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:	972030-001
Policy Effective Date:	January 1, 2025
Policyholder:	Cable Dahmer Chevrolet, Inc.
Employer:	Cable Dahmer Chevrolet, Inc.
Issue State:	Missouri
Amendment Effective Date:	January 1, 2026

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

Signed at Wellesley Hills, Massachusetts.



Kevin Strain
President and Chief Executive Officer



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

Group Basic Short Term Disability Income Insurance Certificate
Non-Participating

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1. BENEFIT HIGHLIGHTS

Eligible Classes:	All Full-Time United States Non-Union Employees working in the United States scheduled to work at least 30 hours per week.
Eligibility Waiting Period:	Until the first of the month coincident with or next following 60 days of employment The Eligibility Waiting Period is None for Employees of Cable Dahmer Kia Lawrence, LLC hired prior to January 1, 2026

1. BENEFIT HIGHLIGHTS

Your disability income insurance will be based on the following:

Benefit:
100% (Benefit Percentage) of your Total Weekly Earnings

Benefits will be paid weekly.

Maximum Benefit:
$400

Minimum Benefit:
$35 or 15% of the Gross Benefit, whichever is greater.

Elimination Period:
Accident: None
Sickness: 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 or Partial Disability begins. Total Weekly Earnings includes commissions, bonuses, overtime pay and 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 any other extra compensation.

If your current weekly earnings includes commissions, bonuses or overtime pay, your Total Weekly Earnings will be averaged over the previous 12 month period of your employment before the first date your Total or Partial Disability begins or averaged from your date of employment, whichever is less.

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

2. DEFINITIONS

Accident means an event that an average person would consider sudden and unforeseeable and is independent of any illness, disease or other bodily malfunction.

A Disability caused by an Accident must:
- occur while covered under the Policy; and
- not otherwise be excluded under the Policy.

An Accident that results in Disability more than 3 calendar days after the Accident will be deemed a Sickness.

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 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.

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 Accident or Sickness.

Confined or Confinement means confined to a Hospital or similar facility.

Continuing Care means you visit a Physician whose medical specialty is the most appropriate specialty to evaluate, manage or treat your Accident or Sickness and you receive care and Treatment as frequently as is Medically Necessary according to generally accepted medical standards.

Deductible Sources of Income means Other Income that is deducted from your Gross Benefit as described in the "Other Income" provisions. Deductible Sources of Income include:
- benefits under Unemployment Compensation Law, or any other act or law of like intent;
- the amount from any mandated benefits act or law that you may receive or be eligible to receive. This includes all Paid Medical Leave, or state disability mandated temporary disability benefits required by law and where such reduction is not prohibited by law;
- an automobile insurance policy providing disability wage loss benefits;
- any labor management trustee, union or employee benefit plans that are funded in whole or in part by your Employer;
- any disability income benefits under:
  - any other group plan of your Employer; or
  - any governmental retirement system as a result of your job with your Employer;
- the amount you receive from any sick leave paid to you by your Employer; or
- the amount you receive from any salary continuation paid to you by your Employer. Deductible Sources of Income includes only the amount of such benefits which, when combined with your benefit, exceeds 100% of your Total Weekly Earnings. The amount in excess of 100% of Total Weekly Earnings will be used to reduce your benefit.

Disability and Disabled means that you are Totally Disabled or Partially Disabled. If a particular occupation requires a license, you will not be considered Disabled solely because you are unable to obtain a license or continue to qualify for a license.

Disability Earnings means the income you receive from work performed while Partially Disabled. Disability Earnings does not include income you receive from work performed prior to your Disability, nor income that is not derived from work performed while Disabled.

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.

2. DEFINITIONS

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 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 Disability that occurs during your Elimination Period.

Employee means a person who is:

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

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

If you are an Employee and you are working on 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 an organized facility licensed in the applicable jurisdiction that provides medical care and Treatment to sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery, with a staff of one or more licensed Physicians and which provides 24 hour nursing service by registered nurses on duty or call. Hospital does not include a rest home, a skilled nursing facility, an extended care facility, a place of convalescence, rehabilitative care, custodial care or a place primarily for the treatment of drug addiction or alcoholism.

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.

Material and Substantial Duties means the essential tasks, functions, skills or responsibilities required by employers generally for the performance of your Regular Occupation. Material and Substantial Duties does not include any tasks, functions, skills or responsibilities that could be reasonably modified or omitted from your Regular Occupation.

Medically Necessary means the Treatment, services or supplies necessary and appropriate for the diagnosis or Treatment of an Accident or Sickness based upon generally accepted medical standards.

Mental Illness means any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders except for chemical dependency.

Mental Illness includes, but is not limited to:

- anxiety and panic;
- somatoform disorders;
- mood disorders, including depression and bipolar disorder (manic depression);
- dissociative disorders and schizophrenia; and
- personality and eating disorders.

