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:	901802-002
Policy Effective Date:	January 1, 2018
Policyholder:	Bronson Healthcare Group, Inc.
Employer:	Bronson Healthcare Group, Inc.
Issue State:	Michigan

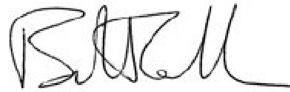
NOTICE TO BUYER: THIS IS A LIMITED BENEFIT HEALTH CERTIFICATE. THIS CERTIFICATE PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

This 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.

Signed at Wellesley Hills, Massachusetts.

Dean A. Connor
President and Chief Executive Officer



Brigitte K. Catellier
Vice-President, Associate General Counsel and
Corporate Secretary

Group Critical Illness Insurance Certificate
Critical Illness and Cancer

Non-Participating

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1. BENEFIT HIGHLIGHTS

Eligible Classes:	All Full-Time and Part-Time United States Exempt Employees working in the United States who are in an approved our position and scheduled to work at least 48 hours per bi-weekly pay period.
Eligibility Waiting Period:	None

	Insurance Amounts
Employee Insurance	Minimum: $15,000
	Maximum: $30,000
	Change Increment Amount: $15,000
Spouse Insurance	Minimum: $15,000
	Maximum: $30,000
	Change Increment Amount: $15,000
Dependent Children Insurance	Minimum: $15,000
	Maximum: $30,000
	Change Increment Amount: $5,000

Circulatory Conditions Category - Employee, Spouse and Dependent Children Insurance

Covered Condition	Benefit Percentages
Heart Attack	100%
Stroke	100%
End-Stage Heart Failure	100%
Coronary Artery Disease	100%

Cancer Conditions Category - Employee, Spouse and Dependent Children Insurance

Covered Condition	Benefit Percentages
Cancer	100%
Non-Life Threatening Cancer	25%

Other Conditions Category - Employee, Spouse and Dependent Children Insurance

Covered Condition	Benefit Percentages
Benign Brain Tumor	100%
Coma	100%
Major Organ Failure	100%
Paralysis	100%
Severe Burns	100%

Childhood Conditions Category - Dependent Children Insurance

Covered Condition	Benefit Percentages
Cerebral Palsy	100%
Complex Congenital Heart Disease	100%
Cystic Fibrosis	100%
Type 1 Diabetes Mellitus	100%
Muscular Dystrophy	100%

Maximum Benefits Payable for each Insured under this Certificate:

- We will only pay one benefit for each Covered Condition shown above;
- We will not pay more than an aggregate of 100% of the benefit payable for Covered Conditions in the same Category; and

- We will not pay more than an aggregate of 200% of the benefit payable for all the Covered Conditions in all Categories shown above.

Wellness Screening Benefit: $100 per calendar year if any one of the wellness screening tests described in this Certificate is performed for you. $100 per calendar year if any one of the wellness screening tests described in this Certificate is performed for your insured Spouse.

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

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 or a site where your Employer's business requires you to travel.

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 not hospital confined; or
- are not 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.

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

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

Dependent Child means your unmarried child from live birth to under age 26.

Dependent Child includes:
- your unmarried step-child;
- a foster child placed with you by a licensed agency;
- your adopted child, including any child placed with you for adoption;
- a child for whom coverage is required pursuant to a Qualified Medical Child Support Order or other court administrative order; or
- a child of a Spouse.

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

that child will continue to be a Dependent 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, Canada, or Mexico. This exclusion does not apply to a Dependent Child who resides with an Employee who is on a temporary work assignment outside the United States.

Diagnosis (Diagnosed) means a definitive identification of the Critical Illness made during the lifetime of the Insured by a Specialist Physician:
- supported by documentation of all appropriate and defined studies;
- based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations; and
- meeting any diagnostic requirements stated in this Certificate for the particular Critical Illness being diagnosed.

Divorce means the dissolution of any relationship identified in the Marriage definition and the term "divorce decree" means the court-issued document appropriate for the termination of such a relationship.

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 or part 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 scheduled to work at least the minimum hours shown in the Benefit Highlights, and paid regular earnings, who has provided the Employer with sufficient and authentic documentation establishing eligibility for employment in the United States as required under the Immigration Reform and Control Act, 8 U.S.C. 1324a (b) (1), and who is not an "unauthorized alien" as defined by 8 U.S.C. 1324a (h) (3). Employee does not include a seasonal or temporary employee whose annual work schedule is less than 12 months during a calendar year.

If you are an Employee and you are working on temporary assignment outside of the United States for 12 months or less, you will be deemed to be working within the United States. If you are an Employee and you are working on a temporary assignment outside of the United States for more than 12 months, you will not be considered an Employee under the Policy unless we agree in writing.

