RELIANCE STANDARD
LIFE INSURANCE COMPANY

Home Office: Schaumburg, Illinois • Administrative Office: Philadelphia, Pennsylvania

GROUP HOSPITAL INDEMNITY BENEFIT CERTIFICATE

Group Policy No. VHI000019 ("the policy"), has been issued to HelpSide which we will refer to as "the Contract Holder". We will refer to Reliance Standard Life Insurance Company as "we", "us", or "our".

The policy was delivered in Utah and will be governed by the laws thereof.

This Certificate of Insurance is evidence of the Insured's insurance under the policy and of its benefits. Everything contained in this Certificate of Insurance is subject to the provisions, definitions, and exceptions in the policy. The policy is on file with the Contract Holder and may be examined at any reasonable time. Only one of our executive officers can authorize a change to the policy.

This Certificate of Insurance replaces all Certificates and Certificate Riders, if any, previously issued to the Insured under the policy.

The President and Secretary of Reliance Standard Life Insurance Company witness this Certificate:

Secretary **President**

THIS CERTIFICATE PROVIDES LIMITED ACCIDENT & SICKNESS COVERAGE. IT IS NOT A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE AND DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE AFFORDABLE CARE ACT. READ THIS CERTIFICATE CAREFULLY

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SCHEDULE OF BENEFITS

1. ELIGIBILITY: Each active full-time employee of HelpSide is eligible the first day of the month following 60 days

   Dependent Coverage: _X_ Yes ___ No

2. COVERAGE YEAR: Begins on August 1st and ends on July 31st of the following year.

3. COVERED EVENTS AND BENEFIT AMOUNTS:

   Hospital Confinement Daily Income Benefit

Daily benefit	$ 200 per day
Maximum benefit per Coverage Year	180 daily benefits

   Hospital Admission Benefit

Daily benefit per Hospital admission	$ 1,700 per day
Maximum benefit per Coverage Year	1 daily benefit

   OTHER BENEFITS
   None

4. INDIVIDUAL EFFECTIVE DATE: the following will apply to eligible employees of the Contract Holder and their eligible dependents.

   Coverage will be effective the first day of the month following enrollment, provided the required premium is paid.

5. PREMIUMS:

   Premium Payable: Monthly

Premium Amount:	Employee Only:	$ 24.46
	Employee Plus Spouse:	$ 51.61
	Employee Plus Child(ren):	$ 36.69
	Employee Plus Family:	$ 63.84

GENERAL DEFINITIONS

"Accident" means a sudden, unforeseeable event that causes Injury to a Covered Person.

“COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985.

“Coverage Year” means the period of time described on the Schedule of Benefits.

"Covered Person" means any eligible person for whom coverage is in effect under the policy.

"Doctor" means any duly licensed practitioner who is recognized by the law of the state in which the care or treatment is rendered as qualified to perform the care or treatment for which claim is made.

"Eligible Dependents" means:

a) the Insured's lawful spouse; and

b) the Insured's eligible children who are less than age 26.

Eligible children include natural children, stepchildren, foster children, legally adopted children, children of adopting parents pending finalization of adoption procedures and children for whom coverage has been court-ordered.

"Hospital" means an institution operated by law for the care and treatment of injured or sick persons; has organized facilities for diagnosis and surgery or has a contract with another hospital for these facilities; and has 24-hour nursing service. Hospital excludes any institution that is primarily a rest home, nursing home, convalescent home, a home for the aged, a facility for treatment of alcoholism or drug addiction, or a facility for treatment of mental disorders.

"Injury" means accidental bodily Injury of a Covered Person:

a) caused by an Accident; and

b) that results in covered loss directly and independently of all other causes.

All Injuries sustained in one Accident, including all related conditions and recurring symptoms of the Injuries, will be considered one Injury.

"Inpatient" means a Covered Person who has been formally admitted to a Hospital for purposes of receiving inpatient Hospital services for no less than 23 hours.

"Insured" means an employee for whom coverage is in effect under the policy.

"Medically Necessary" means the care, treatment or supply is:

a) rendered for the diagnosis, treatment, cure or relief of a health condition, Sickness, Injury or its symptoms; and

b) necessary for and appropriate to the diagnosis or treatment according to the attending medical care provider.

"Outpatient" means a Covered Person who experiences covered events while other than an Inpatient at a Hospital.

"Sickness" means illness or disease of a Covered Person that:

a) is treated by a Doctor while the person is covered under the policy; and

b) results directly and independently of all other causes in loss covered by the policy.

