CHUBB

ACE American Insurance Company
(A Stock Company)
436 Walnut Street
Philadelphia, PA 19106

Group Hospital Indemnity Certificate of Insurance

POLICYHOLDER:	Five Below, Inc.
POLICY NUMBER:	FXD N18133507
POLICY ANNIVERSARY DATE:	November 1, 2021
STATE OF DELIVERY:	Pennsylvania

The Policy takes effect at 12:01 A.M. on the Policy Effective Date. In return for payment of the required premiums, We will pay benefits according to the terms and conditions of coverage described in the Policy.

The Policy is governed by the laws of the state in which it is delivered.

Signed for ACE American Insurance Company in Philadelphia, Pennsylvania.

JOHN J. LUPICA, President

REBECCA L. COLLINS, Secretary

The Certificate of Insurance describes the benefits provided under the policy issued to the Policyholder. This policy provides limited benefits on a fixed indemnity basis. It does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy a person's individual obligation to secure the requirement of minimum essential coverage under the Affordable Care Act (ACA). For more information about the ACA, please refer to www.healthcare.gov.

PLEASE READ THE POLICY CAREFULLY.

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SCHEDULE OF BENEFITS

CLASSES OF ELIGIBLE PERSONS:

You are an Eligible Person if you satisfy the requirements of the class definition shown below. You may be insured only under one Class of Eligible Persons shown in the Policy, even though you may be eligible under more than one class. Also, you may not be insured as a Dependent and an Insured at the same time.

Class 1	All employees who are in active service working 17.5 or more hours per week and are eligible for the Policyholder's Major Medical Plan

Dependents of Class 1 Insureds are eligible for Coverage under this Policy.

ELIGIBILITY WAITING PERIOD:
This is the period of time you must be in an eligible class before you are eligible for coverage.

None

If you are eligible to elect from more than one Plan of coverage, your coverage is subject to your Plan election and payment of the required premium for your Plan election.

Class 1 and Dependents of Class 1

Plan One

Hospital Confinement Benefit

Benefit Amount	$2,000 first day confined per Plan Year; $100 per day thereafter
Maximum Benefit Period	31 days per Plan Year

Intensive Care Unit Benefit

Benefit Amount:	$200 per day confined
Maximum Benefit Period:	15 days per Plan Year

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the *Schedule of Benefits*.

"Active Service" means your are either 1) actively at work performing all regular duties at your employer's place of business or someplace the employer requires you to be; 2) employed, but on a scheduled holiday, vacation day or period of approved paid leave of absence; or 3) if not employed, able to engage in substantially all of the usual activities of a person in good health of like age and sex and not confined in a Hospital or rehabilitation or rest facility.

"Covered Accident" means an accident that occurs while your coverage is in force and results in an Injury for which benefits are payable.

"**Covered Loss**" or "**Covered Losses**" means a loss resulting directly from any Covered Accident or Covered Sickness insured by the Policy.

"Covered Sickness" means a Sickness that occurs while your coverage is in force and results in a loss for which benefits are payable.

"Covered Person" means any eligible person, or Dependent, if eligible for whom the required premium is paid.

"Dependent" means an Insured's lawful spouse or an Insured's unmarried child, from the moment of birth to age 26 who is chiefly dependent on the Insured for support. A child, for eligibility purposes, includes an Insured's natural child; adopted child, beginning with any waiting period pending finalization of the child's adoption; or a stepchild who resides with the Insured or depends on the Insured for financial support. A Dependent may also include any person related to the Insured by blood or marriage and for whom the Insured is allowed a deduction under the Internal Revenue Code.

Insurance will continue for any Dependent child who reaches the age limit and continues to meet the following conditions: 1) the child is disabled, 2) is not capable of self-support and 3) depends mainly on the Insured for support and maintenance. The Insured must send Us satisfactory proof that the child meets these conditions, when requested. We will not ask for proof more than once a year.

"Dependent" also means an Insured's Domestic Partner. **"Domestic Partner"** means a person of the same or opposite sex of the Insured who:

1) shares the Insured's primary residence;
2) has resided with the Insured for at least 12 months prior to the date of enrollment and is expected to reside with the Insured indefinitely;
3) is financially interdependent with the Insured in each of the following ways;
    a. by holding one or more credit or bank accounts, including a checking account, as joint owners;
    b. by owning or leasing their permanent residence as joint tenants;
    c. by naming, or being named by the other as a beneficiary of life insurance or under a will;
    d. by each agreeing in writing to assume financial responsibility for the welfare of the other.

4) has signed a Domestic Partner declaration with the Insured, if recognized by the laws of the state in which the Insured resides;
5) has not signed a Domestic Partner declaration with any other person within the last 12 months.
6) is 18 years of age or older
7) Is not currently married to another person;
8) Is not in a position as a blood relative that would prohibit marriage.