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

Enrollment Period means the period of time each year during which eligible Employees may elect or change insurance under the Policy. The Enrollment Period cannot 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 and/or your Dependent Child's medical history upon which acceptance for insurance will be determined by us. In some cases, we may require that you or your Spouse and/or your Dependent Child submit to a paramedical or other physical examination, at our expense, as part of the Evidence of Insurability.

Family Status Change means any of the following events:
- your Marriage or Divorce;
- the birth of your Child;
- the adoption of a Child by you; and
- the death of your Spouse or Child.

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

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.

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.

Marriage means any of the following relationships recognized under applicable state law: a same-sex or opposite-sex marriage.

Physician means an individual who is operating within the scope of his or her license and is either:
- licensed in the United States or Canada as a medical doctor and authorized to practice medicine and 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. “Family member” means: (a) your Spouse and (b) the following relatives of you or your Spouse: (1) parent; (2) grandparent; (3) child; (4) grandchild; (5) brother; (6) sister; (7) aunt; (8) uncle; (9) first cousin; (10) nephew or niece. This includes adopted, in-law and step-relatives.

Policy means the group insurance policy under which this Certificate is issued.

Proof means any medical, financial, or other information that is required by us and is satisfactory to us.

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 individual who under applicable state law is either recognized as a spouse or is otherwise accorded the same rights as a spouse.

Spouse does not include any person residing outside the United States, Canada, or Mexico. 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.

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 Insurance?
You are initially eligible for Employee Insurance on the later of:

- January 1, 2018;
- the date your Eligibility Waiting Period ends; and
- the date you first are Actively at Work in an Eligible Class.

You are also eligible for Employee 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 Insurance?
You must enroll within 31 days of the date you are initially eligible for Employee Insurance, or within 31 days of the date of a Family Status Change or during any Enrollment Period.

When does Employee Insurance start?
Employee Insurance starts on the later of:

- the date you are eligible;
- the date we approve your application for Employee Insurance and you agree to make any required contribution toward the cost of insurance; and
- the date we approve any required Evidence of Insurability,

if 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. If the date you resume being Actively at Work is more than 90 days after you applied for insurance and Evidence of Insurability was required, then you must submit new Evidence of Insurability and your insurance will not start until the date we approve your request.

How can you make changes in Employee Insurance?
During any Enrollment Period if you are covered under the Policy and Actively at Work, you may request a change in your Employee Insurance Amount or benefit options.

You may also request a change in Employee 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.

You may only increase or decrease your Employee Insurance Amount by the increment amount shown in the Benefit Highlights.

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

When does a change in Employee Insurance start?
If you are Actively at Work, any increase in Employee Insurance or benefits will start on the January 1st following the date of change the later of:

- the date you apply for such change in insurance and you agree to make any required contribution toward the cost of insurance; and
- the date we approve any required Evidence of Insurability.

If you are not Actively at Work on that date, any increase in insurance will not start until you resume being Actively at Work. If the date you resume being Actively at Work is more than 90 days after you applied for an increase in insurance and Evidence of Insurability was required, then you must submit new Evidence of Insurability and your increase in insurance will not start until the date we approve your request.

Any reduction in insurance will start immediately following the date of change the date you apply for such change in insurance, whether or not you are Actively at Work.

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

- apply for reinstatement.

When does Employee Insurance end?
Your insurance will end on the earliest of the following dates:

- the date the Policy terminates;
- the date you are no longer in an Eligible Class;
- the date your class is no longer included for insurance;
- the last date for which any required premium has been paid for your insurance;
- the date you request in writing to end your insurance;
- the last date you are Actively at Work, subject to any Insurance Continuation or Portability provisions; and
- the date all benefits paid for you under the Policy reach the maximum amount payable as described herein.

4. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE

When are you eligible for Spouse Insurance?
If you are in an Eligible Class shown in the Benefit Highlights, you are initially eligible for Spouse Insurance on the later of:
- January 1, 2018;
- the date you are eligible for Employee Insurance; and
- the date you acquire a Spouse.

You are also eligible for Spouse 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 Insurance?
You must enroll within 31 days of the date you are initially eligible for Spouse Insurance, or within 31 days of the date of a Family Status Change or during any Enrollment Period.

When does Spouse Insurance start?
Spouse Insurance starts on the later of:

- the dates we approve your application for Employee and Spouse Insurance and you agree to make any required contribution toward the cost of insurance; and
- the date we approve any required Evidence of Insurability for your Spouse,

if you are Actively at Work on that date.

If you are not Actively at Work on that date, your Spouse Insurance will not start until you resume being Actively at Work. If the date you resume being Actively at Work is more than 90 days after you applied for Spouse Insurance and Evidence of Insurability was required, then you must submit new Evidence of Insurability for your Spouse and your Spouse Insurance will not start until the date we approve your request.

