SUN LIFE AND HEALTH INSURANCE COMPANY (U.S)

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

Home Office:
201 Townsend Street, Suite 900
Lansing, MI 48933

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

Sun Life and Health Insurance Company (U.S.) (the Company) certifies that it has issued and delivered a Group Insurance Policy to the Policyholder shown below.

Policy Number:	903900-001
Policy Effective Date:	January 1, 2024
Policyholder:	Adelphi University
Employer:	Adelphi University
Issue State:	New York
Amendment Effective Date:	January 1, 2024

DISCLOSURE NOTICE: The Short Term Disability Income Insurance evidenced by this Certificate provides disability income insurance only. It does not provide basic hospital or basic medical insurance.

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 New York unless otherwise preempted by the federal Employee Retirement Income Security Act ("ERISA").

Signed for the Company,

David J. Healy
President

Colleen L. Kallas
Assistant Vice President and Senior Counsel and Secretary

Group Basic Short Term Disability Income Insurance Certificate
Non-Participating

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1. BENEFIT HIGHLIGHTS

Eligible Classes: All United States Adjunct Faculty Employees working in the United States scheduled to work at least 1 hours per week.

Eligibility Waiting Period: 30 days

1. BENEFIT HIGHLIGHTS

Your disability income insurance will be based on the following:

Benefit:
50% (Benefit Percentage) of your Total Weekly Earnings

Benefits will be paid weekly.

Maximum Benefit:
$600

Minimum Benefit:
None

Elimination Period:
7 days

Maximum Benefit Duration:
13 weeks

Total Weekly Earnings:
Your basic weekly earnings as reported by your Employer immediately before the first date your Total Disability begins. Total Weekly Earnings includes deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, health savings account or flexible spending account, but does not include income received due to commissions, bonuses, overtime pay or any other extra compensation.

If you are paid on an hourly basis, Total Weekly Earnings will be based on your hourly rate of pay, but will not exceed 40 hours per week.

Contributions:
The cost of your insurance is paid entirely by your Employer. This is your Non-contributory Insurance.

  - The partners have been living together on a continuous basis prior to the date of the application;
  - Neither individual has been registered as a member of another domestic partnership within the last six months; and
- Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
- Proof that the partners are financially interdependent. Two or more of the following are collectively sufficient to establish financial interdependence:
  - A joint bank account
  - A joint credit card or charge card
  - Joint obligation on a loan
  - Status as an authorized signatory on the partner's bank account, credit card or charge card
  - Joint ownership of holdings or investments
  - Joint ownership of residence
  - Joint ownership of real estate other than residence
  - Listing of both partners as tenants on the lease of the shared residence
  - Shared rental payments of residence (need not be shared 50/50)
  - Listing of both partners as tenants on a lease or shared rental payments, for property other than residence
  - A common household and shared household expenses (e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50))
  - Shared household budget for purposes of receiving government benefits
  - Status of one as representative payee for the other's government benefits
  - Joint ownership of major items of personal property (e.g., appliances, furniture)
  - Joint ownership of a motor vehicle
  - Joint responsibility for child care (e.g., school documents, guardianship)
  - Shared child-care expenses (e.g., babysitting, day care. School bills (need not be shared 50/50))
  - Execution of wills naming each other as executor and/or beneficiary
  - Designation as beneficiary under the other's life insurance policy
  - Designation as beneficiary under the other's retirement benefits account
  - Mutual grant of durable power of attorney
  - Mutual grant of authority to make heath care decisions (e.g., health care power of authority)
  - Affidavit by creditor or other individual able to testify to partners' financial interdependence
  - Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

Drug and Alcohol Illness means:
- alcoholism;
- the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance; or
- the use of prescription medications other than as prescribed by your Physician.

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.

Elimination Period means the number of consecutive days of Total Disability, shown in the Benefit Highlights, which must be completed before we will pay you the benefit. No benefits will be paid to you for any portion of your Total Disability that occurs during your Elimination Period.

Employee means a person who is:
- scheduled to work at least the minimum hours shown in the Benefit Highlights;
- paid regular earnings in accordance with applicable state, provincial and federal wage and hour laws; and
- has a legitimate federal tax identification number.