"Doctor" means a licensed health care provider acting within the scope of his or her license and rendering care or treatment to you that is appropriate for the conditions and locality. It will not include a Covered Person or a member of your Immediate Family or household.

"**Eligible Person**" means an individual that meets a class definition shown in the *Schedule of Benefits*. Unless specifically noted in the provision where it is used, the term does not include eligible Dependents.

"Hospital" means an institution that: 1) operates as a Hospital pursuant to law for the care, treatment, and providing of in-patient services for sick or injured persons; 2) provides 24-hour nursing service by Registered Nurses on duty or call; 3) has a staff of one or more licensed Doctors available at all times; 4) provide organized facilities for diagnosis, treatment and surgery, either: (i) on its premises; or (ii) in facilities available to it, on a pre-arranged basis; 5) is not primarily a nursing care facility, rest home, convalescent home, or similar establishment, or any separate ward, wing or section of a Hospital used as such; and 6) is not a place for drug addicts, alcoholics, or the aged.

"Immediate Family" means your parent, grandparent, spouse, child, brother, sister, stepchild, grandchild, step-grandchild or in-laws.

"Injury" means accidental bodily harm sustained by You that results directly and independently from all other causes from a Covered Accident. The Injury must be caused through accidental means. All injuries sustained by one person in any one Covered Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

"Insured" means an employee in a Class of Eligible Persons for whom the required premium is paid making insurance in effect for that person.

"Medically Necessary" means a treatment, service or supply that is: 1) required to treat an Injury; 2) prescribed or ordered by a Doctor or furnished by a Hospital; 3) performed in the least costly setting required by Your condition; and 4) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered. Purchasing or renting 1) air conditioners; 2) air purifiers; 3) motorized transportation equipment; 4) escalators or elevators in private homes; 5) swimming pools or supplies for them; and 6) general exercise equipment are not Medically Necessary. A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may, at Our discretion, consider the cost of the alternative to be the Covered Expense.

"Sickness" means illness or disease contracted by and causing loss to the Covered Person whose Sickness is the basis of claim. A Sickness begins with the first display of symptoms. Any complications or any condition arising out of a Sickness for which You are being treated or has

received treatment will be considered a part of the original Sickness. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

"We", "Our", "Us" means the insurance company underwriting this insurance or its authorized agent.

"**You**", "**Your**" means the Insured, any where applicable, the Insured's Dependents if eligible for benefits.

ELIGIBILITY FOR INSURANCE

Each person in one of the Classes of Eligible Persons shown in the *Schedule of Benefits* is eligible to be insured on the Policy Effective Date, or the day after he or she completes any Eligibility Waiting Period, if later. We retain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

If You are re-employed in an eligible class after your insurance under the Policy ends, you will be treated as a new employee. However, an employee may re-enroll only if he or she is not covered under any Continuation of Insurance provision in the Policy.

Your Dependent is eligible on the latest of the date:
1. You are eligible, if You have Dependents on that date; or
2. the date the person becomes a Dependent

A person who is in one of the Classes of Eligible Persons and who is also eligible as a Dependent may be insured only once under the Policy. In no event will a Dependent be eligible if the Insured is not eligible.

ENROLLMENT: You may enroll for coverage within 31 days of becoming a member of an Eligible Class. Any Eligible Person may enroll for coverage after this 31-day period at the next Annual Enrollment Period or if You experience a Life Status Change.

"Annual Enrollment Period" means the period agreed upon by the Policyholder and Us when an Eligible Person may enroll for or make changes to benefits under the Policy.

"Life Status Change" means an event recognized by the Policyholder and Us that qualifies an Eligible Person to make changes in coverage at a time other than an Annual Enrollment Period. The following events are all considered Life Status Changes.
1) marriage;
2) divorce, annulment or legal separation;
3) birth or adoption of a child;
4) change in a Dependent child's eligibility;
5) death of a spouse;
6) a change in the benefit plan or employment status of Your spouse that affects either person's eligibility for benefits.

EFFECTIVE DATE OF INSURANCE

You will be insured on the later of the Policy Effective Date or the date You are eligible, if not required to contribute to the cost of this insurance.

Your Insurance will be, and insurance for Your eligible Dependent(s), effective on the latest of the following dates:

1. the Policy Effective Date;
2. the date You become eligible;
3. the date We receive the completed enrollment form;
4. the date the required premium is paid
5. the date payroll/account deduction is authorized for this insurance.

Newborn and Adopted Children

Insurance for any newborn Dependent child automatically becomes effective from the moment of birth. Insurance for that Dependent child automatically ends 31 days later unless the Insured has other Dependent children insured under the Policy or within 31 days, makes a request to continue coverage for that child and pays the required premium, when due.