This listing is intended to present examples of Mental Illness and shall not be taken or construed as a limitation of the term as it is defined above.

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;
  - military pension plans;
  - credit disability insurance;
  - franchise disability income plans;
  - a retirement plan from another employer;
  - Individual Retirement Accounts (IRA);
  - vacation pay;
  - holiday pay;
  - any amount you receive under any individual or association disability income policy;
- any disability income benefits you receive from the Veterans Administration;
- disability or retirement benefits under the United States Social Security Act;
- benefits under The Railroad Retirement Act;
- any disability income benefits you receive under your Employer's Retirement Plan; or
- any Retirement Plan benefits.

Other Income means those benefits or sources of income that are provided or available while you are receiving a benefit under the Policy. Other Income includes Deductible Sources of Income and Non-deductible Sources of Income. Other Income includes any benefits that would have been available to you had you applied for that benefit. Except for benefits payable under a Retirement Plan, Other Income must be provided as a result of the same Disability for which a benefit is payable.

Own Job means the specific job or position you are performing for your Employer immediately prior to the first date your Period of Disability commences.

Partial Disability and Partially Disabled means you:

- are unable to perform the Material and Substantial Duties of your Regular Occupation on a Full-time Basis; and
- have Disability Earnings of less than 80% of your Total Weekly Earnings.

The Disability must be the material and substantial factor in causing the earnings loss.

A Partial Disability must be caused by an Accident or Sickness and must commence while you are insured under the policy.

2. DEFINITIONS

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.

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

Physician means an individual 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 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, a business associate, 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; (6) sister; (7) aunt; (8) uncle; (9) first cousin; (10) nephew or niece. 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.

Prior Policy means the plan of disability income insurance provided through or sponsored by your Employer and under which you were insured on the day before January 1, 2025. Prior Policy includes an uninsured disability income plan of your Employer.

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.

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.

An Accident that results in Disability more than 3 calendar days after the Accident will be deemed a Sickness.

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.

Total Disability and Totally Disabled means you are unable to perform the Material and Substantial Duties of your Regular Occupation and you are not working.

Total Disability must be caused by an Accident or Sickness and must commence while you are insured under the Policy.

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 TERMINATIONS

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

- January 1, 2025;
- January 1, 2026 for Employees of Cable Dahmer Kia Lawrence, LLC;
- the first day of the month coincident with or next following 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 30 days 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 30 days 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 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 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 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.

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.

The benefit payable will never be less than the Minimum Benefit shown in the Benefit Highlights.

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. The Benefit will never be less than the Minimum Benefit shown in the Benefit Highlights unless otherwise specified in **"What happens when the Other Income benefits have been awarded or have been denied?"**.

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 full-time 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
- you do not provide Proof that your earnings loss is a direct result of your Disability.

In addition to the circumstances shown above, your benefit is subject to termination as otherwise stated under the terms and conditions of the Policy.

How is Other Income applied to your benefit?
The amount of Deductible Sources of Income you receive will be deducted from your Gross Benefit.

Are you required to apply for Other Income benefits?
If you are, or become eligible, for any Deductible Sources of Income, you must apply for that Other Income and make reasonable efforts to reapply for or appeal the denial of any application for that Other Income. Any assistance in that process is not an acknowledgement that you are Disabled or have an eligible claim for benefits.

What is the Right of Recovery obligation?
You must pursue all valid claims including, but not limited to, claims of negligence or wrong doing by any third-party, claims for restitution, constructive trust, equitable lien, breach of contract, and any other state or federal claims you may have against any third party responsible, in whole or in part, for any Accident, Sickness, or Disability for which any benefits have been paid or are payable under the Policy. You must immediately advise us of any action, claim or proceeding to recover such damages or income and any amount you recover and place any funds received in a constructive trust for payment to us. We reserve the right to pursue any and all claims not pursued by you, and you agree to assign all such claims to us upon our request.

Is Other Income estimated?
We have the right to estimate the amount of any Deductible Sources of Income you are eligible to receive and to reduce your benefit by the estimated amount.

Until approval or denial is made, we will estimate the amount you would receive for any Deductible Sources of Income. That estimate will be considered your Deductible Sources of Income amount. When approval or denial is made, the benefits paid or payable will be adjusted as necessary. We will not estimate if:

- you have applied for the Other Income benefits; and
- you agree to appeal any denials of any Deductible Sources of Income benefits to all administrative levels we deem necessary; and
- you complete and sign the Sun Life Reimbursement Agreement.

What happens when the Other Income benefits have been awarded or have been denied?
You must notify us in Writing within 31 days of receiving notice of approval, denial or an adjustment in the amount of Deductible Sources of Income (other than for cost of living increases). If necessary we will make an adjustment to your benefit. If you have been underpaid, we will immediately make a lump sum payment to you of the amount that has been underpaid. If you have been overpaid, you must reimburse us the amount of the overpayment within 31 days of the award. We have the right to reduce or eliminate your future benefit payments until you have repaid the amount of the overpayment. During the overpayment reimbursement period, the Minimum Benefit will not apply.

