1. SCHEDULE OF BENEFITS (Who Pays What)

Eligible Classes: All United States Exempt Faculty and Administrative Employees working in the United States scheduled to work at least .5 FTE (20 hours) per week

Eligibility Waiting Period: None

1. SCHEDULE OF BENEFITS (Who Pays What)

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: $30,000
	Change Increment Amount: $5,000
Spouse Insurance	Minimum: $2,500
	Maximum: $15,000
	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.

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.

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 January 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. SCHEDULE OF BENEFITS (Who Pays What)

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

Core Conditions Category – Employee, Spouse and Dependent Children Insurance

Covered Condition	Benefit Percentages	Recurrence Benefit Percentages
Heart Attack	100%	100%
Stroke	100%	100%
Major Organ Failure	100%	100%
Occupational Infectious Diseases	100%	N/A
End-stage Kidney Disease	100%	100%
Coronary Artery Bypass Graft	25%	25%
Angioplasty	5%	5%

Cancer Conditions Category – Employee, Spouse and Dependent Children Insurance

Covered Condition	Benefit Percentages	Recurrence Benefit Percentages
Invasive Cancer	100%	N/A
Non-Invasive Cancer	25%	N/A
Skin Cancer	5%	N/A

Other Conditions Category – Employee, Spouse and Dependent Children Insurance

Covered Condition	Benefit Percentages	Recurrence Benefit Percentages
Benign Brain Tumor	100%	N/A
Coma	100%	N/A
Complete Blindness	100%	N/A
Paralysis	100%	N/A
Loss of Speech	100%	N/A
Complete Loss of Hearing	100%	N/A
Advanced ALS/Lou Gehrig's Disease	100%	N/A
Advanced Alzheimer's Disease	25%	N/A
Advanced Parkinson's Disease	25%	N/A
Severe Burns	100%	N/A

Childhood Conditions Category – Dependent Children Insurance

Covered Condition	Benefit Percentages	Recurrence Benefit Percentages
Down Syndrome	100%	N/A
Cerebral Palsy	100%	N/A
Complex Congenital Heart Disease	100%	N/A
Spina Bifida	100%	N/A
Cleft Lip/Palate	100%	N/A
Type 1 Diabetes Mellitus	100%	N/A
Muscular Dystrophy	100%	N/A

Maximum Benefits Payable for each Insured under this Certificate:

- Each Covered Condition is payable 1x during the lifetime of the Policy (except as described in the Recurrence Benefit provision).

1. SCHEDULE OF BENEFITS (Who Pays What)

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.

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:	935916-005
Policy Effective Date:	January 1, 2020
Policyholder:	Colorado Higher Education Insurance Benefits Alliance Trust
Employer:	Metropolitan State University of Denver
Issue State:	Colorado

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.

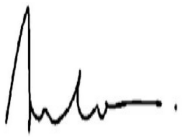
THIS IS A SUPPLEMENTAL POLICY THAT IS NOT INTENDED TO PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA). UNLESS YOU HAVE ANOTHER PLAN (SUCH AS MAJOR MEDICAL COVERAGE) THAT PROVIDES MINIMUM ESSENTIAL COVERAGE IN ACCORDANCE WITH THE ACA, YOU MAY BE SUBJECT TO A FEDERAL TAX PENALTY. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

PLEASE READ YOUR CERTIFICATE CAREFULLY.

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 Critical Illness Certificate

Non-Participating

Sun Life Financial®

3. CONTACT US

How do you contact us?
You can contact us at:

Sun Life Assurance Company of Canada
One Sun Life Executive Park
Wellesley Hills, MA 02481
Toll-free telephone number: 800-247-6875
Hours: Monday - Friday 8:00 A.M. to 6:00 P.M. ET

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5. ELIGIBILITY

Eligibility and Effective Dates 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:

- January 1, 2020;
- your first day of employment; 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 31 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, your insurance 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 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.

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.

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 immediately following the date of change.

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 on the January 1st following, when you apply for a different coverage option.