An adopted child of the Insured will be covered on the same basis as a newborn child from the date of placement for the purpose of adoption. Coverage continues unless the placement is disrupted and the child is removed from placement.

TERMINATION DATE OF INSURANCE

Your coverage will end on the earliest of the date:

1. the Policy terminates
2. You are no longer eligible
3. the date the period ends for which premium is paid
4. You are no longer in Active Service

A Dependent's coverage will end on the earliest of the date:

1. he or she is no longer a Dependent;
2. Your coverage ends; or
3. the period ends for which premium is paid.

DESCRIPTION OF BENEFITS

The following provisions explain the benefits and exclusions applicable under the Policy on a case basis. Please see the *Schedule of Benefits* for the applicability of these benefits on a class or plan level.

HOSPITAL CONFINEMENT BENEFIT

We will pay the Hospital Confinement Benefit Amount shown in the *Schedule of Benefits* for each day that You are confined as an inpatient in a Hospital, if:

1. Confinement is for the treatment of a Covered Loss; and
2. lasts for at least 24 consecutive hours
3. Confinement is ordered by a Doctor as Medically Necessary; and
4. coverage under the Policy is in force when confinement begins; and
5. the Benefit Waiting Period, if any, shown in the *Schedule of Benefits* for this benefit is satisfied.

We will pay the benefit for the Maximum Benefit Period shown in the *Schedule of Benefits*. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.

We will not pay benefits if You are confined in a Hospital and We determine the kind of care needed could be provided elsewhere.

INTENSIVE CARE BENEFIT

We will pay the Intensive Care Benefit Amount shown in the *Schedule of Benefits* if, as the result of a Covered Loss, You are confined in an Intensive Care Unit of a Hospital. We will pay the benefit for each day You are confined in an Intensive Care Unit up to the Maximum Benefit Period shown in the *Schedule of Benefits*. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.

"Intensive Care Unit" means a special area of a Hospital that is:

1. for the treatment of patients who are in acute or critical condition; and
2. furnished with emergency life-saving equipment and supplies that are immediately at hand; and
3. staffed 24-hours a day by nurses who are specially trained to work in an Intensive Care Unit; and
4. equipped and staffed to monitor each patient's vital signs around-the-clock; and
5. not a recovery room or an area used primarily for post-operative or post-anesthesia care.

GENERAL EXCLUSIONS

We will not pay benefits for any Covered Loss or any period of Confinement covered by this Policy that is caused by, or results from:

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- intentionally self-inflicted injury; suicide or attempted suicide.

- war or any act of war, whether declared or not.
- service in the military, naval or air service of any country or international organization.
- commission of, or attempt to commit, a felony.
- bungee-cord jumping, parachuting, skydiving, parasailing, hang-gliding;
- an accident if you are the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, except while participating in Driver's Education Program
- Injury or Sickness that occurs while you are legally intoxicated (as determined by that state's law) or while under the influence of any drug unless administered under the advice and consent of a Doctor;
- alcoholism, drug addiction or the use of any drug or narcotic except as prescribed by a Doctor unless specifically provided herein
- cosmetic surgery, except for reconstructive surgery needed as the result of an Injury or Sickness
- Experimental or Investigational drugs, services, supplies or any procedure held to be Experimental or Investigatory by the Company at the time the procedure is done. For the purposes of this exclusion, "Experimental or Investigational" means medical services, supplies or treatments provided or performed in a special setting for research purposes, under a treatment protocol or as part of a clinical trial (Phase I, II or III). The covered service will also be considered Experimental or Investigational if you are required to sign a consent form that indicates the proposed treatment or procedure is part of a scientific study or medical research to determine its effectiveness or safety. Medical treatment, that is not considered standard treatment by the majority of the medical community or by Medicare, Medicaid or any other government financed programs or the National Cancer Institute regarding malignancies, will be considered Experimental or Investigational. A drug, device or biological product is considered Experimental or Investigational if it does not have FDA approval or approval under an interim step in the FDA process, i.e., an investigational device exemption or an investigational new drug exemption.
- Elective Abortion. "Elective Abortion" means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.
- services related to sterilization, reversal of a vasectomy or tubal ligation; in vitro fertilization and diagnostic treatment of infertility or other problems related to the inability to conceive a child, unless such infertility is a result of a covered Injury or Sickness.
- services, supplies or a period of confinement ordered by persons employed or retained by a Policyholder, or by any Immediate Family Member or member of your household.

This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit Us from providing insurance, including, but not limited to, the payment of claims.

CLAIM PROVISIONS

Notice Of Claim: A claimant must give Us or Our authorized representative written (or authorized electronic or telephonic) notice of claim within 90 days after any loss covered by the Policy occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. This notice should include your name and your Policy Number.