What happens if you receive increases in your Other Income benefits?
After the first deduction for each of your Deductible Sources of Income benefits, we will not reduce your benefit payments due to cost of living increases you receive from any sources described as Deductible Sources of Income. This does not apply to any increase in earnings you receive from employment.

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 or your active duty in any armed service during a time of war (this does not include acts of terrorism) (upon receipt of written request, we will refund the pro rata unearned premium upon notice that an Insured has been placed on active duty in the armed forces);
- your active Participation in a Riot, Rebellion or Insurrection;
- your committing or attempting to commit an assault, felony or other criminal act;
- Accident or Sickness for which you are entitled to benefits under any Workers' Compensation, Occupational Disease or similar law;
- Accident or Sickness sustained while you are doing any act or thing pertaining to any occupation or employment for wage or profit.

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;
- for any period you do not submit to any medical examination or clinical assessment requested by us; or
- for any Period of disability during which you are incarcerated.

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.

If notice cannot be given within the applicable time period, no claim shall be invalidated or reduced if we are 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 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 Proof of claim forms. You will satisfy the notice of claim requirement if your claim information includes the occurrence, character and extent of loss for which claim is made.

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 90 days after the end of your Elimination Period.

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

If Proof cannot be given within the time limit, valid claims will not be invalidated or reduced, provided such Proof is 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;
- 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 as we may reasonably require.

Proof must be satisfactory to us.

PAYMENT OF BENEFITS

When are benefits payable?
Benefits are payable within 30 days of the date we receive Proof of the claim.

Benefits are based on the coverage that is in force on the date you are Disabled. 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 30 days after receipt of the claim. If we cannot make a decision within 30 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.

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

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.

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;

- 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 Labor Office and your State Insurance regulatory agency."

To whom are benefits payable?
All benefits payable during your lifetime are payable to you 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 benefits as defined in the Benefit Provisions section of the Certificate.

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 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 $2,000 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 $2,000; or
- if you have no Spouse, up to a cumulative amount of $2,000 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.

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 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.

8. CONTINUITY OF COVERAGE

What happens if your Employer replaces other insurance with the Policy?
If your Employer replaces insurance provided by the Prior Policy with the insurance provided by the Policy, 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 Prior Policy were substantially similar to the insurance provided by the Policy.

What if you are not Actively at Work when your Employer replaces your Prior Policy with the Policy?
You will be covered under the Policy if you are not Actively at Work on January 1, 2025 and:

- you were insured under the Prior Policy on the day before January 1, 2025;
- 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 Prior Policy.

If you become Disabled and were never Actively at Work while covered under the Policy, any benefit payable will be the lesser of:

- the weekly benefit payable under the Policy; or
- the weekly benefit payable under the Prior Policy had it remained in force.

Does the Eligibility Waiting Period apply when your Employer replaces the Prior Policy with the Policy?
We will apply any period of time satisfied under the Prior Policy to meet the requirements of the Eligibility Waiting Period toward the satisfaction of the period of time required by the Policy's Eligibility Waiting Period.

9. 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.

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 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?
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, unless otherwise pre-empted by federal law.

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 reasonably necessary during the pendency of a claim. Unless authorized by the examining Physician, the examination may not be recorded nor may another person be present during the examination.

9. GENERAL PROVISIONS

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.

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 AGE

What happens if there is a misstatement of age?
If the age of the Employee is determined not to be accurate:

- any refund of premium overpayment will be made, subject to the “Limit of Premium Refunds” section; and
- the actual age 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 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.

9. 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 a copy of your Written application for insurance is or has been given to you 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 Basic Short Term Disability Income Insurance Certificate
Non-Participating



Cable Dahmer Chevrolet, Inc. 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 Assurance Company of Canada. Sun Life Assurance Company of Canada assumes no responsibility for the accuracy or sufficiency of the information in the Summary Plan Description.

SUMMARY PLAN DESCRIPTION

Plan Sponsor: Cable Dahmer Chevrolet, Inc.
1200 E 104th Street
Kansas City, MO 64131

Plan Administrator and Named Fiduciary:
Cable Dahmer Chevrolet, Inc.
1200 E 104th Street
Kansas City, MO 64131

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

Subsidiaries/Affiliates: Cable Dahmer Kia Lawrence, LLC

Agent for Service of Legal Process for the Plan:

Cable Dahmer Chevrolet, Inc.
1200 E 104th Street
Kansas City, MO 64131

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

Employer Identification Number (EIN): 82-4027592

Plan Number: 501

End of Plan Year: December 31st

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

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

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

Contributions: The cost of the insurance premiums are paid for by 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 Assurance Company of Canada. Those insurance benefits are described in your Certificate.

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

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

Your Rights under ERISA:

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

Receive Information About Your Plan and Benefits

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

Assistance with Your Questions

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