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:	930883-002
Policy Effective Date:	July 1, 2019
Policyholder:	Town of Carolina Beach
Employer:	Town of Carolina Beach
Issue State:	North Carolina

NOTICE TO BUYER: THIS IS A LIMITED BENEFIT HEALTH CERTIFICATE. THIS CERTIFICATE PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, Review the Guide to Health Insurance for People with Medicare.

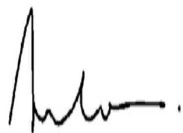
PLEASE READ YOUR CERTIFICATE CAREFULLY. THIS CERTIFICATE HAS A TERMINATION PROVISION.

This Certificate may exclude or limit benefits for pre-existing conditions. See the "Limitations" or "Exclusions" section.
IMPORTANT CANCELLATION INFORMATION – PLEASE READ SECTION 3, 4 AND 5.

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 preempted by the federal Employee Retirement Income Security Act.

Signed at Wellesley Hills, Massachusetts.



Dean A. Connor
President and Chief Executive Officer

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

Group Specified Disease Insurance Certificate

Non-Participating

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1. BENEFIT HIGHLIGHTS

Eligible Classes:	All Full-Time United States Employees working in the United States scheduled to work at least 35 hours per week.
Eligibility Waiting Period:	Until the first of the month coincident with or next following 30 days of employment

1. BENEFIT HIGHLIGHTS

At the time of enrollment, you may be eligible to select an amount of Critical Illness insurance. We will pay benefits corresponding to the elections you made as shown below. You may change your or your Spouse's and Dependent Children's amount of Critical Illness insurance according to the When can you make Changes in Insurance provision.

Any limitation applies separately to you, your Spouse and Dependent Children. Please see Covered Conditions and Exclusions and Limitations for a complete description of benefits, limitations and exclusions.

Insurance Amounts

Employee Insurance	Minimum: $5,000 Maximum: $50,000 Guaranteed Issue Amount - Initial Enrollment only: $20,000 Change Increment Amount: $5,000
Spouse Insurance	Minimum: $2,500 Maximum: $25,000 Guaranteed Issue Amount - Initial Enrollment only: $10,000 Change Increment Amount: $2,500
Dependent Children Insurance	Minimum: $2,500 Maximum: $5,000 Change Increment Amount: $2,500

The Spouse and Dependent Children Insurance Amount will not be more than 50% of your Insurance Amount.

When are you required to provide Evidence of Insurability?
You must submit Evidence of Insurability each time you do any of the following or any of the following occurs:

- you enroll for Employee, Spouse or Dependent Children Insurance as a Late Entrant;
- you apply for an increase in your Insurance Amount in excess of $0, or your Spouse Insurance Amount in excess of $0 or your Dependent Children Insurance Amount in excess of $0;
- you enroll for Employee, Spouse Insurance in excess of the Guaranteed Issue Amount; or
- you discontinue coverage and subsequently re-enroll.

Any amount of insurance that requires Evidence of Insurability will NOT go into effect unless it is approved by us in Writing. To submit Evidence of Insurability, you must complete an Evidence of Insurability application and send it to us. Once we receive it, we will determine whether to approve the additional insurance.

Age Reduction

If you are age 70 or more on the date you apply for Employee Insurance, your amount of Employee Insurance will be limited to 50% of the amount that you could have otherwise elected rounded to the next higher multiple of $1,000, if not already an exact multiple.

If you were insured before age 70, your amount of Employee Insurance shown above reduces to 50% rounded to the next higher multiple of $1,000, if not already an exact multiple when you reach age 70.

1. BENEFIT HIGHLIGHTS

Your Spouse and Dependent Children Insurance Amount will be reduced if it exceeds 50% of your amount following an age reduction.

This reduction will take effect on the July 1st following the date of change . No further increases to your benefit amount will be allowed after the age reduction has been applied. Any reduction will be subject to the other provisions of the Policy.

1. BENEFIT HIGHLIGHTS

If you enrolled in this option, your insurance will be based on the following.

Category 1 – Employee, Spouse and Dependent Children Insurance

Category 1 Critical Illness	Heart/Stroke	Percentage of Schedule Amount
	Heart Attack	100%
	End-Stage Heart Failure	100%
	Stroke	100%
	Coronary Artery Bypass Graft	25%
	Recurrence Benefit	25% of the previously paid benefit for the same Critical Illness

Category 2 – Employee, Spouse and Dependent Children Insurance

Category 2 Critical Illness	Other Major Illnesses	Percentage of Schedule Amount
	Blindness	100%
	Major Organ Failure	100%
	End-Stage Kidney Disease	100%
	Paralysis	100%
	Coma	100%
	Recurrence Benefit	25% of the previously paid benefit for the same Critical Illness

Maximum Benefits Payable for each Insured under this Certificate:
For Categories 1 & 2, we will not pay more than an aggregate of 125% of the benefit payable for Covered Conditions in the same Category inclusive of the Recurrence Benefit.

Wellness Screening Benefit: $50 per Benefit Year if any one of the wellness screening tests described in this Certificate is performed for you. $50 each Benefit Year if any one of the wellness screening tests described in this Certificate is performed for your insured Spouse and Dependent Children.

Contributions: The cost of your insurance is paid for entirely by you. This is your Contributory insurance.

2. DEFINITIONS

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 will be 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 Injury or sickness.

Benefit Percentage means the percentage that is applied to the Insurance Amount to determine the amount of Critical Illness benefits payable under the Policy.

Benefit Year means a calendar year beginning on January 1 of any year and ending on December 31 of that year.

Confined or Confinement means:
- confined to a hospital or similar facility; or
- confined at home due to a sickness or Injury and under the care of a Physician.

Contributory means you pay all or part of the premium.

Coronary Artery Disease means acute coronary occlusion, coronary atherosclerosis, aneurysm and dissection of the coronary arteries or coronary atherosclerosis due to plaque.

Critical Illness means only the illnesses defined in the Covered Conditions section of this Certificate for which benefits are payable.

Dependent means your insured Spouse and Dependent Children.

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

Dependent Child includes:
- your step-child;
- a child for whom coverage is required pursuant to a Qualified Medical Child Support Order or other court or administrative order;
- a foster child placed with you by a licensed agency;
- a child for whom you have or your Spouse has legal guardianship of the child's person;
- your adopted child, including any child placed with you for adoption, regardless of whether or not the adoption decree is final;
- a child of your Spouse.

If an unmarried child is age 26 or older and is:
- incapable of self-sustaining employment because of a mental or physical handicap; and
- chiefly dependent on you for support ;

that child will continue to be considered a Dependent Child under the Policy for as long as these conditions exist.

Proof of dependency may be requested by Us within 31 days of the date the child attains age 26, but not more frequently than annually after that.

No person may be considered to be a Dependent Child of more than one Employee.

Dependent Child does not include:
- any person who is insured as an Employee; or
- any person residing outside the United States or Canada. This exclusion does not apply to a Dependent Child who:
  - resides with you while you are on a temporary work assignment outside the United States.