INDIVIDUAL EFFECTIVE DATES

Insured - Individual insurance will become effective as indicated on the Schedule of Benefits.

An eligible person may enroll only within 31 days after becoming eligible or experiencing a qualified change in their family situation (e.g. a divorce, legal separation, death, marriage, or birth/adoption of a new child), or during an open enrollment period, unless otherwise indicated by the policy. Open enrollment period means a pre-determined term during which any eligible person who previously did not enroll for coverage under the policy may enroll for coverage.

Dependents - Dependent insurance will become effective on the latest of:

a) the Insured's effective date if the dependent is eligible as of the Insured's effective date and the Insured enrolls and pays premium for the dependent on or before that date; or

b) if a dependent is not eligible as of the Insured's effective date, such dependent's coverage will be effective on the date they become eligible, provided the Insured enrolls and pays premium for the dependent within 31 days of the date the dependent becomes eligible; however, if a dependent is eligible as of the Insured's effective date but not enrolled, such dependent's coverage will be effective on the date the Insured enrolls and pays premium for the dependent provided that occurs within 31 days of the date the Insured experiences a qualified change to their family situation; or

c) as provided on the Schedule of Benefits.

In no case will coverage for eligible dependents take effect before the Insured's.

Newborn Child Coverage: A child of the Insured born while the policy is in force is provided coverage for covered events rendered for Injury and Sickness (including covered events that are necessary to care and treat congenital defects, birth abnormality and premature birth), as well as those for routine newborn care for the first 31 days. The child is covered from the moment of birth until the 31st day of age. A notice of birth and the additional premium, if any, must be submitted to us within 31 days of the birth in order to continue coverage for Injury and Sickness beyond the initial 31-day period.

Adopted Children Coverage: An adopted child who comes under the charge, care and control of the Insured while the policy is in force is provided coverage for covered events rendered for Injury and Sickness, beginning from the:

a) moment of birth, if placement for adoption occurs within 30 days of the child's birth; or

b) date of placement, if placement for adoption occurs within 30 days or more after the child's birth.

If payment is required to provide coverage for an adopted child, the Insured must enroll the child within 30 days after the day of placement for adoption. If payment is not required to provide coverage for an adopted child, the Insured must enroll the child no later than 30 days after the first notification of denial of a claim for services for such child. The coverage provided to such child will be the same as provided for other members of the Insured's family. Coverage for such child will continue unless the petition for adoption is dismissed or denied.

INDIVIDUAL TERMINATION DATES

Insured - Coverage for an Insured will end on the earliest of:

a) the date the Insured is no longer eligible unless contributions for coverage were made in advance, in which case coverage will terminate at the end of the period for which premiums have been paid; or

b) any premium due date, if full payment for the Insured's coverage is not made within 31 days following the premium due date; or

c) the date that the policy terminates; or

d) the date the Insured enters an armed service on full-time active duty. Premium will be returned on a pro-rata basis if the Contract Holder notifies us in writing.

Dependents - Coverage for dependents will end on the earlier of:

a) the Insured's termination date; or

b) any premium due date, if full payment for the dependent's coverage is not made within 31 days following the premium due date; or

c) the end of the month in which the dependent is no longer eligible unless contributions for coverage were made in advance, in which case coverage will terminate at the end of the period for which premiums have been paid.

Coverage will continue for any child who reaches the age limit and is both:

a) totally incapable of self-sustaining employment due to a physical or intellectual disability; and

b) chiefly dependent on the Insured for financial support and maintenance.

The Insured must give us proof of the child's incapacity and dependency within 31 days of the child reaching the age limit. We may require proof again from time to time but not more often than once a year after the 2 years that follow the child reaching the age limit.

In no case will coverage end later than the Insured's.

Termination will not affect a claim for benefits for covered events that occur while the person is covered by the policy.

EXTENSION OF BENEFITS

If coverage under the policy ends while the Covered Person is totally disabled due to Injury or Sickness, we will pay benefits for covered events occurring after the date coverage under the policy ends as long as they meet the following requirements:

a) the covered event must be rendered due to the same Injury or Sickness causing the Covered Person to be totally disabled on the date coverage ends; and

b) the covered event must occur within 90 days after the date the Covered Person's coverage under the policy ends; and

c) coverage must not have ended as a result of the Covered Person's or, in the case of a dependent child, the child's parents voluntary termination of the coverage.

This extension of benefits terminates at the end of the 90-day period specified above.