5. ELIGIBILITY

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; or
- the date of your Family Status Change.

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.

- the last day you are Actively at Work, subject to any applicable Portability provision provided.

Eligibility and Effective Dates 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:

- January 1, 2020;
- 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 31 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, your insurance 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 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.

5. ELIGIBILITY

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.

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 January 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.

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 on the January 1st following, 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.

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 January 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.
- the last day you are Actively at Work, subject to any applicable Portability provision provided.

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:

- January 1, 2020 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 31 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.

When does Dependent Children Critical Illness Insurance start?
For Contributory Dependent Children Critical Illness Insurance, 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 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 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.

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.

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

5. ELIGIBILITY

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 January 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.

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 on the January 1st following, 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.

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 January 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.

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.

5. ELIGIBILITY

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.

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. BENEFITS / COVERAGE (What is Covered)

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 listed in the Benefit Highlights, if there are more than 6 consecutive months between Diagnoses.

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 12 consecutive months later; and
- the Insured has not received Treatment for the same Critical Illness for 12 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?
We will multiply the Insured's Insurance Amount by the Recurrence Benefit Percentage for the applicable Covered Condition as shown in the Benefit Highlights to determine the benefit to be paid.

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.

COVERED CONDITIONS

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

CORE CONDITIONS CATEGORY

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.

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.

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 heart, 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.

Occupational Infectious Disease means, that while insured under the Policy, the Insured is Diagnosed with Human Immunodeficiency Virus (HIV) infection or Hepatitis B, C and/or D resulting from accidental exposure to HIV or Hepatitis B, C and/or D by contaminated body fluids during the course of performing the Insured's regular occupation for which remuneration is earned. To prove occupational exposure, all of the following must be submitted:

- documentation showing that within five days of the accidental exposure, the exposure was reported and recorded by the appropriate person according to legislation, regulations or standard guidelines that apply to the occupation;
- a negative antibody for HIV or Hepatitis B, C and/or D test, performed by a state certified and licensed laboratory within five days of exposure; and
- a positive antibody for HIV or Hepatitis B, C and/or D test, taken in the 90 to 180 days following the exposure.

Occupational Infectious Disease does not include HIV or Hepatitis B, C and/or D that occurs as a result of IV drug use, sexual transmission or is determined not to be accidental.

The Diagnosis of Occupational Infectious Disease must be made by a Specialist Physician. In order for a benefit to be paid, the initial Diagnosis of Occupational Infectious Disease must occur while insured under the Policy.

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.

Angioplasty means, that while insured under the Policy, the Insured has been Diagnosed with Coronary Artery Disease requiring a procedure to correct the narrowing or blockage of one or more coronary arteries by balloon. Angioplasty does not include a laser based intra-arterial procedure.

CANCER CONDITIONS CATEGORY

Invasive Cancer means, that while insured under the Policy, the Insured has been Diagnosed with a malignant neoplasm, which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of neighboring tissue.

The Diagnosis must be:
- made by a Specialist Physician; and
- supported by pathological confirmation or its equivalent.

A Clinical Diagnosis will be accepted only if a pathological confirmation of the Diagnosis cannot be made because it is medically inappropriate or life threatening.

Exclusions:
No benefit will be payable for the following:
- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumors classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- early prostate cancer classified as T1a or T1b (or equivalent staging) without lymph node or distant metastasis; or
- thyroid cancer less than or equal to 1.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis.

No benefit will be payable under this provision for the cancers listed in the Non-Invasive Cancer provision below.

Non-Invasive Cancer means, that while insured under the Policy, the Insured has been Diagnosed with a cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue.

The Diagnosis must be:
- made by a Specialist Physician; and
- supported by pathological confirmation or its equivalent.

A Clinical Diagnosis will be accepted only if a pathological confirmation of the Diagnosis cannot be made because it is medically inappropriate or life threatening.