Diagnosed, Diagnosis or Diagnoses means an evaluation of an Insured's medical condition that is performed by a Physician whose specialty is appropriate for the condition being evaluated, and who is board certified in that specialty in accordance with the American Board of Medical Specialties criteria. The evaluation must be consistent with the most current medically accepted diagnostic standards according to Nationally Recognized Authorities. A Diagnosis must be based on conditions, clinical signs on examination, or test results that have changed substantially since becoming insured under the Policy. In addition, if cognitive function is being evaluated, the conclusions must be confirmed with neuropsychological testing conducted by a clinical psychologist at the doctorate level certified through the American Board of Professional Psychology in the area of clinical neuropsychology.

Eligibility Waiting Period means the length of time you must be a member in an Eligible Class before you can apply for insurance. The Eligibility Waiting Period is shown in the Benefit Highlights. Any period of time prior to the Policy Effective Date you were Actively at Work for the Employer as a full-time Employee will count towards completion of the Eligibility Waiting Period.

Employee means a person who is:
- employed by the Employer within the United States;
- 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 a temporary assignment outside of the United States for 12 months or less, you will be deemed to be working within the United States. If you are an Employee and you are working on a temporary assignment outside of the United States for more than 12 months, you will not be considered an Employee under the Policy unless we agree in Writing.

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

Enrollment Period means the period of time each year not to exceed 30 days during which eligible Employees may elect, or change, or cancel insurance under the Policy. The Enrollment Period cannot exceed 30 days or occur more than once in any 12-month period, unless we agree in Writing.

Evidence of Insurability means a statement or records of your or your Spouse's medical history upon which acceptance for insurance will be determined by us. Evidence of Insurability must be satisfactory to us.

Family Member means: (a) your Spouse, civil union partner or domestic partner and (b) the following relatives of you or your Spouse, civil union partner 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.

Family Status Change means one of the following events:
- your marriage or divorce;
- the birth of your child;
- the adoption of a child by you;

- the addition of a foster child;
- the placement of a child with you, pending adoption;
- the death of your Spouse or child;
- the commencement or termination of employment of your Spouse.

Guaranteed Issue Amount means the maximum amount of insurance available to you and your Spouse under the Policy without having to provide Evidence of Insurability. The Guaranteed Issue Amount is shown in the Benefit Highlights.

Initial Enrollment means the first date you are eligible to enroll for Employee Insurance, Spouse Insurance and Dependent Children Insurance.

Injury means unintentional physical damage or harm caused directly by an accident occurring while insured under the Policy and not due to sickness, disease or any other causes.

Insurance Amount means the amount of insurance available under the Policy as shown in the Benefit Highlights and for which a person covered under the Policy is insured.

Insured means any person covered under the Policy.

Intoxicated means:
- under the influence of alcohol, illegal drugs or prescription drugs other than as prescribed by your Physician; or
- at or above the minimum blood alcohol level for which you would be considered operating a motorized vehicle under the influence of alcohol in the jurisdiction where the Intoxication occurred.

For the purposes of this definition, "operating" includes allowing the engine to run even if not seated in the vehicle and "motorized vehicle" includes, but is not limited to, automobiles, motorcycles, boats and snowmobiles.

Late Entrant means you apply for any insurance more than 90 days after you first become eligible to enroll in it.

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.

Nationally Recognized Authorities means the American Medical Association (AMA) Council on Scientific Affairs, the AMA Diagnostic and Therapeutic Technology Assessment Project, the AMA Board of Medical Specialties, the American College of Physicians and Surgeons, the Food and Drug Administration, the Centers for Disease Control and Prevention, the Office of Technology Assessment, the National Institutes of Health, the Health Care Finance Administration, the Agency for Health Care Policy and Research, the Department of Health and Human Services, the National Cancer Institute, and any additional organizations we choose which attain similar status.

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.

2. DEFINITIONS

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.

Physician means a person who is operating within the scope of his or her license and is either:
- licensed in the United States or Canada as a medical doctor and authorized to practice medicine and prescribe and administer drugs or to perform surgery; or
- any other duly licensed medical practitioner who is deemed by applicable state or provincial law to have the same authority as a legally qualified medical doctor.

The Physician cannot be you, a business associate or any Family Member.

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 group insurance policy(ies) for critical illness insurance issued to the Policyholder that was in effect immediately prior to the Policy.

Proof means any medical, financial or other information that we require to make a claim determination.

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.

Specialist Physician means a medical doctor who is licensed and practicing in the United States or Canada and who has completed an accredited specialty training program recognized by the American Board of Medical Specialties and has passed the examination leading to Board Certification in the field most applicable to the condition being evaluated or equivalent certification acceptable to us.

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.

Spouse does not include:
- any person who is insured as an Employee; or
- any person residing outside the United States or Canada. This exclusion does not apply to a Spouse who resides with you while you are on a temporary work assignment outside the United States.

Treatment means a Physician's consultation, care or services; diagnostic measures; or the prescription, refill or taking of prescribed drugs or medicines.

We, Us, Our (we, us, our) means Sun Life Assurance Company of Canada.

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 TERMINATION OF EMPLOYEE INSURANCE

When are you eligible for Employee Critical Illness Insurance?
You are initially eligible for Employee Critical Illness Insurance on the latest of:
- July 1, 2019;
- 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.

You are also eligible for Employee Critical Illness Insurance during any Enrollment Period or as a result of a Family Status Change, provided you are Actively at Work and in an Eligible Class.

When must you enroll for Employee Critical Illness Insurance?
You must enroll within 90 days of the date you are initially eligible for Employee Critical Illness Insurance otherwise you will be considered a Late Entrant.

If you refuse your insurance or do not enroll when you are eligible, then you will not be allowed to enroll until the next Enrollment Period or until a Family Status Change.

When does your Employee Critical Illness Insurance start?
For Contributory Employee Critical Illness Insurance, if you are not a Late Entrant, your insurance up to your applicable Guaranteed Issue Amount starts on the later of the date:
- you are eligible; or
- you enroll and agree to make any required contribution toward the cost of insurance; and

you are Actively at Work on that date.

If you are a Late Entrant, Evidence of Insurability is required for any amount of insurance, and your insurance will not start until we approve Evidence of Insurability in Writing, but you need to be Actively at Work on that date.

If Evidence of Insurability is required for any amount of insurance in excess of the Guaranteed Issue Amount, that amount will not start until we approve it in Writing, but you need to be Actively at Work on that date.

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

When can you make changes in Employee Critical Illness Insurance?
You may request a change in your Employee Critical Illness Insurance Amount or benefit elections during any Enrollment Period after you are covered under the Policy and Actively at Work.

You may also request a change in Employee Critical Illness Insurance at any time due to a Family Status Change. Such request must be made within 31 days of the date the Family Status Change occurred.

Evidence of Insurability may be required for any change in insurance.

