

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:	935916-002
Policy Effective Date:	January 1, 2020
Policyholder:	Colorado Higher Education Insurance Benefits Alliance Trust
Employer:	Metropolitan State University of Denver
Issue State:	Colorado

THIS POLICY PROVIDES BENEFITS FOR ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS ONLY. THIS POLICY IS LIMITED IN NATURE AND DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE.

THIS POLICY DOES NOT PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA). UNLESS YOU HAVE ANOTHER PLAN (SUCH AS MAJOR MEDICAL COVERAGE) THAT PROVIDES MINIMUM ESSENTIAL COVERAGE IN ACCORDANCE WITH THE ACA, YOU MAY BE SUBJECT TO A FEDERAL TAX PENALTY.

THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

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.

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

Employee Voluntary Accidental Death and Dismemberment Insurance

All United States Exempt Faculty and Administrative Employees working in the United States scheduled to work at least .5 FTE (20 hours) per week

Dependent Voluntary Accidental Death and Dismemberment Insurance

All United States Exempt Faculty and Administrative Employees working in the United States scheduled to work at least .5 FTE (20 hours) per week

Eligibility Waiting Period: None

1. BENEFIT HIGHLIGHTS
EMPLOYEE VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

CLASSIFICATION

All Eligible Employees

AMOUNT OF INSURANCE

You may elect an amount of Voluntary AD&D Insurance in \$10,000 increments. The minimum amount you may elect is \$10,000.

The **Maximum Benefit** is the lesser of:

- \$500,000; or
- 10 times your Basic Annual Earnings, rounded to the nearest \$10,000.

Your amount of Voluntary AD&D Insurance reduces to 65% when you reach age 70, to 45% when you reach age 75, to 30% when you reach age 80 and to 15% when you reach age 85.

Your Voluntary AD&D Insurance cancels at your retirement.

The following Additional Benefit(s) are included:

Common Carrier Benefit

Repatriation Benefit

Seat Belt Benefit

Waiver of Premium Benefit

CONTRIBUTIONS

The cost of your Voluntary Accidental Death and Dismemberment Insurance is paid for by you.

The following Questions and Answers will help you to better understand your benefits.

Please read them carefully and refer any questions to your Employer or call the Sun Life Group Customer Service Center toll free at 1-800-247-6875.

1. BENEFIT HIGHLIGHTS
DEPENDENT VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

CLASSIFICATION

All Eligible Employees

AMOUNT OF INSURANCE

Spouse Only	60% of your amount of Voluntary Accidental Death and Dismemberment Insurance in force.
Child Only*	20% of your amount of Voluntary Accidental Death and Dismemberment Insurance in force.
Family Coverage	50% of your amount of Voluntary Accidental Death and Dismemberment Insurance in force.
Spouse	
Child*	10% of your amount of Voluntary Accidental Death and Dismemberment Insurance in force.

* child under age 26

Your Dependent Spouse's amount of Voluntary AD&D Insurance cancels when your Dependent Spouse reaches age 70.

Your Dependent's amount of Voluntary AD&D Insurance cancels when you retire.

CONTRIBUTIONS

The cost of your Dependent Voluntary Accidental Death and Dismemberment Insurance is paid for by you.

The following Questions and Answers will help you to better understand your benefits.

Please read them carefully and refer any questions to your Employer or call the Sun Life Group Customer Service Center toll free at 1-800-247-6875.

2. DEFINITIONS

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 or a site where your Employer's business requires you to travel.

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 not Confined; or
- are not disabled due to an injury or sickness.

You are 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, if required, and you:

- are not Confined; or
- are not disabled due to an injury or sickness.

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

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 attached to it.

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

Dependent Child includes:

- your unmarried or married step-child;
- 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 a Spouse.

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

- incapable of self-sustaining employment because of a developmental disability or physical handicap; and
- dependent on you for support;

that child will continue to be 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

2. DEFINITIONS

- any person residing outside the United States, Canada or Mexico. 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.

Divorce means the dissolution of any relationship identified in the Marriage definition and the term "divorce decree" means the court-issued document appropriate for the termination of such a relationship.

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.

Employee means a person who is employed by the Employer within the United States, who is a U.S. citizen or a U.S. resident, scheduled to work at least the minimum hours shown in the Benefit Highlights, and paid regular earnings, and has a legitimate federal tax identification number. Employee does not include a seasonal or temporary employee whose annual work schedule is less than 12 months during a calendar year.