As used in this section, "totally disabled" means:

a) with respect to a Covered Person who would otherwise be employed, the complete inability to perform all of the substantial and material duties of such person's occupation; and

b) with respect to a Covered Person who is not otherwise gainfully employed, confinement as an Inpatient in a Hospital.

DESCRIPTION OF BENEFITS

The following provisions describe the benefits we will pay for covered events. We will pay benefits for a covered event only once, even if the event could be included under more than one benefit description, unless otherwise indicated.

Hospital Confinement Daily Income Benefit

We will pay the applicable daily benefit amount shown on the Schedule of Benefits for each day a Covered Person is confined as an Inpatient in a Hospital if:

a) the Hospital confinement is Medically Necessary; and

b) the Covered Person is under a Doctor's care; and

c) the Hospital confinement begins while the Covered Person is covered under the policy.

Payment of the applicable daily benefit will start on the first day of Hospital confinement and will continue for a period not to exceed the maximum benefit, as shown on the Schedule of Benefits.

Hospital Admission Benefit

We will pay the applicable daily benefit amount shown on the Schedule of Benefits for the first day a Covered Person is admitted to a Hospital as an Inpatient if:

a) the Hospital admission is Medically Necessary; and

b) the Covered Person is under a Doctor's care; and

c) the Hospital admission occurs while the Covered Person is covered under the policy.

Daily benefits for Hospital admissions will be paid up to the applicable maximum benefit, as shown on the Schedule of Benefits. This benefit is payable in addition to any other benefit payable under the policy.

Additional Definitions - Wherever used in this benefit:

“Hospital admission” means each separate time a Covered Person is admitted to a Hospital as an Inpatient.

CONTINUATION OF COVERAGE

Coverage for covered events that occur as a result of Injury or Sickness may be continued as described below. Medical information regarding the condition of a person's health is not required for this continued coverage.

Eligibility:

Insured - Insureds may elect to continue coverage for themselves and their covered dependents. Coverage may be continued for 18 months if one of the following events occurs:

a) an Insured's employment is terminated for any reason other than gross misconduct; or

b) a reduction in an Insured's hours results in the loss of such coverage.

Disabled Insured - Insureds who are determined to be disabled under the Social Security Act within 60 days of the

date they become eligible for continuation under this provision, may continue coverage for themselves and their covered dependents for up to 29 months. A copy of the Social Security Administration's "determination of disability" must be given to the Contract Holder within 60 days of the determination and within the original 18 months of continuation coverage. If, during the 11-month extension, a Covered Person is no longer disabled, the Contract Holder must be notified within 30 days and coverage will terminate.

Dependents - A covered dependent may elect to continue coverage for a period of 36 months if one of the following events occurs:

a) the death of the Insured;

b) the divorce or legal separation of the Insured and dependent spouse;

c) the Insured becomes entitled to Medicare benefits;

d) a dependent child is no longer a dependent child for the purposes of the plan.

Coverage:

If a Covered Person exercises this option, coverage will be identical in scope to the coverage provided in the policy.

Premiums:

The Covered Person will pay premiums directly to the Contract Holder with the option of paying in monthly installments. The premiums will not exceed 102 percent of the applicable premium for such period. The initial premium must be paid within 45 days from the election of the continuation coverage.

Premium for the 11-month extension due to disability may be substantially greater than the premium for the initial 18-month continuation of coverage.

Notice Requirements:

We must give written notice of the right to continue coverage to affected Covered Persons within 14 days after the date we are notified, by the Contract Holder that:

a) the Insured dies; or

b) the Insured's employment is terminated or the Insured's hours are reduced; or

c) the Insured becomes entitled to Medicare benefits.

Affected Covered Persons who wish to continue coverage must notify us in writing within 60 days after the date they receive notice of their right to continue coverage.

Each covered dependent who wishes to continue coverage must notify us in writing within 60 days after the date:

a) of divorce or legal separation from the Insured; or

b) a dependent child is no longer a dependent child for the purposes of the plan.

Covered dependents who wish to continue coverage must notify us in writing within 60 days after the date they receive notice of their right to continue coverage.

Termination:

Covered Persons who exercise this option will not have their coverage interrupted or canceled or otherwise terminated until the date on which:

a) they fail to make a premium payment in the time required to make that payment; or

b) they become covered under another group health plan, without limitation as to any pre-existing condition that affects coverage; or

c) they become entitled to Medicare benefits; or

d) the required period for continued coverage ends; or

e) the policy is terminated.