Any amount or increase in Employee Insurance is subject to the Pre-Existing Conditions limitation. A pre-existing condition will be considered to have occurred in relation to the effective date of the change, not the original effective date of your coverage.

You may only increase or decrease your Employee Insurance Amount within the limits shown in the Benefit Highlights.

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF EMPLOYEE INSURANCE

When does a change in Employee Critical Illness Insurance start?
If you are Actively at Work, any increase in Employee Critical Illness Insurance or benefits, for reasons other than a Family Status Change, will start:

- on the July 1st following the date of change, when you apply for a different incremental amount coverage option and you agree to make any required contribution toward the cost of insurance; or
- on the date we approve any required Evidence of Insurability.

If Evidence of Insurability is required for any increase in your amount of insurance, the increase in your insurance will not start until we approve the increase in Writing, but you need to be Actively at Work on that date.

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

Whether or not you are Actively at Work, any reduction in Employee Critical Illness Insurance or benefits, for reasons other than a Family Status Change, will start immediately following the date of change, when you apply for a different coverage option.

If you are Actively at Work, any increase in insurance or benefits due to a Family Status Change will start on the latest of:

- the date you apply for such change in Employee Critical Illness Insurance, if you apply within 31 days of the Family Status Change and you agree to make any required contribution toward the cost of insurance;
- the date of your Family Status Change; or
- the date we approve any required Evidence of Insurability.

If Evidence of Insurability is required for any increase in your amount of insurance, the increase in your insurance will not start until we approve the increase in Writing, but you need to be Actively at Work on that date.

If you are not Actively at Work on that date, any increase due to a Family Status Change in Employee Critical Illness Insurance or benefits will not start until you resume being Actively at Work.

Whether or not you are Actively at Work, any reduction in Employee Critical Illness Insurance or benefits due to a Family Status Change will start on the date of your Family Status Change.

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 45 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 Evidence of Insurability if you apply for an increase in your amount of insurance after your coverage is reactivated;
- be subject to a new Pre-existing Condition limitation for any condition which manifested during the period of time between the date your employment terminated and the date you are rehired;
- be subject to all the terms and provisions of the Policy.

You will be subject to a new Pre-existing Condition limitation as of the date you are rehired. You will be given credit for the time you were insured prior to your termination of employment.

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 45 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.

Coverage will not be reactivated for any amount of insurance which you continued under the Portability Provision, unless you cancel such coverage.

When does Employee Critical Illness Insurance end?
Your Employee Critical Illness 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 Employee Critical Illness Insurance or any part of your insurance;
- the date you request in Writing to cancel your Employee Critical Illness Insurance;
- the date all benefits paid or payable for you under the Policy reach the maximum amount payable as described herein; or
- the date you die.

Your Employee Critical Illness 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, subject to any applicable Portability provision provided.

If your coverage has ended, can it be reinstated?
If your insurance ends for any reason other than you have voluntarily terminated your insurance, then your insurance may be reinstated within 12 months from when your insurance ended. To reinstate your insurance, you must submit a Written request within 31 days after you return to being Actively at Work in an Eligible Class.
Reinstatement will be effective on the latest date when all of the following have occurred:
- you agree to make any required contribution toward the cost of your insurance; and
- you return to being Actively at Work.

Any Diagnosis occurring between your termination date and your reinstatement effective date will not be considered a Covered Benefit.

A new Eligibility Waiting Period will not apply.

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

Coverage will not be reinstated for any amount of insurance which you continued under the Portability provision, unless you cancel such coverage.

4. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE

When are you eligible for Spouse Critical Illness Insurance?
If you are in an Eligible Class, you are initially eligible for Spouse Critical Illness Insurance on the latest of:
- July 1, 2019;
- the date you are eligible for Employee Critical Illness Insurance; or
- the date you acquire a Spouse.

You are also eligible for Spouse Critical Illness Insurance during any Enrollment Period or as a result of a Family Status Change, provided you are in an Eligible Class and have a Spouse.

When must you enroll for Spouse Critical Illness Insurance?
You must enroll within 90 days of the date you are initially eligible for Spouse Critical Illness Insurance otherwise you will be considered a Late Entrant.

If you refuse your Spouse insurance or do not enroll when you are eligible, then you will not be allowed to enroll your Spouse until the next Enrollment Period or until a Family Status Change.

When does Spouse Critical Illness Insurance start?
For Contributory Spouse Critical Illness Insurance, if you are not a Late Entrant, your insurance up to your applicable Guaranteed Issue Amount starts on the latest of the date:
- you are eligible for Spouse Critical Illness Insurance; or
- you are insured under the Policy for Employee Critical Illness Insurance; or
- you enroll for Spouse Critical Illness Insurance and you agree to make any required contribution toward the cost of insurance; and

you are Actively at Work on that date and your Spouse is not Confined on that date.

If you are a Late Entrant, Evidence of Insurability is required for any amount of insurance, and your Spouse insurance will not start until we approve your Spouse's Evidence of Insurability in Writing, but you need to be Actively at Work on that date and your Spouse is not Confined on that date.

If Evidence of Insurability is required for any amount of insurance in excess of the Guaranteed Issue Amount, that amount will not start until we approve your Spouse's Evidence of Insurability in Writing, but you need to be Actively at Work on that date and your Spouse is not Confined on that date.

If you are not Actively at Work on that date, your Spouse Critical Illness Insurance will not start until you resume being Actively at Work.

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

When can you make changes in Spouse Critical Illness Insurance?
You may request a change in your Spouse Insurance Amount or benefit elections during any Enrollment Period after you are covered under the Policy and Actively at Work.

You may also request a change in Spouse Critical Illness Insurance at any time due to a Family Status Change. Such request must be made within 31 days of the date the Family Status Change occurred.

Evidence of Insurability may be required for any change in insurance.

Any amount or increase in Spouse Critical Illness Insurance is subject to the Pre-existing Conditions limitation. A pre-existing condition will be considered to have occurred in relation to the effective date of the change, not the original effective date of your coverage.

You may only increase or decrease your Spouse Insurance Amount within the limits shown in the Benefit Highlights.

4. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE

When does a change in Spouse Critical Illness Insurance start?
If you are Actively at Work, any increase in your Spouse Insurance Amount or benefits, for reasons other than a Family Status Change, will start:

- on the July 1st following the date of change, when you apply for a different coverage option and you agree to make any required contribution toward the cost of insurance; or
- on the date we approve any required Evidence of Insurability for your Spouse.

If Evidence of Insurability is required for any increase in your amount of Spouse insurance, the increase in your Spouse insurance will not start until we approve the increase in Writing, but you need to be Actively at Work on that date.

Your Spouse must not be Confined on the date of the increase in benefits.

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

If your Spouse is Confined on that date, your increase in Spouse Critical Illness Insurance or benefits will not start until your Spouse is no longer Confined.

Whether or not you are Actively at Work, any reduction in Spouse Critical Illness Insurance or benefits for reasons other than a Family Status Change will start immediately following the date of change, when you apply for a different coverage option.