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

Employer means Metropolitan State University of Denver and includes any Subsidiary or Affiliated company insured under the Group Policy.

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

Family Member means: (a) your Spouse and (b) the following relatives of you or your Spouse: (1) parent; (2) child; (3) brother; (4) sister. 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;
- the change from part-time to full-time employment by you or your Spouse; or
- the taking of an unpaid leave of absence by you or your Spouse.

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.

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.

Insured means any person covered under the Policy.

2. DEFINITIONS

Intoxicated means:

- under the influence of alcohol, illegal drugs or prescription drugs other than as prescribed by an Insured's Physician; or
- 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.

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 Hearing, Limb, Sight, Speech or Thumb and Index Finger

- Loss of Hearing means the permanent and irrecoverable loss of hearing.
- Loss of Limb means that the foot is completely cut off at or above the ankle joint or the hand is completely cut off at or above the wrist joint.
- Loss of Sight of an eye means total and permanent loss of vision of the eye.
- Loss of Speech means the permanent and irrecoverable loss of speech or the ability to speak.
- Loss of a Thumb and Index Finger means that the thumb and index finger are each completely cut off at the metacarpophalangeal joint.

Marriage means any of the following relationships recognized under applicable state law: a same-sex or opposite-sex marriage; and a civil union partnership under which the partners have the same legal rights and responsibilities as a married couple.

Motorcycle means a motor vehicle licensed for use on public highways which requires a Motorcycle endorsement on a driver's license to operate the vehicle.

Paralysis means injury to the brain or spinal cord that results in complete and irreversible loss of use of both arms, both legs or one arm and/or one leg.

- Hemiplegia is the complete and irreversible Paralysis of one arm and one leg on the same side.
- Paraplegia is the complete and irreversible Paralysis of both legs.
- Quadriplegia is the complete and irreversible Paralysis of both arms and both legs.

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 or any Family Member.

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

Sickness means disease or illness, mental illness, drug and alcohol illness or pregnancy.

Spouse means any individual who under applicable state law is either recognized as a spouse, or partner to a civil union under which the partners have the same legal rights and responsibilities as a married couple, or are otherwise accorded the same rights as a spouse.

2. DEFINITIONS

Spouse does not include:

- any person who is insured as an Employee; or
- any person residing outside the United States, Canada or Mexico. 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.

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 Insurance?

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

- January 1, 2020;
- your first day of employment; or
- the date you first are Actively at Work in an Eligible Class.

You are also eligible for Employee 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 Insurance?

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

When does Employee Insurance start?

Employee Voluntary Insurance starts on the later 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 Employee Insurance?

During any Enrollment Period after you are covered under the Policy and Actively at Work, you may request a change in your Employee Insurance benefit option.

You may also request a change in Employee 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 Employee Insurance start?

If you are Actively at Work, any increase in insurance or benefits will start on the January 1st following the date you apply for a change in your coverage.

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

Any reduction in insurance due to your age will start on the January 1st following the date of change, whether or not you are Actively at Work.

Whether or not you are Actively at Work, any other reduction in insurance will start immediately following the date you apply for a change in your coverage.

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

When does Employee Insurance end?

Your insurance under the Policy will end upon the earliest of the following:

- the date the Policy terminates;
- the date you are no longer in an Eligible Class;
- the date your class is no longer included for insurance;
- the last day for which any required premium has been paid for your insurance;
- the last day you are Actively at Work, subject to any applicable Insurance Continuation provisions provided;

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF EMPLOYEE INSURANCE

- the date you enter active duty in any armed service during time of war, declared or undeclared;
- the date you retire; or
- the date you die.

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 you may apply to reinstate your insurance within 24 months from when your insurance ended. To reinstate your insurance, you must apply within 31 days after you return to being Actively at Work in an Eligible Class. Reinstatement will be effective on the latest date when all 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.

4. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE

When are you eligible for Spouse Insurance?

If you are in an Eligible Class shown in the Benefit Highlights, you are initially eligible for Spouse Insurance on the latest of:

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

You are also eligible for Spouse 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 Insurance?

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

When does Spouse Insurance start?

Spouse Voluntary Insurance starts on the latest of the date:

- you are eligible for Spouse Insurance;
 - you are insured under the Policy;
 - you enroll for Spouse Insurance; and
 - you agree to make any required contribution toward the cost of insurance;
- if your Spouse is not Confined on that date.