If we do not approve your application for Employee Insurance because of an inability to provide satisfactory Evidence of Insurability, your application for Spouse Insurance may still be approved subject to all other Policy provisions.

How can you make changes in Spouse Insurance?
During any Enrollment Period after your Spouse is covered under the Policy, and you are Actively at Work, you may request a change in your Spouse Insurance.

You may also request a change in Spouse 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.

You may only increase or decrease your Spouse Insurance Amounts by the increment amounts shown in the Benefit Highlights.

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

When does a change in Spouse Insurance start?
If you are Actively at Work, any increase in insurance or benefits will start on the January 1st following the date of change the later of:

- the date you apply for such change in Spouse Insurance and you agree to make any required contribution toward the cost of insurance; and
- the date we approve any required Evidence of Insurability for your Spouse.

If you are not Actively at Work on that date, any increase in Spouse Insurance or benefits will not start until you resume being Actively at Work. If the date you resume being Actively at Work is more than 90 days after you applied for an increase in Spouse Insurance or benefits and Evidence of Insurability was required, then you must submit new Evidence of Insurability for your Spouse and your increase in insurance or benefits will not start until the date we approve your request.

Any reduction in insurance will start immediately following the date of change the date you apply for such change in insurance, whether or not you are Actively at Work.

When does Spouse Insurance end?
Spouse Insurance will end on the earliest of the following dates:

- the date the Policy terminates;
- the date you are no longer in an Eligible Class;
- the date your class is no longer included for insurance;
- the last date for which any required premium has been paid for your insurance or your Spouse Insurance;
- the date you request in writing to end your insurance or your Spouse Insurance;
- the last date you are Actively at Work, subject to any or Portability provisions;
- the date all benefits paid for your Spouse under the Policy reach the maximum amount payable for your Spouse as described herein; and
- the date your Spouse no longer meets the definition of Spouse as described in this Certificate.

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

When are you Eligible for Dependent Children Insurance?
If you are in an Eligible Class shown in the Benefits Highlights, then you are initially eligible for Dependent Children Insurance on the later of:

- January 1, 2018;
- the date you are eligible for Employee Insurance; and
- the date you acquire your Dependent Children.

You are also eligible for Dependent Children 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 Insurance?
You must enroll within 31 days of the date you are initially eligible for Dependent Children Insurance, or within 31 days of the date of a Family Status Change or during any Enrollment Period.

When does Dependent Children Insurance start?
Dependent Children Insurance starts on the later of:

- the dates we approve your applications for Employee and Dependent Children Insurance and you agree to make any required contribution toward the cost of insurance; and
- the date we approve any required Evidence of Insurability for your Dependent Child,

if you are Actively at Work on that date.

If you are not Actively at Work, your Dependent Children Insurance will not start until you resume being Actively at Work. If the date you resume being Actively at Work is more than 90 days after you applied for Dependent Children Insurance and Evidence of Insurability was required, then you must submit new Evidence of Insurability for your Dependent Children and Dependent Children Insurance will not start until the date we approve your request.

If we do not approve your application for Employee Insurance because of an inability to provide satisfactory Evidence of Insurability, your application for Dependent Children Insurance may still be approved subject to all other Policy provisions.

How can you make changes in Dependent Children Insurance?
During any Enrollment Period after your Dependent Children are covered under the Policy, and you are Actively at Work, you may request a change in your Dependent Children Insurance.

You may also request a change in Dependent Children 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.

When does a change in Dependent Children Insurance start?
If you are Actively at Work, any increase in Dependent Children Insurance or benefits will start on the January 1st following the date of change the date you apply for such change in Dependent Children Insurance and you agree to make any required contribution toward the cost of insurance.

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

Any reduction in Dependent Children Insurance will start immediately following the date of change the date you apply for such change in insurance, whether or not you are Actively at Work.

How can you add a child or children to your Dependent Children 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 without Evidence of Insurability.

How does Dependent Children 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 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 they become your Dependent Child. To continue coverage beyond 31 days you must:

- enroll for Dependent Children 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 contribution toward the cost of Dependent Children Insurance.

If you are insured under the Policy and have Dependent Children 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 Insurance end?
Dependent Children Insurance will end on the earliest of the following dates:

- the date the Policy terminates;
- the date you are no longer in an Eligible Class;
- the date your class is no longer included for insurance;
- the last date for which any required premium has been paid for your insurance or your Dependent Children Insurance;
- the date you request in writing to end your insurance or your Dependent Children Insurance;
- the last date you are Actively at Work, subject to any or Portability provisions;
- the date all benefits paid for a specific Dependent Child reach the maximum amount payable as described herein; and
- the date your Dependent Child no longer meets the definition of Dependent Child as described in this Certificate.