Non-Invasive Cancer includes, but is not limited to:
- chronic lymphocytic leukemia that has not progressed beyond Rai stage 0;
- Stage 1A (T1a) malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion);
- early prostate cancer Diagnosed as T1a or T1b, or equivalent staging without lymph node or distant metastasis;
- thyroid cancer (less than or equal to 1 cm in diameter) and confined to the thyroid and classified as T1a, without lymph node or distant metastasis; and
- ductal carcinoma in situ (DCIS) of the breast.

Exclusions:
Non-Invasive Cancer does not include any of the following:
- pre-malignant lesions (such as intraepithelial neoplasia);
- Benign tumors or polyps;
- other skin cancer, such as squamous cell or basal cell cancer; or
- Invasive Cancer.

Skin Cancer means, that while insured under the Policy, the Insured has been Diagnosed with basal cell cancer or squamous cell cancer of the skin.

OTHER CONDITIONS CATEGORY

Advanced Alzheimer's Disease means, that while insured under the Policy, an Insured has:
- been initially Diagnosed with Functional Assessment Staging Scale (FAST) Stage 6 or higher for Alzheimer's related dementia; and
- demonstrated memory impairment; decreased ability to plan, organize, sequence; language disturbance; or other cognitive disturbance; and
- been unable to perform 3 or more of the Activities of Daily Living without the assistance of another person.

The Diagnosis of Advanced Alzheimer's Disease must be made by a Specialist Physician. In order for a benefit to be paid, the initial Diagnosis of any stage of Alzheimer's disease must occur while insured under the Policy.

Advanced Parkinson's Disease means, that while insured under the Policy, an Insured has:
- been initially Diagnosed with primary idiopathic Parkinson's disease at stage 4 or higher on the Hoehn and Yahr scale; and
- demonstrated resting tremor, rigidity, bradykinesia and dementia despite a generally accepted drug regimen; and
- been unable to perform 3 or more of the Activities of Daily Living without the assistance of another person.

The Diagnosis of Advanced Parkinson's Disease must be made by a Specialist Physician. In order for a benefit to be paid, the initial Diagnosis of any stage of Parkinson's disease must occur while insured under the Policy.

Advanced ALS or Lou Gehrig's Disease means, that while insured under the Policy, the Insured has:

- been initially Diagnosed with definite amyotrophic lateral sclerosis (ALS) according to criteria established by the World Federation of Neurology; and
- been determined to require either a feeding tube or non-invasive ventilation; and
- been unable to perform 3 or more of the Activities of Daily Living without the assistance of another person.

The Diagnosis of Advanced ALS or Lou Gehrig's Disease must be made by a Specialist Physician. In order for a benefit to be paid, the initial Diagnosis of any stage of amyotrophic lateral sclerosis (ALS) or Lou Gehrig's Disease must occur while insured under the Policy.

Benign Brain Tumor means, that while insured under the Policy, the Insured is initially Diagnosed with a non-malignant tumor located in the cranial vault and limited to the brain, meninges, or cranial nerves or pituitary gland. The tumor must require surgical or radiation Treatment or cause irreversible objective neurological deficit(s). The Diagnosis of Benign Brain Tumor must be made by a Specialist Physician.

Exclusions:

No benefit will be payable for the following:

- hematomas, cysts or granulomas; or
- intracranial malformations of the arteries or veins; or
- pituitary tumors, spine or cranial nerves, including pituitary adenomas less than 10 mm. in diameter, acoustic neuroma or craniopharyngioma.

The Diagnosis of Benign Brain Tumor must be made by a Specialist Physician. In order for a benefit to be paid, the initial Diagnosis of Benign Brain Tumor must occur while insured under the Policy.

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.

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. Coma must be caused by a sickness.

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

Exclusions:

Coma does not include any of the following:

- a coma does not include medically induced coma; or
- a coma which results from an injury or accident.

Complete Loss of Hearing means, that while insured under the Policy, the Insured has been initially Diagnosed with a condition that results in the total and irreversible loss of hearing in both ears to a point that an Insured is unable to hear sounds at or below 70 decibels. The Diagnosis must be confirmed using audiometric testing.