What if my Spouse is Confined?

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

How can you make changes in Spouse Insurance?

During any Enrollment Period after your Spouse is covered under the Policy and not Confined, and you are Actively at Work, you may request a change in your Spouse Insurance.

You may also request a change in Spouse 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 Spouse Insurance start?

If you are Actively at Work, any increase in insurance or benefits will start on the January 1st following the date you apply for a change in your coverage.

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

Whether or not you are Actively at Work, any other reduction in insurance will start immediately following the date you apply for a change in your coverage.

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

When does Spouse Insurance end?

Spouse Insurance will end on the earliest of the following to occur:

- the date the Policy terminates;
- the date you are no longer in an Eligible Class;
- the date your class is no longer included for insurance;
- the last day for which any required premium has been paid for your insurance or your Spouse Insurance;
- the date you are no longer insured under the Policy;

4. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE

- the last day you are Actively at Work, subject to any applicable Insurance Continuation provisions provided;
- the date your Spouse enters active duty in any armed service during time of war, declared or undeclared;
- the date your Spouse no longer meets the definition of Spouse as described in this Certificate;
- the date you retire;
- the date your Spouse attains age 70; or
- the date your Spouse dies.

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

When are you eligible for Dependent Children Insurance?

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

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

You are also eligible for Dependent Children 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 Insurance?

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

When does Dependent Children Insurance start?

Dependent Children Voluntary Insurance starts on the latest of the date:

- you are eligible for Dependent Children Insurance;
 - you are first insured under the Policy;
 - you enroll for Dependent Children Insurance; and
 - you agree to make any required contribution toward the cost of insurance;
- if your Dependent Child is not Confined on that date.

What if my Dependent Child is Confined?

If your Dependent Child is Confined on the date your Dependent Children Insurance would normally start, your Dependent Children Insurance will not start until your Dependent Child is no longer Confined. Confinement does not apply to a newborn child.

How can you make changes in Dependent Children Insurance?

During any Enrollment Period after your Dependent Children are covered under the Policy and not Confined, and you are Actively at Work, you may request a change in your Dependent Children Insurance.

You may also request a change in Dependent Children 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 Dependent Children Insurance start?

If you are Actively at Work, any increase in insurance or benefits will start on the January 1st following the date you apply for a change in your coverage.

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

Whether or not you are Actively at Work, any reduction in insurance will start immediately following the date you apply for a change in your coverage.

Any change in insurance for your Dependent Child 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 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.

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

How does Dependent Children 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 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 they become your Dependent Child. To continue coverage beyond 31 days, then you must:

- enroll for Dependent Children 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 Insurance.

If you are covered under the Policy and have Dependent Children 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 Insurance end?

Dependent Children Insurance will end on the earliest of the following to occur:

- the date the Policy terminates;
- the date you are no longer in an Eligible Class;
- the date your class is no longer included for insurance;
- the last day for which any required premium has been paid for your insurance or your Dependent Children Insurance;
- the date you are no longer insured under the Policy;
- the last day you are Actively at Work;
- the date your Dependent Child enters active duty in any armed service during time of war, declared or undeclared;
- 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 you retire; or
- the date your Dependent Child dies.

6. COVERED ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

VOLUNTARY ACCIDENTAL DEATH BENEFIT

What is the Voluntary Accidental Death Benefit?

We will pay a Voluntary Accidental Death Benefit when an Insured dies within 365 days of the date of the Covered Accident as a result of Injuries received from that Accident. The amount payable is 100% of the amount of insurance in force for your class shown in the Benefit Highlights on the Insured's date of death.

What happens if you disappear or your Spouse disappears or your Dependent Child disappears?

We will presume, subject to no objective evidence to the contrary, that the Insured is dead and death is a result of an Accidental Injury if:

- the Insured disappears as a result of an accidental wrecking, sinking or disappearance of a public conveyance in which the Insured was known to be a fare-paying passenger; and
- the Insured's body is not found within 365 days after the date of the conveyance's disappearance.

VOLUNTARY ACCIDENTAL DISMEMBERMENT BENEFIT

What is the Voluntary Accidental Dismemberment Benefit?