If you are Actively at Work, any increase in Spouse Critical Illness Insurance or benefits due to a Family Status Change will start on the latest of:

- the date you apply for such change in Spouse Critical Illness Insurance, if you apply within 31 days of the Family Status Change and you agree to make any required contribution toward the cost of insurance; or
- the date of your Family Status Change; or
- the date we approve any required Evidence of Insurability for your Spouse.

If Evidence of Insurability is required for any increase in your amount of Spouse insurance, the increase in your Spouse insurance will not start until we approve the increase in Writing, but you need to be Actively at Work on that date.

Your Spouse must not be Confined on the date of the increase in benefits.

If you are not Actively at Work on that date, any increase due to a Family Status Change in Spouse Critical Illness Insurance or benefits will not start until you resume being Actively at Work.

If your Spouse is Confined on that date, your increase in Spouse Critical Illness Insurance or benefits will not start until your Spouse is no longer Confined.

Whether or not you are Actively at Work, any reduction in Spouse Critical Illness Insurance or benefits due to a Family Status Change will start on the date of your Family Status Change.

Any reduction in Spouse Critical Illness Insurance or benefits due to your age will start on the July 1st following the date of change, whether or not you are Actively at Work or your Spouse is Confined on the date of the decrease.

When does Spouse Critical Illness Insurance end?
Spouse Critical Illness 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 your Spouse Critical Illness Insurance or any part of your insurance or your Spouse Insurance;
- the date you request in Writing to cancel your Spouse Critical Illness Insurance;

- the date all benefits paid or payable for you under this Policy reach the maximum amount payable as described herein;
- the date all benefits paid or payable for your Spouse under the Policy reach the maximum amount payable for your Spouse as described herein;
- the date you die; or
- the date your Spouse dies.

Your Spouse Critical Illness 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 are no longer insured under the Policy;
- the date your Spouse no longer meets the definition of Spouse as described in this Certificate;
- the date your Spouse enters 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, subject to any applicable Portability provision provided.

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

When are you eligible for Dependent Children Critical Illness Insurance?
If you are in an Eligible Class, then you are initially eligible for Dependent Children Critical Illness Insurance on the latest of:

- July 1, 2019 or;
- the date you are eligible for Employee Critical Illness Insurance; or
- the date you acquire your Dependent Children.

You are also eligible for Dependent Children Critical Illness Insurance during any Enrollment Period or as a result of a Family Status Change, provided you are in an Eligible Class and have one or more Dependent Children.

When must you enroll for Dependent Children Critical Illness Insurance?
You must enroll within 90 days of the date you are initially eligible for Dependent Children Critical Illness Insurance otherwise you will be considered a Late Entrant.

If you refuse your Dependent Child insurance or do not enroll when you are eligible, then you will not be allowed to enroll until the next Enrollment Period or until a Family Status Change. However, if you enroll a Dependent Child pursuant to a court or administrative order, such Dependent Child will not be subject to this requirement.

When does Dependent Children Critical Illness Insurance start?
For Contributory Dependent Children Critical Illness Insurance, if you are not a Late Entrant, your insurance starts on the latest of the date:

- you are eligible for Dependent Children Critical Illness Insurance;
- you are first insured under the Policy, for Employee Critical Illness Insurance; or
- you enroll for Dependent Children Critical Illness Insurance and you agree to make any required contribution toward the cost of insurance, and

if you are Actively at Work on that date and your Dependent Child is not Confined on that date.

If you are a Late Entrant, Evidence of Insurability is required for any amount of insurance, and your Dependent Children insurance will not start until we approve your Dependent Child's Evidence of Insurability in Writing, but you need to be Actively at Work on that date and your Dependent Child is not Confined on that date.

If you are not Actively at Work on that date, your Dependent Children Critical Illness Insurance will not start until you resume being Actively at Work.

If your Dependent Child is Confined on the date your Dependent Children Critical Illness Insurance would normally start, your Dependent Children Critical Illness Insurance for that Child will not start until your Child is no longer Confined. Confinement does not apply to a newborn child, newly placed foster child or a newly adopted child.

When can you make changes in Dependent Children Critical Illness Insurance?
You may request a change in your Dependent Children Insurance Amount or benefit elections during any Enrollment Period after you are covered under the Policy and Actively at Work.

You may also request a change in Dependent Children Critical Illness Insurance at any time due to a Family Status Change. Such request must be made within 31 days of the date the Family Status Change occurred.

Evidence of Insurability may be required for any change in insurance.

Any amount or increase in Dependent Children Critical Illness Insurance is subject to the Pre-existing Conditions limitation. A pre-existing condition will be considered to have occurred in relation to the effective date of the change, not the original effective date of your coverage.

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

You may only increase or decrease your Dependent Children Insurance Amount within the limits shown in the Benefit Highlights.

When does a change in Dependent Children Critical Illness Insurance start?
If you are Actively at Work, any increase in Dependent Children Critical Illness Insurance or benefits, for reasons other than a Family Status Change, will start:

- on the July 1st following the date of change, when you apply for a different coverage option and you agree to make any required contribution toward the cost of insurance; or
- on the date we approve any required Evidence of Insurability for your Dependent Child.

If Evidence of Insurability is required for any increase in your amount of Dependent Children insurance, the increase in your Dependent Children insurance will not start until we approve the increase in Writing, but you need to be Actively at Work on that date.

Your Dependent Child must not be Confined on the date of the increase in benefits.

If your Dependent Child is Confined on that date, your increase in Dependent Children Critical Illness Insurance or benefits will not start until your Dependent Child is no longer Confined.

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

Whether or not you are Actively at Work, any reduction in Dependent Children Critical Illness Insurance or benefits, for reasons other than a Family Status Change, will start immediately following the date of change, when you apply for a different coverage option.

If you are Actively at Work, any increase in Dependent Children Critical Illness Insurance or benefits due to a Family Status Change will start on the latest of:

- the date you apply for such change in Dependent Children Critical Illness Insurance, if you apply within 31 days of the Family Status Change and you agree to make any required contribution toward the cost of insurance; or
- the date of your Family Status Change; or
- the date we approve any required Evidence of Insurability for your Dependent Child.

If Evidence of Insurability is required for any increase in your amount of Dependent Children insurance, the increase in your Dependent Children insurance will not start until we approve the increase in Writing, but you need to be Actively at Work on that date.

Your Dependent Child must not be Confined on the date of the increase in benefits.

If you are not Actively at Work on that date, any increase due to a Family Status Change in Dependent Children Critical Illness Insurance or benefits will not start until you resume being Actively at Work.

If your Dependent Child is Confined on that date, your increase in Dependent Children Critical Illness Insurance or benefits will not start until your Dependent Child is no longer Confined.

Whether or not you are Actively at Work, any reduction in Dependent Children Critical Illness Insurance or benefits due to a Family Status Change will start on the date of your Family Status Change.