Complete Loss of Hearing does not include loss of hearing that can be corrected to above 70 decibels by the use of any hearing aid or device. Benefits for Complete Loss of Hearing 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 Loss of Hearing must be made by a Specialist Physician. In order for a benefit to be paid, the initial Diagnosis of Complete Loss of Hearing must occur while insured under the Policy.

Loss of Speech means, that while insured under the Policy, the Insured is initially Diagnosed with total, permanent and irreversible loss of the ability to speak. The loss must:

- be as a result of sickness affecting the speech organs; and
- have continued without interruption for a period of at least six (6) consecutive months.

Loss of Speech does not include any loss that could be restored, totally or partially, by use of a device or implant. Benefits for Loss of Speech are not payable if the condition is a consequence of another condition for which another Critical Illness benefit has been paid.

The Diagnosis of Loss of Speech must be made by a Specialist Physician. In order for a benefit to be paid, the initial Diagnosis of Loss of Speech must occur while insured under the Policy.

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 disease 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.

Exclusions:
Paralysis does not include paralysis as the result of an injury or accident.

Severe Burns means, that while insured under the Policy, the Insured is initially Diagnosed with third-degree burns over at least 18% of the body surface. Severe Burns must occur while the Insured's insurance is in force to be eligible for a benefit. The Diagnosis of Severe Burns must be made by a Specialist Physician.

CHILDHOOD CONDITIONS CATEGORY
The following covered childhood conditions apply only to children who meet the definition of Dependent Children and are insured under this Certificate:

Cerebral Palsy means a Diagnosis of nonprogressive, neurological defect affecting muscle control resulting from an Injury to or congenital abnormality. The initial Diagnosis of Cerebral Palsy must be made by a Specialist Physician supported by abnormal brain imaging (MRI or equivalent) while your Dependent Child is under the age of 5 and insured under the Policy.

***Exclusions*:**
No benefit will be payable for the following:

- Autism-as primary Diagnosis; and
- motor deficits due to an underlying medical condition (syndrome, genetic or hereditary condition).

Cleft Lip/Palate means that your covered Dependent Child under the age of 18 has been initially Diagnosed with either a cleft lip or a cleft palate. A Cleft Lip means a congenital failure of the upper lip to close and results in a narrow gap in the upper lip that extends to the nostril on one side or both sides of the mouth. A Cleft Palate means a congenital failure to close an opening in the roof of the mouth that extends to the nasal cavity. When a combination of Cleft Lip and Cleft Palate is Diagnosed, only one Diagnosis is eligible for benefits.

The Diagnosis of Cleft Lip/Palate must be made by a Specialist Physician. In order for a benefit to be paid, the initial Diagnosis of Cleft Lip/Palate must occur while insured under the Policy.

Complex Congenital Heart Disease means your covered Dependent Child under the age of 18 has been initially Diagnosed with at least one of the following covered heart conditions:

- coarctation of the aorta;
- Ebstein's anomaly;
- Eisenmenger syndrome;
- Tetralogy of Fallot;
- transposition of the great vessels; or
- any other congenital cardiac condition that requires open heart surgery.

The Diagnosis of Complex Congenital Heart Disease must be made and the surgery must be recommended by a Specialist Physician. In order for a benefit to be paid, the initial Diagnosis of Complex Congenital Heart Disease must occur while insured under the Policy.

Type 1 Diabetes Mellitus means that your covered Dependent Child under the age of 18 has been initially Diagnosed with a chronic autoimmune, genetic or infectious destruction of the insulin producing cells in the pancreas and that requires continuous, lifelong insulin therapy.

The Diagnosis of Type 1 Diabetes Mellitus must be made by a Specialist Physician. In order for a benefit to be paid, the initial Diagnosis of Type 1 Diabetes Mellitus must occur while insured under the Policy.

Down Syndrome means that your covered Dependent Child under the age of 18 has been initially Diagnosed with Down Syndrome by a Specialist Physician.