We will pay a Voluntary Accidental Dismemberment Benefit if an Insured sustains any of the losses shown below due to Injuries received in a Covered Accident, and the loss occurs within 365 days after the date of the Covered Accident. The amount payable is a percentage of the amount of insurance in force for your class shown in the Benefit Highlights on the date of the Accidental Injury. The following is a list of the losses and applicable percentages:

Life.....	100%
Sight of one eye.....	50%
One limb.....	50%
Speech and hearing.....	100%
Speech or hearing.....	50%
Thumb and index finger of the same hand.....	25%
Quadriplegia.....	100%
Paraplegia.....	75%
Hemiplegia.....	50%

The maximum amount of Voluntary Accidental Death and Dismemberment Benefit payable for losses resulting from any one accident is 100%.

7. ADDITIONAL BENEFITS

You are insured for the additional benefits shown below provided you are eligible for those benefits.

These additional benefits are subject to all the terms and conditions of the Policy. In addition to the termination provisions shown in the Eligibility, Effective Dates and Terminations section, termination provisions specific to an additional benefit are shown in this section.

COMMON CARRIER BENEFIT

What is the Common Carrier Benefit?

If an Insured's loss of life occurs while traveling as a fare paying passenger on a public conveyance operated by a common carrier, an additional Common Carrier benefit will be payable.

The Common Carrier Benefit is 100% of the amount of Voluntary Accidental Death Benefit payable.

REPATRIATION BENEFIT

What is the Repatriation Benefit?

If a Voluntary Accidental Death Benefit is payable and your death occurs at least 100 miles from your permanent place of residence, we will reimburse the Executor or Administrator of your estate for the reasonable and customary expenses incurred for the preparation of the body and its transportation to the place of burial or cremation up to a maximum benefit of \$2,000. Written Proof of the expenses incurred must be submitted to us prior to payment.

What is the Seat Belt Benefit?

We will pay a Seat Belt Benefit if your loss of life occurs as a result of an automobile accident and you were wearing a seat belt at the time of the accident.

The Seat Belt Benefit is 25% of the amount of Voluntary Accidental Death Benefit payable or \$25,000, whichever is less.

We must receive satisfactory written proof that your death resulted from an automobile accident and that you were wearing a seat belt at the time of the accident. A copy of the police report is required.

What is the Air Bag Benefit?

We pay an Air Bag Benefit if the Seat Belt Benefit is payable and you were positioned in a seat protected by a Supplemental Restraint System which inflated on impact.

The Air Bag Benefit is 10% of the amount of Voluntary Accidental Death Benefit payable or \$5,000, whichever is less.

We must receive satisfactory written proof that your death resulted from an automobile accident and that the Supplemental Restraint System properly inflated. A copy of the police report is required.

Seat Belt means a properly installed seat belt, lap and shoulder restraint, or other restraint approved by the National Highway Traffic Safety Administration.

Supplemental Restraint System means a factory installed air bag which inflates for added protection to the head and chest areas.

Automobile means a motor vehicle licensed for use on public highways.

7. ADDITIONAL BENEFITS

WAIVER OF PREMIUM BENEFIT

What is the Waiver of Premium Benefit?

If you become Totally Disabled while insured, and your Total Disability is a result of an Accidental Injury received while insured, the Waiver of Premium Benefit may continue your Voluntary Accidental Death and Dismemberment Insurance without any further payment of premiums by you or your Employer.

You are eligible if we receive Notice and Proof of Claim that you became Totally Disabled:

- while insured; and
- before your 60th birthday; and
- before you retire; and
- your Total Disability has continued for at least 9 months.

Notice of Claim is required no later than 12 months after you cease to be Actively at Work. Proof of Claim is required no later than 15 months after you cease to be Actively at Work. We may require periodic proof of the continuance of your Total Disability at reasonable intervals, but not more often than twice a year after you have been continuously Totally Disabled for two years.

We will continue the amount of your Voluntary Accidental Death and Dismemberment Insurance in force on the last day you were Actively at Work. This amount is subject to the same reductions or terminations that would have been applicable had you not become Totally Disabled.

When does your Waiver of Premium end?

Your Waiver of Premium ceases on the earliest of:

- the date you are no longer Totally Disabled;
- the date you do not provide Proof that you continue to be Totally Disabled;
- the date you are no longer under the regular and continuing care of a Physician providing appropriate treatment by means of examination and testing in accordance with your disabling condition;
- the date you do not submit to an examination by a Physician of our choice;
- the date you reach age 99;
- the date you retire;
- the date you die.