Any reduction in Dependent Children Critical Illness Insurance or benefits due to your age will start on the July 1st following the date of change, whether or not you are Actively at Work or your Dependent Child is Confined on the date of the decrease.

How can you add a child or children to your Dependent Children Critical Illness Insurance?
After you and a Dependent Child are covered under the Policy, and you are Actively at Work, any child who becomes one of your Dependent Children will automatically be covered.

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

How does Dependent Children Critical Illness Insurance apply to newborn children, newly placed foster children or newly adopted children?

If you are insured under the Policy but do not have Dependent Children Critical Illness Insurance when a newborn child, newly placed foster child or newly adopted child becomes one of your Dependent Children, then such child will automatically be covered for 31 days from the date he or she becomes your Dependent Child. To continue coverage beyond 31 days, you must:

- enroll for Dependent Children Critical Illness Insurance within 31 days from the date the newborn child, newly placed foster child or newly adopted child becomes your Dependent Child; and
- pay the required premium to continue your Dependent Children Critical Illness Insurance.

If you are covered under the Policy and have Dependent Children Critical Illness Insurance when a newborn child, newly placed foster child or newly adopted child becomes one of your Dependent Children, then such child will automatically be covered.

When does Dependent Children Critical Illness Insurance end?

Dependent Children Critical Illness 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 your Dependent Children Critical Illness Insurance or any part of the insurance;
- the date you request in Writing to cancel your Dependent Children Critical Illness Insurance;
- the date all benefits paid or payable for you under this Policy reach the maximum amount payable as described herein;
- the date all benefits paid or payable for a specific Dependent Child reach the maximum amount payable as described herein;
- the date you die; or
- the date your Dependent Child dies.

Your Dependent Children Critical Illness 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 are no longer insured under the Policy;
- the date your Dependent Child no longer meets the definition of Dependent Child as described in this Certificate, but only with respect to that person;
- the date your Dependent Child enters active duty in any armed service;
- the date you retire; or
- the date your class is no longer included for insurance; or
- the last day you are Actively at Work, subject to any applicable Portability provision provided.

6. BENEFIT PROVISIONS

What benefits are payable?
We will pay you a lump-sum benefit for the insurance in force when any eligible Insured, on or after the effective date of insurance, is Diagnosed with a Critical Illness condition as defined in the Covered Conditions section of this Certificate.

Any benefits payable are subject to the limitations, exclusions and other conditions stated in the Policy.

How is the amount of the benefit determined?
We will multiply the Insured's Insurance Amount by the Benefit Percentage for the applicable Covered Condition as shown in the Benefit Highlights to determine the benefit to be paid.

If benefits for a particular Critical Illness have been paid, an Insured is not eligible for any additional benefits if the Insured is ever Diagnosed with that Critical Illness again except as described in Recurrence Benefit.

If an Insured is Diagnosed with more than one Critical Illness on the same date, we will pay only the benefit for the Critical Illness with the largest Benefit Percentage.

Additional Occurrence

When is an additional benefit payable?
If we pay benefits for a particular Critical Illness, we will pay benefits for a different Critical Illness in another category listed in the Benefit Highlights, if there are more than 6 consecutive months between Diagnoses. However, we will not pay more than the Maximum Benefits Payable shown in the Benefit Highlights.

Recurrence Benefit

When is a Recurrence Benefit payable?
We will pay a Recurrence Benefit, as shown in the Benefit Highlights, if:
- benefits have been paid under this Policy because an Insured was Diagnosed with a Critical Illness; and
- an Insured is Diagnosed with the same Critical Illness more than 18 consecutive months later; and
- the Insured has not received Treatment for the same Critical Illness for 18 consecutive months after the Diagnosis for the Critical Illness. For the purposes of this provision, we will not consider follow-up visits to a Physician or prescription medications other than cytotoxic medications (cancer chemotherapy) to be Treatment.

How is the amount of the Recurrence Benefit determined?
The amount of the recurrence benefit is 25% of the benefit previously paid because of that Critical Illness.

What is the maximum benefit payable under the Recurrence Benefit?
We will pay the Recurrence Benefit for an Insured only once for each applicable Covered Condition. However, we will not pay more than the Maximum Benefits Payable shown in the Benefit Highlights.

7. COVERED CONDITIONS

What Critical Illness conditions are covered?
The Critical Illness conditions listed below are covered under the Policy.

CATEGORY 1 CONDITIONS

Heart Attack means, that while insured under the Policy, the Insured has been Diagnosed with Coronary Artery Disease that results in the death of heart muscle due to acute obstruction of a coronary artery that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction and includes at least one of the following:
- heart attack symptoms; or
- new electrocardiogram (ECG) changes consistent with a Heart Attack.

The Diagnosis of Heart Attack must be made by a Specialist Physician.

Exclusions:
Heart Attack does not include:
- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty; or
- silent myocardial infarction, including ECG or imaging changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

End-stage Heart Failure means, that while insured under the Policy, the Insured has been Diagnosed with severe and irreversible failure of the heart which is not remediable by medical or device therapy or by surgical therapy other than heart transplant. To qualify under End-stage Heart Failure, the Insured must be listed with the United Network of Organ Sharing (UNOS) on a heart transplant waiting list. Severe and irreversible failure of the heart shall be conclusively proven if an Insured has undergone a heart transplant as the recipient while insured under the Policy.

The Diagnosis of End-stage Heart Failure must be made by a Specialist Physician.

Stroke means, that while insured under the Policy, the Insured has been Diagnosed with cerebrovascular disease resulting in a brain tissue infarction or hemorrhage documented by brain imaging in association with acute onset of new neurologic deficits consistent with central nervous system damage.

The Diagnosis of Stroke must be made by a Specialist Physician.

Exclusions:
For the purposes of this Policy, Stroke does not include:
- Transient Ischemic Attacks (TIAs);
- Transient Global Amnesia (TGA); or
- External trauma causing Injury to the brain.

Coronary Artery Bypass Graft means, that while insured under the Policy, an Insured has been Diagnosed with Coronary Artery Disease requiring a procedure to bypass one or more diseased, narrowed or blocked coronary arteries with arterial or venous grafts and is performed by a board certified cardiovascular surgeon.

***Exclusions*:**
No benefit will be payable for diseases requiring other procedures such as percutaneous transluminal coronary angioplasty (PTCA) or laser procedures.

CATEGORY 2 CONDITIONS

Complete Blindness means, that while insured under the Policy, the Insured has been initially Diagnosed with an irreversible reduction in sight, lasting at least 180 days, that results in a corrected visual acuity of 20/400 or less or a visual field less than 20 degrees when testing both eyes together.

Benefits for Complete Blindness are not payable if the condition is a consequence of another condition for which another Critical Illness benefit has been paid.

The Diagnosis of Complete Blindness must be made by a Specialist Physician.