In order for a benefit to be paid, the initial Diagnosis of Down Syndrome must occur while insured under the Policy.

Muscular Dystrophy means your covered Dependent Child under the age of 18 has been initially Diagnosed with either Duchenne muscular dystrophy or Becker muscular dystrophy by specific testing. Clinical evidence of neuromuscular features of muscular dystrophy must be present. The Diagnosis must be made by a Specialist Physician.

In order for a benefit to be paid, the initial Diagnosis of Muscular Dystrophy must occur while insured under the Policy.

Spina bifida means that your covered Dependent Child under the age of 18 has been initially Diagnosed with congenital conditions of meningocele or myelomeningocele. Spina Bifida does not include spina bifida occulta.

The Diagnosis must be made by a Specialist Physician and be associated with neurologic symptoms including motor impairment identified by a Specialist Physician. In order for a benefit to be paid, the initial Diagnosis of Spina Bifida must occur while insured under the Policy.

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.

7. LIMITATIONS / EXCLUSIONS (What is Not Covered)

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 6 months following the effective date of any Insured's insurance and results from a Pre-Existing Condition.

Pre-Existing Condition means during the 6 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:

- sought medical Treatment, consultation, advice, care or services, including diagnostic measures for the condition or 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.

8. MEMBER PAYMENT RESPONSIBILITY

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

9. CLAIMS PROCEDURE (How to File a Claim)

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 upon 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 of our decision on your claim within a reasonable time after we receive the claim but not later than 90 days after receipt of the claim. If we cannot make a decision within 90 days after receiving your claim, we will request a 90 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.

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 $5,000 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 $5,000; or
- if you have no Spouse, up to a cumulative amount of $5,000 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.

10. GENERAL POLICY 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 option.

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.

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.

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.

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.

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.

10. GENERAL POLICY PROVISIONS

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 Dependent Child are not eligible for coverage, you should contact your Employer regarding the refund of premiums due, if any.

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.

11. TERMINATION / NONRENEWAL / CONTINUATION

Termination of Employee Insurance

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 Continuation provisions.

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 24 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.

Termination of Spouse Insurance

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.

11. TERMINATION / NONRENEWAL / CONTINUATION

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.

Termination of Dependent Children Insurance

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

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 1 months;
- Leave of Absence including Family and Medical Leave of Absences - up to 24 months;
- Sabbatical– up to 24 months;
- School Recess – up to 3 months;
- 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.

11. TERMINATION / NONRENEWAL / CONTINUATION

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.

Are there any conditions under which you can continue your insurance?
You may elect to continue your insurance 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 employment terminates and your insurance is not being continued by your Employer under any conditions as set forth above; and
- the Policy is still in force; and
- you reside in the United States or Canada; and
- you have not exercised your right to continue your insurance under a similar certificate issued by us.

When must you apply to continue insurance after your insurance terminates?
You must complete an application for continuation of insurance and send it to us with payment of the first premium within 45 days of the date your insurance terminates. The application for continuation of insurance and applicable rates are available from your Employer.

What is the amount of insurance you can continue after your insurance terminates?
You may apply to continue 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. When you attain age 70, the amount of your continued insurance benefits will be reduced by 50.0%.

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

- the date we approve your application for continuation of insurance; and
- the date we receive your first premium payment for continuation of insurance.

When does your continuation of insurance end?
Your continuation of insurance will end on the earliest of the following to occur:

- the date the Policy terminates;
- the last day for which any required premium has been paid for your continuation of insurance;
- the date you request in Writing to end your continuation of insurance;
- the date all benefits paid or payable for you under the Policy reach the maximum amount payable as described herein;
- the date you reside outside the United States or Canada;
- the date you die; or
- the date you become insured again under the Policy.