For the purpose of this benefit, you are considered retired when you receive any compensation from a retirement or pension plan of your Employer, or when you reach age 99, whichever is earlier.

For the purpose of this benefit, Total Disability or Totally Disabled means because of your Accidental Injury, you are unable to perform the material and substantial duties of any occupation for which you are or become reasonably qualified for by education, training or experience.

Your right to continued benefits pursuant to this Waiver of Premium Benefit is determined on the date Total Disability begins. This right is subject to the terms of the Policy and will not be affected by subsequent amendment or termination of this Waiver of Premium Benefit.

8. 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:

- committing or attempting to commit suicide while sane;
- injuring oneself intentionally;
- a Sickness or infection including physical or mental condition which is not caused solely by or as a direct result of a Covered Accident;
- war or an act of war, or any involvement in any period of any type of armed conflict (this does not include acts of terrorism);
- active Participation in a Riot, Rebellion or Insurrection;
- riding in or driving any motor-driven vehicle in a race, stunt show, speed test or while Intoxicated;
- injuries sustained from any aviation activities, other than riding as a fare paying passenger;
- committing of or attempting to commit an assault, felony or other criminal act; or
- 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.

9. 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 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?

For the Accidental Death Benefit written notice of claim must be given to us no later than 30 days after date of death.

For the Accidental Dismemberment Benefit written notice of claim must be given to us no later than 12 months after the Insured's date of loss.

For the Waiver of Premium Benefit, written notice of claim must be given to us no later than 12 months after you cease to be Actively at Work.

For all other claims, written notice of claim must be given to us no later than 12 months after the Insured's date of loss, or within 12 months after the date the expense is incurred.

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?

For the Accidental Death Benefit written proof of claim must be given to us no later than 90 days after date of death.

For the Accidental Dismemberment Benefit written proof of claim must be given to us no later than 15 months after the Insured's date of loss.

For the Waiver of Premium Benefit, written proof of claim must be given to us no later than 15 months after you cease to be Actively at Work.

For all other claims, proof of claim must be given to us no later than 15 months after the Insured's date of loss or within 15 months after the date the expense was incurred.

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 or disability or expense;
- the date the loss or disability or expense occurred; and
- the cause of the loss or disability.
- 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.

9. CLAIM PROVISIONS

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 45 days after receipt of the claim. If we cannot make a decision within 45 days after receiving your claim we will request a 30 day extension as permitted by U.S. Department of Labor regulations. If we cannot render a decision within the extension period, we will request an additional 30 day extension. 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 to the request for additional 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 setting forth:

- the specific reason(s) for the denial;
- the specific Policy provision(s) on which the denial is based;
- your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
- a description of any additional material or information needed to prove entitlement to benefits and an explanation of why such material or information is necessary;
- a description of the appeal procedures and time limits;
- your right to bring a civil action under ERISA, §502(a) following an adverse determination on review.
- the identity of an internal rule, guideline, protocol or other similar criterion, if any, that was relied upon to deny the claim and a copy of the rule, guideline, protocol or criterion or a statement that a copy is available free of charge upon request; and
- the identity of any medical or vocational experts whose advice was obtained in connection with the claim, regardless of whether the advice was relied upon to deny the claim.

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 180 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 45 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 45 days from the end of the initial period.

9. CLAIM PROVISIONS

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 setting forth:

- 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);
- the identity of an internal rule, guideline, protocol or other similar criterion, if any, that was relied upon to deny the claim and a copy of the rule, guideline, protocol or criterion or a statement that a copy is available free of charge upon request;
- 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."; and
- the identity of any medical or vocational experts whose advice was obtained in connection with the appeal, regardless of whether the advice was relied upon to deny the appeal.

Are there any other remedies available if a claim is denied?

If a claim has been denied in whole or in part, and the claimant has exhausted all claim review and appeals procedures available, Colorado state law requires us to state that the claimant is entitled to file a lawsuit and have the claim reviewed de novo in any court with jurisdiction and to a trial by jury. If the Policy issued to fund the employee welfare benefit plan is subject to the Employee Retirement Income Security Act of 1974, the claimant may not have the right to have the claim reviewed de novo in any court with jurisdiction or the right to a jury trial.

To whom are benefits payable?

Benefits payable for loss of life will be payable in accordance with the beneficiary designation (other than your Employer). Unless you otherwise specify, if more than one beneficiary survives you, all surviving beneficiaries will share equally. 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, 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 none of the above, to your estate.