Major Organ Failure means, that while insured under the Policy, the Insured is Diagnosed with any end-stage disease as specified by the most current edition of the International Classification of Diseases (ICD) of the liver, lung, small intestine, pancreas or bone marrow that has resulted in the chronic and irreversible failure of the organ to function.

For all organs listed above, a transplant is recommended as soon as an appropriate donor is located, and the Insured is either registered with the:

- United Network of Organ Sharing (UNOS); or
- National Marrow Donor Program (NMDP).

The Diagnosis of Major Organ Failure must be made by a Specialist Physician.

Exclusions:
Major Organ Failure does not include any of the following:

- bone marrow failure that results from the Treatment process for cancer;
- failure of any other organ not listed above; or
- a transplant in which the Insured’s own bone marrow is used.

If multiple organs are to be replaced at the same time, only one benefit for Major Organ Failure is payable.

End-Stage Kidney Disease means, that while insured under the Policy, the Insured has been Diagnosed with a renal disease that has resulted in either:

- the chronic and irreversible failure of both kidneys to function and which requires regular dialysis for a minimum of 90 days; or
- the need for a kidney transplant.

The Diagnosis of End-Stage Kidney Disease must be made by a Specialist Physician. In the event a kidney is transplanted at the same time as other organs, only one benefit is payable.

Paralysis means, that while insured under the Policy, the Insured has been Diagnosed with total and irreversible loss of use of two or more limbs due to Injury of the spinal cord and that is continuously present for a period of at least 180 days. Limb is defined as the complete arm or the complete leg.

The Diagnosis of Paralysis must be made by a Specialist Physician and shall not include any impairment caused by a Stroke or other sickness.

Coma means a Diagnosis, while insured under the Policy, of a state of unconsciousness with no reaction to external stimuli and which requires an external life support system, both of which have persisted continuously for at least 168 hours.

The Diagnosis of Coma must be made by a Specialist Physician.

Exclusions:
Coma does not include medically induced coma.

8. EXCLUSIONS AND LIMITATIONS

What exclusions apply to the benefits payable?
In addition to the exclusions stated in the Covered Conditions section of this Certificate, we will not pay any benefit that is caused by, contributed to in any way, or resulting from any Critical Illness condition Diagnosed outside the United States or Canada without confirmation of the Diagnosis by the type of Specialist Physician specified for each of the Covered Conditions in Section 7 who practices in the United States or Canada.

We will not pay a benefit for any Critical Illness that is due to or results from:

- services or Treatment not included in the Benefit Highlights;
- services or Treatment provided by a Family Member;
- Treatment or complications of Treatment not related to a Critical Illness;
- an autologous bone marrow transplant, one in which your own bone marrow is used;
- intentionally self-inflicted injuries;
- elective plastic or cosmetic surgery;
- active military duty;
- 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);
- your active Participation in a Riot, Rebellion or Insurrection;
- committing or attempting to commit an assault, felony or other criminal act;
- your engagement in dangerous conduct or hazardous activity where there is a likelihood of death or serious Injury;
- committing or attempting to commit suicide, whether sane or insane;
- incarceration in a penal institution of any kind; or
- being legally Intoxicated or under the influence of any narcotic unless taken on the advice of a Physician and taken as prescribed.

What limitations apply to the benefits payable?
In addition to the limitations stated in the Covered Conditions section of this Certificate, we will not pay any benefit for any Critical Illness that is Diagnosed in the first 12 months following the effective date of any Insured's insurance and results from a Pre-Existing Condition.

This provision does not apply to any amount of Critical Illness insurance for which you, your Spouse or Dependent Child were insured on the effective date of the Policy.

Pre-Existing Condition means during the 12 months prior to any Insured's effective date of insurance or the effective date of an increase in any Insured's amount of insurance, any condition for which any Insured:

- received medical Treatment, consultation, advice, care or services, including diagnostic measures for the condition symptoms related to the condition, regardless of whether the condition was Diagnosed or suspected at that time; or
- took prescribed drugs or medicines for the condition.

When newborn children, newly placed foster children or newly adopted children are added to your Dependent Children Insurance within 31 days of the birth, placement or adoption, the Pre-Existing Condition limitation does not apply.

9. WELLNESS SCREENING BENEFIT

What is the wellness screening benefit?
While your insurance under the Policy is in force, we will pay you a wellness screening benefit each Benefit Year during which you or your insured Spouse or your insured Dependent Child has any one of the following wellness screening tests performed:

- CA15-3 (blood test for breast cancer)
- Breast Cancer Screening (clinical breast exam, mammography, MRI, thermography, ultrasound)
- CA 125 (blood test for ovarian cancer)
- Colorectal Cancer Screening (fecal occult blood test, colonoscopy, sigmoidoscopy)
- CEA (blood test for colon cancer)
- Lipid panel (cholesterol, triglycerides, HDL, LDL)
- Pap smear
- Prostate Cancer Screening (digital rectal exam, PSA blood test)
- Skin Cancer Screening
- Diabetes tests (fasting blood glucose test, hemoglobin A1c)
- Cardiac exercise stress test
- Electrocardiogram (ECG)-resting or stress
- Chest x-ray
- Hemocult stool analysis
- Serum protein electrophoresis
- Carotid Doppler
- Echocardiogram
- Immunizations
- Interscholastic Sports Physical Exam

What is the amount of the wellness screening benefit?
We will pay you the amount as shown in the Benefit Highlights once each Benefit Year if any one of the wellness screening tests described in this Certificate is performed for you regardless of the results of the test. We will pay you the amount as shown in the Benefit Highlights once each Benefit Year if any one of the wellness screening tests described in this Certificate is performed for your insured Spouse. We will pay you the amount as shown in the Benefit Highlights once each Benefit Year if any one of the wellness screening tests described in this Certificate is performed for your insured Dependent Child. The wellness screening benefit is paid in addition to any other benefits payable under the Policy.

What conditions apply to the wellness screening benefit?
To receive this benefit, you must notify us of which wellness screening test was performed.

10. CLAIM PROVISIONS

How is a claim submitted?
To submit a claim, you or someone on your behalf must send us Written notice and Proof of claim 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 no later than 90 days after the date of Diagnosis or within 180 days of the initial Treatment of the Critical Illness.

If notice cannot be given within the applicable time period, we must be notified as soon as it is reasonably possible.

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

PROOF OF CLAIM

When does Written Proof of claim have to be submitted?
Written Proof of claim must be given to us no later than 180 days after the date of Diagnosis of the Critical Illness.

If Proof cannot be given within the time limit, Proof must be given as soon as reasonably possible. Proof of claim may not be given later than one year after the time Proof is otherwise required unless the individual is legally incompetent.

What is considered Proof of claim?
Proof of claim must consist of at least the following information:
- a description of the Critical Illness;
- the date the Diagnosis occurred;
- the cause of the Critical Illness; and
- any other information we may require to make a claim determination.

Proof of claim may include, but is not limited to, police accident reports, laboratory results, toxicology results, hospital records, x-rays, narrative reports, or other diagnostic testing materials, as required.