When does your Spouse's continuation of insurance end?
Continuation of insurance for your Spouse will end on the earliest of the following to occur:

- the date the Policy terminates;
- the last day for which any required premium has been paid for your continuation of insurance or your Spouse's continuation of insurance;
- the date you are no longer insured for continuation of insurance under the Policy;
- the date you request in Writing to end your Spouse's continuation of insurance;
- the date all benefits paid or payable for you under the 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 as described herein;
- the date your Spouse no longer meets the definition of Spouse as described in this Certificate; or
- the date your Spouse dies.

11. TERMINATION / NONRENEWAL / CONTINUATION

When does your Dependent Children continuation of insurance end?
Your Dependent Children's continuation of insurance will end on the earliest of the following to occur:

- the date the Policy terminates;
- the last day for which any required premium has been paid for your continuation of insurance or your Dependent Children's continuation;
- the date you are no longer insured for continuation of insurance under the Policy;
- the date you request in Writing to end your Dependent Children's continuation of insurance;
- the date all benefits paid or payable for you under the Policy reach the maximum amount payable as described herein;
- the date all benefits paid or payable for your Dependent Child under the Policy reach the maximum amount payable as described herein;
- the date your Dependent Child no longer meets the definition of a Dependent Child as described in this Certificate, but only with respect to that person; or
- the date your Dependent Child dies.

12. APPEALS AND COMPLAINTS

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.”

Are there any other remedies available if a claim is denied?
If a claim has been denied in whole or in part, and the claimant has exhausted all claim review and appeals procedures available, Colorado state law requires us to state that the claimant is entitled to file a lawsuit and have the claim reviewed de novo in any court with jurisdiction and to a trial by jury. If the Policy issued to fund the employee welfare benefit plan is subject to the Employee Retirement Income Security Act of 1974, the claimant may not have the right to have the claim reviewed de novo in any court with jurisdiction or the right to a jury trial.

13. INFORMATION ON POLICY AND RATE CHANGES

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.

When can premium rates be changed?
We determine initial or any subsequent monthly premium rates on the basis of the insurance being provided. After the initial monthly premium rates have been in effect for 48 months from the Policy Effective Date, we have the right to recalculate any premium rate. However, we have the right to recalculate the initial or any subsequent monthly premium rate when any of the following occurs:

- the terms or benefits of this Policy are changed;
- a new division or subsidiary or affiliated Company is added to or deleted from this Policy;
- the number of Employees covered under this Policy or a benefit changes by more than 25% from the number on the Policy Effective Date or any anniversary of the Policy Effective Date thereafter; or
- one or more classes are added to or deleted from this Policy.

We will provide written notification of any increases in the premium rates to the Policyholder at least 31 days prior to the effective date of the increase. Premium rate increases may take effect on an earlier date when both the Policyholder and we agree.

14. 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.

Activities of Daily Living means:

- Bathing – washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- Continence – the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
- Dressing – putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- Eating – feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by feeding tube or intravenously.
- Toileting – getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Transferring – moving into or out of a bed, chair or wheelchair.

The assessment must be made by a medical professional such as an occupational therapist or equivalent.

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.

Clinical Diagnosis means a Diagnosis of Cancer based on observation and history, diagnostic and laboratory studies, and symptoms.

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 under age 26.

14. DEFINITIONS

Dependent Child includes:
- your step-child;
- a foster child placed with you by a licensed agency;
- your adopted child, including any child placed with you for adoption; or
- a child of your Spouse.

If an unmarried child is age 26 or older and is:
- incapable of self-sustaining employment because of an intellectual disability, developmental disability or physical handicap; and
- chiefly dependent on you for his or her support;

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

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.

14. DEFINITIONS

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.

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

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 31 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.

14. DEFINITIONS

Participation in a Riot, Rebellion or Insurrection, the words "Participation" and "Riot" in this phrase mean:
Participation includes promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but will not include actions taken in defense of public or private property, or actions taken in your own defense, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firefighters.

Riot includes all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether or not acting with a common intent and whether or not damage to person or property or unlawful act or acts is the intent or the consequence of such disorder.

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.

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.

SUN LIFE ASSURANCE COMPANY OF CANADA

Group Critical Illness Insurance Certificate

Non-Participating