; or
- the date we receive your first premium payment for portable insurance.

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 you attain age 70 or 12 months from the date your 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;
- 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 in an amount up to 100% of the amount of Spouse Accident Insurance and Dependent Children Accident Insurance in force under the Policy on the date of your death or divorce.

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

10. PORTABILITY

When does your Spouse's portable insurance start?

After your death or divorce, your Spouse's portable insurance will start on the later of the following:

- the date we approve your Spouse's application for portable insurance; or
- the date we receive your Spouse's first premium payment for portable insurance.

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 accident insurance benefits.

BENEFICIARY

How can you change your Beneficiary?
You can change your beneficiary at any time by giving us Written notice. The beneficiary's consent is not required for this or any other change in this Certificate, unless the designation of the beneficiary is irrevocable.

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 options.

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.

11. GENERAL PROVISIONS

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 AND AUTOPSY

What are our examination and autopsy 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.

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.

We, at our expense, may have an autopsy made unless prohibited by law. The autopsy must be performed in this State.

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 6 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.

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 or your Dependent Child or Spouse 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.

11. GENERAL PROVISIONS

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 Accident Insurance Certificate

Non-Participating

Coastal States Bank Employee Benefit Plan (The Plan) has been established to provide welfare benefits for its employees.

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 Policyholder and is included in this Certificate for your convenience. 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: Coastal States Bank
2530 Devine Street
Columbia, SC 29205

Plan Administrator: Benefit Coordinators
Coastal States Bank
PO Box 197
Irmo, SC 29063

The Plan Administrator has authority to control and manage the operation and administration of the Plan.

Agent for Service of Legal Process: Benefit Coordinators
PO Box 197
Irmo, SC 29063

Employer Identification Number (EIN): 03-0546702

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.

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 your benefits under the Plan includes the cost of any insurance premiums contributed by you.

Funding: Sun Life provides the Plan Administrator with certain insurance benefits in connection with the Plan. 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. 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, 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.