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

PAYMENT OF BENEFITS

When are benefits payable?
Benefits are payable within 30 days of our receipt of satisfactory Proof of claim that establishes benefit eligibility according to the provisions of the Policy.

When will a decision on your claim be made?
We will send you a Written notice to acknowledge 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 45 days after receiving your claim, we will request a 45 day extension as permitted by U.S. Department of Labor regulations. 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 any medical or vocational experts whose advice was obtained in connection with the claim, regardless of whether the advice was relied upon to deny the claim.

Can you request a review of a claim denial?
If all or part of your claim is denied, you may request in Writing a review of the denial within 60 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 60 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 60 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; 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?
We will pay you all benefits, if your Proof of claim is satisfactory to us, 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 to such person or persons.

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 solely 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 $3,000 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 $3,000; or
- if you have no Spouse, up to a cumulative amount of $3,000 to any one or more of the following relatives in the following order of priority:
- first, your child or children; or
- then, your mother or father.

11. INSURANCE CONTINUATION

Are there any conditions under which your Employer can continue your insurance?
While the Policy is in force and subject to the conditions stated in the Policy, your Employer may continue your insurance 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:

- absence due to Injury or sickness - up to 12 months;
- Layoff – up to 3 months;
- Leave of Absence - up to 3 months; including Family and Medical Leave of Absences
- 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.

Federal Continuance
Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), an Insured may have the right to continue Critical Illness insurance coverage beyond the date insurance would otherwise terminate. You should contact your Employer concerning your right to continue coverage.

12. PORTABILITY

What is portable insurance and when are you eligible?
Portable insurance is an optional benefit that you may elect to continue your insurance for each Insured up to the later of the day before you attain age 65 or 12 months from the date your portable insurance started if:

- your insurance ends because you are no longer in an Eligible Class; or
- your insurance ends because your class is no longer included for insurance; or
- your insurance ends because you terminate employment; or
- a revision is made to the Policy to reduce your amount of insurance; and
- you meet the following requirements:
  - you reside in the United States or Canada; and
  - you have not exercised your portable insurance right under a similar certificate issued by us; and
  - your insurance is not being continued under any Insurance Continuation provision.

You may not elect portable insurance for your Spouse or Dependent Children if you have not elected portable insurance for yourself.

Your portable insurance will be provided under an insurance policy we make available for this purpose. Your portable insurance may not be identical to your current insurance under the Policy.

When must you apply for portable insurance?
You must complete an application for portable insurance and send it to us with payment of the first premium within 31 days of the date your insurance under the Policy terminates. The application for portable insurance and applicable rates are available from your Employer.

What is the amount of portable insurance?
You may apply for portable insurance in an amount up to 100% of each Insured's remaining amount of insurance in force under the Policy on the date your insurance terminates. You may port to a lower amount of insurance if available. You cannot port to a higher amount of insurance. Your portable insurance policy will not provide any benefits beyond those described in the section of this Certificate titled Benefit Provisions. When you attain age 70, the amount of your portable insurance benefits will be reduced by 50%.

When does your portable insurance start?
After your insurance under the Policy terminates, your portable insurance will start on the later of the following:

- the date we approve your application for portable insurance; or
- the date we receive your first premium payment for portable insurance.

If you are Diagnosed with a covered Critical Illness within 31 days after your insurance ends, but before you have applied to port, we will pay any benefits as if you had ported. However, you must pay any premium due.

When is portable insurance available to your Spouse and when is your Spouse eligible?
Portable Insurance is available for your Spouse up to the later of the day before you attain age 65 or 12 months from the date your portable insurance started if all of the following requirements are met:

- you die or divorce your Spouse and your Spouse was Insured under the Policy at the time;
- your Spouse resides in the United States or Canada.

Your Spouse's portable insurance will be provided under an insurance policy we make available for this purpose. Their portable insurance may not be identical to your current insurance under the Policy.

12. PORTABILITY

When must your Spouse apply for portable insurance?
Your Spouse must complete an application for portable insurance and send it to us with payment of the first premium within 31 days of the date of your death or divorce. The application for portable insurance and applicable rates are available from your Employer.

What is the amount of your Spouse's portable insurance?
Your Spouse may apply for portable insurance in an amount up to 100% of the remaining amount of Spouse Insurance and Dependent Children Insurance in force under the Policy on the date of your death or divorce. Your Spouse's portable insurance policy will not provide any benefits beyond those described in the section of this Certificate titled Benefit Provisions.

Your Spouse may not apply for portable insurance for a Dependent Child whose insurance has not terminated under the Policy due to divorce.

When does your Spouse's portable insurance start?
After your death or divorce, your Spouse's portable insurance will start on the later of the following:
- the date we approve your Spouse's application for portable insurance; or
- the date we receive your Spouse's first premium payment for portable insurance.

13. CONTINUITY OF COVERAGE

What happens if your Employer replaces other insurance with this Certificate and the Policy?
If your Employer replaces insurance provided by another insurance company ("Prior Policy") with the insurance provided by this Certificate and the Policy ("This Policy"), the Continuity of Coverage benefits set forth in this Section may be available to you. These benefits will be available if the insurance and level of benefits under the Prior Policy were substantially similar to the insurance provided by This Policy.

What if you are not Actively at Work when your Employer replaces your Prior Policy with This Policy?
You and your Spouse and Dependent Children will be covered under This Policy if you are not Actively at Work on July 1, 2019 if:

- you were insured under the Prior Policy on the day before July 1, 2019;
- you are a member of an Eligible Class;
- your Employer continues to remit premiums for your coverage; and
- you are not receiving or eligible to receive benefits under the Employer's Prior Policy.

If you are Diagnosed with a Critical Illness condition as defined in the Covered Conditions section of This Policy, and were never Actively at Work while covered under This Policy, any benefit payable will be the lesser of:

- the benefit payable under This Policy; or
- the benefit payable under the Prior Policy.

What if your Spouse or Dependent Child is Confined when your Employer's Prior Policy is replaced with This Policy and you are Actively at Work?
Your Spouse and Dependent Children will be covered under This Policy if they are not Confined on July 1, 2019 if:

- your Spouse or Dependent Child was insured under your Employer's Prior Policy on the day before July 1, 2019;
- you are a member of an Eligible Class for Spouse or Dependent Children coverage;
- your employer continues to remit premiums for your Spouse or Dependent Children coverage; and
- your Spouse or Dependent Child not receiving or eligible to receive Spouse or Dependent Child benefits under your Employer's Prior Policy.

Any Spouse or Dependent Child benefit payable will be the lesser of:

- the benefit payable under This Policy; or
- the benefit payable under your Employer's Prior Policy.

Does the Eligibility Waiting Period apply when your Employer's Prior Policy is replaced with This 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 This Policy's Eligibility Waiting Period.