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

2. DEFINITIONS

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

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

Full-time Basis means you are or have the capacity to perform the Material and Substantial Duties of your Regular Occupation for the number of hours you normally performed your Regular Occupation prior to your Disability.

If you normally performed your Regular Occupation in excess of 40 hours per week, we will consider you as being able to perform that requirement if you work or have the capacity to work 40 hours per week.

Gross Benefit means your benefit before reductions for any Deductible Sources of Income or Disability Earnings.

Hospital means a short-term, acute general hospital which:

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2. DEFINITIONS

Non-Contributory Insurance means insurance for which the premium is paid entirely by your Employer.

Non-deductible Sources of Income means Other Income that is not deducted from your Gross Benefit as described in the "Other Income" provisions. Non-deductible Sources of Income include:

- Income from:
  - 401(k) plans;
  - 403(b) plans;
  - profit sharing plans;
  - thrift plans;
  - tax sheltered annuities;
  - stock ownership plans;
  - non-qualified plans of deferred compensation;
  - pension plans for partners;
  -

2. DEFINITIONS

Period of Disability means the number of consecutive days that you are Disabled beginning with the first day you are Totally Disabled and under the Continuing Care of a Physician for the Accident or Sickness causing your Disability.

Physician means an individual who is a legally qualified practitioner of the healing arts operating within the scope of his or her license and is either:

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

The Physician cannot be you or any family member. "Family member" means: (a) your Spouse or Domestic Partner and (b) the following relatives of you or your Spouse or Domestic Partner: (1) parent; (2) grandparent; (3) child; (4) grandchild; (5) brother; or (6) sister. This includes adopted, in-law and step-relatives.

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.

Regular Occupation means the occupation you are performing immediately prior to the first date your Period of Disability commences. Regular Occupation is deemed to mean Own Job.

Retirement Plan means a program that provides retirement benefits to Employees and is not funded wholly by Employee contributions. Retirement Plan does not include:

- a profit-sharing plan;
- a thrift plan;
- a deferred compensation plan;
- a non-qualified pension plan;
- an Individual Retirement Account (IRA);
- a Tax Sheltered Annuity (TSA);
- a salary reduction plan (401(k), 403(b) or like plan);
- a Keogh plan (HR-10) with respect to Partners;
- an Employee Stock Ownership Plan (ESOP); or
- any amount rolled over or transferred to any other retirement plan as defined in Section 402 of the Internal Revenue Code.

Riot means a concerted action:

- made in furtherance of an express common purpose;
- through the use of threat of violence, disorder or terror to the public; and
- resulting in a disturbance of the peace.

Sickness means disease or illness, Mental Illness, Drug and Alcohol Illness or pregnancy. A Disability caused by a Sickness must:

- occur while covered under the Policy; and
- not otherwise be excluded under the Policy.

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.

Total Disability and Totally Disabled means you are unable to perform the Material and Substantial Duties of your Regular Occupation.

2. DEFINITIONS

Total Disability must be caused by an Accident or Sickness and must commence while you are insured under the Policy. You must be Totally Disabled during your Elimination Period.

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 and Health Insurance Company (U.S.).

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 TERMINATIONS

When are you eligible for insurance?
You are initially eligible for insurance on the latest of:

- January 1, 2024;
- the date your Eligibility Waiting Period ends; or
- the date you first are Actively at Work in an Eligible Class.

When does your insurance start?
Your insurance starts on the date you are eligible, if you are Actively at Work on that date.

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

When does a change in your insurance start?
If you are Actively at Work, any increase in insurance or benefits will start on the date of change, for an increase in your Total Weekly Earnings.

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

Whether or not you are Actively at Work, any decrease in insurance or benefits will start on the date of change, for a decrease in your Total Weekly Earnings.

Any change is subject to all the terms of the Policy.

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

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

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

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

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

When does your insurance end?
Your insurance under the Policy will end on the earliest of the following dates:

- the date the Policy terminates;
- the last day of the period for which any required premium has been paid for your insurance or any part of your insurance; or
- the date you die.

Your insurance will also end when any of the following occur, but coverage may be extended subject to any

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATIONS

If your coverage has ended, can it be reinstated?
If your insurance ends for any reason other than you have voluntarily terminated it, your insurance may be reinstated. Reinstatement will be effective on the date you return to being Actively at Work in an Eligible Class.