For other benefits, we will pay you if your Proof of claim is satisfactory to us, except in the following situations:

1. 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;
2. 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 in item 1; or
3. 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 a benefit is payable to your estate, if you are a minor, or you are not competent, we have the right to pay an amount of the benefit up to \$5,000 to any of your relatives that we consider entitled. If we pay benefits in good faith to a relative, we will not have to pay those benefits again.

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

9. CLAIM PROVISIONS

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.

10. 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 by paying the required premium to us for any of the following reasons and durations:

- Layoff - up to 1 month
- Leave of Absence (including Family and Medical Leave of Absences) – up to 24 months
- Absence due to injury or sickness – for up to 12 months
- Sabbatical Leave of Absence – up to 24 months
- School Recess– 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). You should contact your Employer for more details.

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

You may elect to continue your insurance if:

- your employment terminates for reasons other than retirement, sickness or injury; and
- the Policy is still in force; and
- your insurance is not being continued under the Waiver of Premium Benefit; and
- you are under age 70 at the time your insurance terminates; and
- you reside in the United States or Canada.

When must you apply to continue insurance after your insurance terminates?

You must complete an application for continuation of insurance and send it to us with payment of the first premium within 45 days of the date your insurance terminates. The application for continuation of insurance and applicable rates are available from your Employer.

What is the amount of insurance you can continue after your insurance terminates?

You may apply to continue 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 to a maximum of \$500,000.

When does your continuation of insurance start?

After your insurance terminates, your continuation of insurance will start on later of the following:

- the date we approve your application for continuation of insurance; and
- the date we receive your first premium payment for continuation of insurance.

When does your continuation of insurance end?

Your continuation of insurance will end on the earliest of the following to occur:

- the date the Policy terminates;
- the last day for which any required premium has been paid for your continuance of insurance;
- the date you request in writing to end your continuance of insurance;
- the date you attain age 70;
- the date you reside outside the United States or Canada;
- the date you die; or
- the date you become insured again under the Policy.

11. CONTINUITY OF COVERAGE

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

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

What if you are not Actively at Work when your Employer replaces your Previous Plan with This Plan?

You will be covered under This Plan if you are not Actively at Work on January 1, 2020 if:

- you were insured under the Previous Plan on the day before January 1, 2020;
- you are a member of an Eligible Class;
- premiums for you are paid up to date; and
- you are not receiving or eligible to receive benefits under the Previous Plan.

If you sustain Injuries that result from a Covered Accident Benefit as defined in the Covered Accident Benefit section of This Plan, and were never Actively at Work while covered under This Plan, any benefit payable will be the lesser of:

- the benefit payable under This Plan; or
- the benefit payable under the Previous Plan.

12. GENERAL PROVISIONS

ALTERATION

Who can alter this Certificate?

The only persons with the authority to alter or modify this Certificate 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.

Any change which reduces or eliminates coverage must be requested in writing and signed by the Policyholder.

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 connection with 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 continuation options.

CONFORMITY WITH STATUTES

What is the effect of Conformity with Statutes?

If any provision of the Policy conflicts with any applicable law, the provisions of Policy will be automatically amended to meet the minimum requirements of the law and to reflect updated statutory references.

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 own expense, have the right to have any person whose claim is pending or ongoing be:

- 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 reasonably required.

12. GENERAL PROVISIONS

We, at our own expense, may have an autopsy made unless prohibited by law.

INCONTESTABILITY

What is the Incontestability Provision?

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

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

LEGAL PROCEEDINGS

What are the time limits for legal proceedings?

No legal action may start:

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

LIMIT OF PREMIUM REFUNDS

Is there a limit on premium refunds?

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

MISSTATEMENT OF FACTS

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

If relevant facts about the Employee relating to this insurance are not accurate:

- a fair adjustment of premium will be made, subject to the "Limit of Premium Refunds" section; and
- the true 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.

NOTICE

How are required notices provided?

Any obligation we may have to give written notice will be satisfied by sending such notice to the last known address of the person or institution entitled to such notice.

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 all Policy requirements must be satisfied.

12. GENERAL PROVISIONS

REIMBURSEMENT

What if a benefit is underpaid or overpaid?

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

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

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

STATEMENTS

Are statements warranties?

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

SUN LIFE ASSURANCE COMPANY OF CANADA

This is a Limited Certificate - Read it Carefully

Group Accident Insurance Certificate

Non-Participating