Claim Forms: Upon receiving written notice of claim, We will send claim forms to the claimant within 15 days. If We do not furnish such claim forms, the claimant will satisfy the requirements

of written proof of loss by sending the written (or authorized electronic or telephonic) proof as shown below. The proof must describe the occurrence, extent and nature of the loss.

Proof Of Loss: Written (or authorized electronic or telephonic) proof of loss must be sent to the agent authorized to receive it. Written (or authorized electronic or telephonic) proof must be given within 90 days after the date of loss. If it cannot be provided within that time, it should be sent as soon as reasonably possible. In no event, except in the absence of legal capacity, should proof of loss be sent later than one year from the time proof is otherwise required.

Claimant Cooperation Provision: Failure of a claimant to cooperate with the Us in the administration of a claim may result in the termination of a claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Time Payment Of Claims: Any benefits due will be paid when We receive written (or authorized electronic or telephonic) proof of loss.

Payment Of Claims: If the Insured dies, any death benefits or other benefits unpaid at the time of the Insured's death will be paid to the beneficiary. If no named beneficiary or surviving beneficiary is on record with Us or Our authorized agent, We pay benefits in equal shares to the first surviving class of the following: 1) spouse; 2) children; 3) parents; 4) brothers and sisters

If there are no survivors in any of these classes, We will pay the Insured's estate. All other benefits will be paid to the Insured. If you are: (1) a minor; or (2) in Our opinion unable to give a valid release because of incompetence, We may pay any amount due to a parent, guardian, or other person actually supporting him or her. Any payment made in good faith will end Our liability to the extent of the payment.

Beneficiary: The Insured may designate a beneficiary. The Insured has the right to change the beneficiary at any time by written (or electronic and telephonic) notice. If you are a minor, your parent or guardian may exercise this right for you. The change will be effective when We or Our authorized agent receive it. When received, the effective date is the date the notice was signed. We are not liable for any payments made before the change was received. We cannot attest to the validity of a change.

The Insured is the beneficiary for any covered Dependent.

Physical Examinations And Autopsy: We have the right to have a Doctor of Our choice examine you as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy.

Legal Actions: No lawsuit or action in equity can be brought to recover on the Policy: (1) before 60 days following the date proof of loss was given to Us; or (2) after 3 years following the date proof of loss is required.

Recovery of Overpayment: If benefits are overpaid or paid in error, We have the right to recover the amount overpaid or paid in error by any of the following methods:

1. A request for lump sum payment of the amount overpaid or paid in error.

2. Reduction of any proceeds payable under the Policy by the amount overpaid or paid in error.

ADMINISTRATIVE PROVISIONS

Premiums: The premiums for the Policy will be based on the rates currently in force, the plan and amount of insurance in effect.

Changes In Premium Rates: We may change the premium rates from time to time with at least 31 days advanced written, or authorized electronic or telephonic notice. No change in rates will be made until 24 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12-month period. However, We reserve the right to change rates at any time if any of the following events take place:

1. The terms of the Policy change.
2. A division, subsidiary, affiliated organization or eligible class is added or deleted from the Policy.
3. There is a change in the factors bearing on the risk assumed.
4. Any federal or state law or regulation is amended to the extent it affects Our benefit obligation.
5. There is a misrepresentation in the information We relied on in establishing the rate.
6. There is a change in the experience rating.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

Payment of Premium: The first Premium is due on your coverage Effective Date. After that, premiums will be due monthly unless We agree with the Policyholder on some other method of premium payment.

If any premium is not paid when due, the Policy will be canceled as of the Premium Due Date, except as provided in the Grace Period section.

Grace Period: A Grace Period of 31 days will be granted for the payment of the required premiums. Your coverage will remain in force during the Grace Period. If the required premiums are not paid during the Policy Grace Period, insurance will end on the last Premium Due Date on which required premiums were paid. You will be liable to Us for any unpaid premium for the time the Policy was in force.

GENERAL PROVISIONS

Entire Contract; Changes: The Policy (including any endorsements or amendments), the signed application of the Policyholder, and any individual applications of Covered Persons, are the entire contract. Any statements made by the Policyholder or you will be treated as representations and not warranties. No such statement shall void the insurance, reduce the benefits, or be used in defense of a claim for loss incurred unless it is contained in a written application.

To be valid, any change or waiver must be in writing (or authorized electronic or telephonic communications). It must be signed by Our President or Secretary and be attached to the Policy. No agent has authority to change or waive any part of the Policy.

Clerical Error: If a clerical error is made, it will not affect your insurance. No error will continue your insurance beyond the date it should end under the Policy terms.

Conformity With State Laws: On the effective date of the Policy, any provision that is in conflict with the laws of the state where it is issued is amended to conform to the minimum requirements of such laws.

Not In Lieu Of Workers' Compensation: The Policy is not a Workers' Compensation policy. It does not provide Workers' Compensation benefits.