EXCLUSIONS

No benefits will be paid for loss caused by or resulting from:

a) intentionally self-inflicted injuries, suicide or any attempt thereat while sane or insane;

b) declared or undeclared war or any act thereof;

c) the Covered Person's voluntary commission of a felony;

d) work-related Injury or Sickness.

In addition to the above exclusions, no benefits will be paid for:

a) dental care, treatment or supplies other than covered events rendered in connection with the care and treatment of sound, natural teeth and gums required on account of Injury to the Covered Person resulting from an Accident that happens while covered under the policy, and rendered within 6 months of the Accident;

b) care, treatment or supplies rendered in connection with cosmetic surgery, except covered events rendered in connection with cosmetic surgery the Covered Person needs for breast reconstruction following a mastectomy or as a result of an Accident that happens while covered under the policy. Cosmetic surgery for an accidental Injury must be performed within 90 days of the Accident causing the Injury and while such person's coverage is in force;

c) care, treatment or supplies rendered to a Covered Person while outside the United States of America;

d) care, treatment or supplies rendered by a member of the Covered Person's immediate family or provided by the Contract Holder.

PREMIUMS

Premiums are shown on the Schedule of Benefits. Premium must be paid to us on or before the premium due date and not more than 31 days after the effective date of an eligible person's coverage. A person's coverage will not be affected by the Contract Holder's failure, due to clerical error, to remit premiums to us on time.

Rates are provided on a group basis. Premiums may be changed on any premium due date, on or after the first Policy Anniversary Date, with 31 days' advance notice in writing to the Contract Holder.

Grace Period: The Contract Holder has a 31-day grace period after each ensuing premium due date once the first premium has been paid. During the grace period, the policy stays in force. If a subsequent premium is not paid by the end of the grace period, coverage will end as of the premium due date. If this happens, the Contract Holder will still owe us all premiums then due, including any premium due for the grace period or for any part of the grace

period through which claims were paid.

CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given to us within 30 days after a loss occurs, or as soon as reasonably possible. Notice should include information that identifies the claimant and the policy.

Claim Forms: When we receive notice of claim that does not contain all necessary information or is not on an appropriate claim form, we will send forms for filing proof of loss to the claimant along with a request for any missing information. If these forms are not sent within 15 days after receiving notice of claim, the claimant will meet the proof of loss requirements if we are given, within 90 days, written proof of the nature and extent of the loss.

Proof of Loss: Written proof of loss must be given to us within 90 days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. Failure to give notice or file proof of loss as required does not bar recovery under the policy if the insurer fails to show it was prejudiced by the failure.

Time of Payment of Claim: Benefits for loss covered by the policy will be paid immediately upon our receipt of proper written proof of such loss.

Payment of Claims: All benefits will be paid to the Insured, if living, unless an Assignment of Benefits has been requested by the Insured. Any benefits due and unpaid at the Insured's death will be paid to the Insured's estate. Any payment made by us in good faith pursuant to this provision will fully release us to the extent of such payment.

Physical Examination: At our expense, we may have a person claiming benefits examined as often as reasonably necessary while the claim is pending.

Legal Action: No legal action may be brought to recover on the policy before 60 days after written proof of loss has been furnished as required by the policy. No such action may be brought after 3 years from the time written proof of loss is required to be furnished.

GENERAL PROVISIONS

Incontestability: The validity of the policy will not be contested except for nonpayment of premiums. No statement made by the Contract Holder or any Covered Person, except a fraudulent one, will be used to contest a claim under the policy. We may only contest coverage if the misstatement is made in a written instrument signed by the Contract Holder or the Covered Person and a copy is given to the Contract Holder or Covered Person. No statement made by a Covered Person relating to insurability will be used for avoidance of a policy, coverage, or denial of a claim for loss incurred or disability commencing after the coverage has been in effect for two years.

Not in Lieu of Workers' Compensation: The policy is not in lieu of and does not affect requirements for coverage under Workers' Compensation laws.

Termination of Policy: The Contract Holder may terminate the policy at any time on or after the first anniversary of the policy's effective date, by sending us written notice. The policy will be terminated on the date that we receive the notice or later if specified in the notice. We may terminate the policy at any time on or after the first anniversary of its effective date, by sending the Contract Holder at least 31 days' prior written notice to its most recent address in our records. The Contract Holder is obligated to provide the Insureds with 30 days prior written notice of any such termination. We will return pro-rata the unearned portion of the premiums, if any, that were paid. Termination will be without prejudice to a claim for covered events that occurred while the policy was in force.