A new Eligibility Waiting Period will not apply.

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

4. BENEFIT PROVISIONS

What is the disability income benefit?
Disability income benefits are benefits paid to you to partially replace your income if you become Disabled while insured.

When do disability income benefits become payable?
We will pay you a benefit as calculated below, for a Period of Disability, subject to all the terms of the Policy if you:

- send Proof to us that you have become Disabled;
- are insured under the Policy at the time your Disability commences; and
- have completed your Elimination Period shown in the Benefit Highlights.

How is the benefit calculated for a Total Disability?
To determine the benefit we will pay each week you are Totally Disabled we will subtract all Deductible Sources of Income from the lesser of:

- the Benefit Percentage multiplied by your Total Weekly Earnings; or
- the Maximum Benefit.

The result is your Total Disability benefit.

How is the benefit calculated for a Partial Disability?
To determine the benefit we will pay while you are Partially Disabled, add your Deductible Sources of Income and your Disability Earnings to your Gross Benefit for a Total Disability.

If the calculation above is more than 100% of your Total Weekly Earnings, subtract the amount in excess of 100% from your benefit for a Total Disability. The result is your benefit for a Partial Disability.

If the calculation above is 100% or less than your Total Weekly Earnings, your benefit for a Partial Disability is the same as your benefit for a Total Disability.

If you are earning 20% or less of your Total Weekly Earnings, a Total Disability Benefit will be paid.

When is the benefit paid?
The benefit will be paid as follows:

- benefits will be paid weekly following your Elimination Period as specified in the Benefit Highlights; and
- for each day for which a benefit is payable, the amount paid will be equal to 1/7th of the benefit.

What happens if you return to work and become Disabled again?
We will treat this new Disability as part of your prior Disability if you returned to work and were Actively at Work for less than:

- 14 days, if due to the same or related causes; or
- one day, if due to an entirely unrelated cause.

You will not have to complete a new Elimination Period.

Your benefit will be subject to the same terms and conditions as were applicable to the original Disability.

Your benefit will not continue if:

- your coverage under the Policy terminates; or
- you become eligible for coverage under any other group disability income policy.

If your new disability begins later than the time periods specified, you will need to complete a new Elimination Period.

When does your benefit end?
Your benefit will end on the earliest of the date:

- you do not submit to any medical examination or clinical assessment requested by us;
- we determine you are no longer Disabled, even if you choose not to work;
- you reach the end of your Maximum Benefit Duration;
- you do not provide Proof to us that you continue to be Disabled; or

4. BENEFIT PROVISIONS

5. EXCLUSIONS AND LIMITATIONS

What are the exclusions?
No benefit is payable to you under the Policy for any Period of Disability or other loss for which benefits are payable that is caused by, contributed to in any way or resulting from:

- intentionally self-inflicted injuries;
- war or any act of war (this does not include acts of terrorism);
- service in the Armed Forces or units auxiliary thereto;
- your Participation in a Riot;
- your committing or attempting to commit a felony or being engaged in an illegal occupation.

What are the limitations?
No benefit is payable to you for any Period of Disability or other loss:

- while you are not under the Continuing Care of a Physician for the Accident or Sickness causing your Disability, unless you have reached your maximum point of recovery and are still Disabled; or
- for any period you do not submit to any medical examination or clinical assessment requested by us.

6. CLAIMS

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:

- for a disability, no later than 30 days after you cease to be Actively at Work or within 30 days after the termination of the Policy, if earlier.

Failure to give notice within such time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

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

PROOF OF CLAIM

When does Written Proof of claim have to be submitted?
Proof of claim must be given to us:

- for a disability, no later than 120 days after the end of your Elimination Period.

If requested Proof is not provided, your claim will be denied.

Failure to furnish such proof within such time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof within such time, provided such proof was furnished as soon as reasonably possible.

What is considered Proof of claim?
Proof of claim must consist of at least the following information:

- a description of the loss or disability;
- the date the loss or disability occurred;
- the cause of the loss or disability;
- evidence demonstrating the disability and should include at least Hospital records, Physician records, psychiatric records, x-rays, narrative reports, or lab, toxicology or other diagnostic testing materials as appropriate for the disabling condition;
- police reports;
- incidence reports from your Employer;
- payroll records from your Employer; and
- copies of your wage or earnings statements.