Does the Pre-Existing Condition limitation apply when your Employer's Prior Policy is replaced with This Policy?
We will apply any period of time satisfied under the Prior Policy to meet the requirements of the Pre-Existing Condition limitation toward the satisfaction of the period of time required by This Policy's Pre-Existing Condition limitation.

14. GENERAL PROVISIONS

AGENCY

Can the Policyholder, Employer, or third party administrator act as our agent?
For all purposes of the Policy, the Policyholder, Employer or third party administrator acts on its own behalf or as your agent. Under no circumstances will the Policyholder, Employer or third party administrator be deemed our agent.

ALTERATION

Who can alter the Policy?
The only persons with the authority to alter or modify the Policy or to waive any of its provisions are our president, actuary, secretary or one of our vice presidents and any such changes must be in Writing.

ASSIGNMENT

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

CLERICAL ERROR

What happens when there is a clerical error in the administration of the Policy?
Clerical errors in the administration of the Policy or delays in keeping records for the Policy whether by us, the Policyholder, or the Employer:
- will not terminate insurance that would otherwise have been effective; and
- 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 or Portability 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, except as otherwise pre-empted by federal law.

DISCHARGE OF OUR RESPONSIBILITY

What is the effect of payments under the Policy?
Payment made under the terms of the Policy will, to the extent of such payment, release us from all further obligations under the Policy. We will not be obligated to see to the application of such payment.

ENTIRE CONTRACT

What is the entire contract?
The following are incorporated in and made part of this Policy:

- any Policy amendments, endorsements or riders;
- the application of the Policyholder;
- the certificate(s); and
- any certificate amendments, endorsements or riders.

The Policy is the entire contract.

The certificate(s) and/or any certificate amendments, endorsements or riders include but are not limited to the following provisions that apply to the Employees of the Policyholder:
- benefit amounts and maximum limits;
- eligibility and effective date provisions;
- termination provisions;
- exclusions and limitations; and
- other certificate provisions pertaining to state insurance requirements or that are related to the benefits provided under the certificate(s).

EXAMINATION

What are our examination rights?
We, at our expense, have the right to have any person whose Critical Illness is the basis of a claim:
- examined by a Physician, other health professional or vocational expert of our choice; and/or
- interviewed by an authorized representative.

This right may be used as often as we determine necessary. Unless authorized by the examining Physician, the examination may not be recorded nor may another person be present during the examination.

GRACE PERIOD

What is the Grace Period?
The grace period is the 31-day period of time following the Premium Due Date during which the Policyholder may make an unpaid premium payment. If the Policyholder does not pay the required premium before the end of the grace period, the Policy will automatically cease at the end of the grace period. If the Policyholder gives us advance written notice that this Policy will cease on an earlier date, then this Policy will cease on that date; but no such termination will take effect during any period for which the required premium has been paid to us.

The Policyholder is responsible for the premium that is due during that part of the grace period that the insurance remains in force or the entire grace period if written notice is not received prior to the end of the grace period.

INCONTESTABILITY

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

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

14. GENERAL PROVISIONS

INSURER'S AUTHORITY

What is our authority?
Sun Life has discretionary authority to make all final determinations regarding claims for benefits under the Policy. This discretionary authority includes, but is not limited to, the right to determine eligibility for benefits and the amount of any benefits due and to construe the terms of the Policy.

Any decision made by us in the exercise of this authority, including review of denials of benefit, is conclusive and binding on all parties. Any court reviewing such a decision shall uphold it unless the claimant proves that it was arbitrary and capricious.

LEGAL PROCEEDINGS

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

Any decision made by us, including review of denial of claims, is conclusive and binding on all parties. Any court reviewing our determination shall uphold such determination unless the claimant proves Sun Life's claim determination is without any rational basis. In any legal proceeding, the Court is limited in its review to the administrative record compiled by Sun Life prior to its final claim determination.

LIMIT OF PREMIUM REFUNDS

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

MISSTATEMENT OF FACTS

What happens if there is a misstatement of facts in the administration of the Policy?
If relevant facts about the Employer or Employee relating to this insurance are determined not to be accurate:
- a fair adjustment of premium will be made, subject to the "Limit of Premium Refunds" section; and
- the actual facts will decide whether, and in what amount, and for what duration insurance is valid under the Policy.

NON-PARTICIPATING

Does the Policy participate in dividends?
The Policy is non-participating and will not share in any profits or surplus earnings of Sun Life 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 a benefit under the Policy, all Policy requirements must be satisfied.

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

14. 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, your beneficiary, if any, 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

CERTIFICATE ENDORSEMENT

This endorsement is part of the Certificate issued under Policy Number 930883-002 and is effective on July 1, 2019. It is part of, and subject to, the other terms and conditions of the Certificate. If the terms of this endorsement and the Certificate conflict then this endorsement's provisions will control.

For the purposes of this endorsement:

Prior Policy means the group insurance policy(ies) for Critical Illness Insurance issued to the Policyholder by Union Security Insurance Company that was in effect immediately prior to the Policy.

The Certificate and the Policy replace your insurance with us under the Prior Policy. The following provisions apply to any insured person who was covered under the Prior Policy on the day before the effective date of the Policy:

1. Any representation made for the purposes of obtaining or continuing insurance under the Prior Policy shall be deemed to have been made also for the purposes of obtaining insurance under this Policy. However, for the sole purpose of applying the section entitled INCONTESTABILITY, the effective date of an Employee's or Dependent's coverage under the Prior Policy shall be deemed the effective date of the Employee's or Dependent's coverage under the Policy.

2. For the purposes of determining any waiting period (by whatever name called) before insurance becomes effective or benefits become payable under the Policy, credit will be given for the completion or partial completion of any waiting period under the Prior Policy.

3. For the purposes of determining any benefit maximum, duration or limitation of benefits under the Policy, all benefits paid under the Prior Policy with respect to any person shall be deemed to have been paid as benefits under the Policy with respect to any person. All periods of time with respect to which benefits were paid under the Prior Policy shall be deemed to be periods of time with respect to which benefits were paid under the Policy.

4. Any claim incurred while the Prior Policy was in effect will be paid under the Prior Policy.

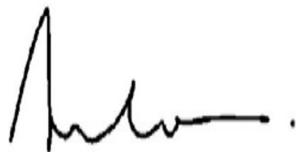
5. Any request, election, designation of beneficiary or assignment made under the Prior Policy shall be deemed to have been made under the Policy.

6. Any uninterrupted period of time during which insurance was in force under the Prior Policy with respect to any person, shall be deemed included in the period of time insurance for said person was in effect without interruption under this Policy.

7. Any reference to Employee or Dependents in this Policy will be deemed to include any insured regardless of what they are called in the Prior Policy.

8. In no event will any benefit be payable under this Policy which duplicates any benefit payable under the Prior Policy.

In the event of a conflict between the Policy and the Prior Policy, the terms of the Policy will control.



Dean A. Connor
President and Chief Executive Officer

SUN LIFE ASSURANCE COMPANY OF CANADA

Group Specified Disease Insurance Certificate

Non-Participating