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

Proof of your continued Disability and regular and Continuing Care must be given to us within 30 days of the request for Proof.

Proof must be satisfactory to us.

PAYMENT OF BENEFITS

When are benefits payable?
Benefits are payable not less frequently than monthly during the continuance of the period for which we are liable, when we receive satisfactory Proof of the claim. Any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

Benefits are based on the coverage that is in force on the date you are Disabled or the expense was incurred. Any change to the Policy will not affect a payable claim that occurs prior to the change.

6. CLAIMS

When will a decision on your claim be made?
We will send you a Written notice of 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 and provide the requested information. You will have 45 days to provide the specified information.

- 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 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

7. INSURANCE CONTINUATION

Are there any conditions under which your insurance can continue?
If you are absent due to Accident or Sickness, your insurance will be continued during the Elimination period.

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:

- Layoff – up to 1 month
- Leave of Absence – up to 1 month
- 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

8. 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?
You cannot assign any interest in the Policy unless we agree in Writing to such an assignment. We have the right to determine the extent to which any assignment will be honored and the priority of such assignment. We do not assume any responsibility for the validity or sufficiency of any assignment. Any payments made under such assignment after consented to by us will discharge our liabilities under the Policy, to the extent of such payments.

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.

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

- not enrolling for insurance within required time limits;
- failing to request increased amounts of insurance within required time limits;
- failing to provide any required Evidence of Insurability; or
- failing to exercise any available Insurance Continuation options.

CONFORMITY WITH STATUTES

What is the effect of Conformity with Statutes?
Any provision of the Policy, which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

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.

8. GENERAL PROVISIONS

EXAMINATION

What are our examination rights?
We, at our expense, have the right to have any person, whose Disability is the basis of a claim:
- 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.

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 your initial, increased, additional or reinstated insurance, no statement made by you 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 your lifetime. The statement must be contained in a form Signed by you.

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

LEGAL PROCEEDINGS

What are the time limits for legal proceedings?
No legal action may start:
- until 60 days after Proof of claim has been given; nor
- more than 3 years after the time Proof of claim is required.

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; 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 and Health Insurance Company (U.S.), 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 the benefit under the Policy all Policy requirements must be satisfied.

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

8. GENERAL PROVISIONS

SUN LIFE AND HEALTH INSURANCE COMPANY (U.S)

Group Basic Short Term Disability Income Insurance Certificate
Non-Participating

Adelphi University Employee Benefit Plan (The Plan) has been established to provide welfare benefits for its eligible 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 Plan Administrator who is the Policyholder and is included in this Certificate for your convenience. This Summary Plan Description applies only to the benefits under the Plan to the extent they are funded by the Group Insurance Policy issued by Sun Life and Health Insurance Company (U.S.). Sun Life and Health Insurance Company (U.S.) assumes no responsibility for the accuracy or sufficiency of the information in the Summary Plan Description.

SUMMARY PLAN DESCRIPTION

Plan Sponsor: Adelphi University
1 South Ave
P.O. Box 701
Garden City, NY 11530

Plan Administrator and Named Fiduciary:
Adelphi University
1 South Ave
Garden City, NY 11530

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

Agent for Service of Legal Process for the Plan:

Adelphi University
1 South Ave
Garden City, NY 11530

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

Employer Identification Number (EIN): 11-1630741

Plan Number: 502

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 and Health Insurance Company (U.S.) are included in the Plan. Sun Life and Health Insurance Company (U.S.) is the claims administrator for those benefits and has full authority to make all benefit claim determinations.

Participants: The insured employees described in the Sun Life and Health Insurance Company (U.S.) Certificate.

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

Contributions: The cost of the insurance premiums are paid for by your employer and (if applicable) includes the cost of any insurance premiums contributed by you.

Funding: The benefits under the Plan are funded, at least in part, by the Group Insurance Policy issued by Sun Life and Health Insurance Company (U.S.). Those insurance benefits are described in your Certificate.

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

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

Your Rights under ERISA:

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report, if required by ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part and if you have exhausted the claims and appeal procedures described in the Certificate, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance of the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.