6. BENEFIT PROVISIONS

What benefits are payable?
We will pay you a lump-sum benefit for the insurance in force each time 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.

7. COVERED CONDITIONS

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

CIRCULATORY CONDITIONS CATEGORY

Heart Attack means a confirmed Diagnosis of 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;
- new electrocardiogram (ECG) changes consistent with a Heart Attack; or
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

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, in the absence of new Q waves; 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 (cerebrovascular accident) means a confirmed Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or hemorrhage, or cerebral embolism from an extra-cranial source, with:
- acute onset of new neurological symptoms; and
- new objective neurological deficits on clinical examination which persist for 30 days following the date of Diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing.

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

Exclusions:
Stroke does not include any of the following:
- transient ischemic attacks;
- intracranial vascular events due to trauma; or
- lacunar infarcts which do not meet the definition of stroke as described above.

End-Stage Heart Failure means a confirmed diagnosis of 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.

Coronary Artery Disease means a narrowing or blockage of one or more coronary arteries for which a cardiologist recommends that coronary artery bypass surgery occur within 60 days following the date of the recommendation. For the purposes of this definition, coronary artery bypass surgery is a surgical procedure to bypass a narrowing or blockage of one or more coronary arteries utilizing venous or arterial grafts.

CANCER CONDITIONS CATEGORY

Cancer means a confirmed Diagnosis of a tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The Diagnosis of Cancer must be made by a Specialist Physician.

A Clinical Diagnosis will be accepted only if:

- a pathological Diagnosis cannot be made because it is medically inappropriate or life threatening;
- there is medical evidence to support the Diagnosis; and
- a Physician is treating you for Cancer.

In all other cases, Cancer must be Diagnosed with histopathological confirmation.

Exclusions:
Cancer does not include:

- carcinoma in situ;
- evidence of cancer cells or cancer genetic material detected by molecular or biochemical probes only (including, but not limited, to proteomic or DNA/RNA-based techniques) with no lesion amenable to tissue diagnosis; or
- any non-melanoma skin cancer that has not become metastasized.

No benefit will be payable under this provision for the Non-Life Threatening Cancers listed in the Non-Life Threatening Cancer provision below.

Cancer Benefit Waiting Period:
No benefit will be payable for Cancer and the Insured's insurance for Cancer and Non-Life Threatening Cancer will terminate if, within 30 days following the later of:

- the date we receive enrollment information for the Insured’s insurance; and
- the effective date of the Insured’s insurance,

the Insured has any of the following:

a. signs, symptoms or investigations, that lead to Diagnosis of any cancer (covered or excluded under this insurance), regardless of when the Diagnosis is made, or
b. a Diagnosis of any cancer (covered or excluded under this insurance).

Although the Insured's insurance for Cancer and Non-Life Threatening Cancer terminates, insurance for all other Covered Conditions remains in force.

This information described above must be reported to us within 6 months of the date of Diagnosis. If this information is not provided, we have the right to deny any claim for Cancer or Non-Life Threatening Cancer or any Critical Illness caused by any cancer or its Treatment.

If an Insured's Critical Illness insurance ends and the Insured is covered again under this benefit, we will use the latest date the Insured's insurance began when applying the Cancer Benefit Waiting Period.

Non-Life Threatening Cancer is limited to the following:

- 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);
- Stage A (T1a or T1b) prostate cancer;
- papillary microcarcinoma of the thyroid, which for the purposes of the Policy means a papillary carcinoma of the thyroid (1 cm or less in diameter) and confined to the thyroid;
- noninvasive papillary cancer of the bladder histologically described as TNM classification TaN0M0; and
- ductal carcinoma in situ (DCIS) of the breast.

Non-Life Threatening Cancer must be Diagnosed by a Specialist Physician with histopathological confirmation.

Exclusions:
Non-Life Threatening Cancer does not include any of the following:

- pre-malignant lesions;

- any carcinoma in situ except ductal carcinoma in-situ of the breast; or
- evidence of cancer cells or cancer genetic material detected by molecular or biochemical probes only (including but not limited to proteomic or DNA/RNA-based techniques) with no lesion amenable to tissue diagnosis.

Non-Life Threatening Cancer Benefit Waiting Period:
No benefit will be payable for Cancer and Non-Life Threatening Cancer and the Insured's insurance for Cancer and Non-Life threatening Cancer will terminate if, within 30 days following the later of:

- the date we receive enrollment information for the Insured’s insurance; and
- the effective date of the Insured’s insurance,

the Insured has any of the following:

a. signs, symptoms or investigations, that lead to Diagnosis of any cancer (covered or excluded under this insurance), regardless of when the Diagnosis is made, or
b. Diagnosis of any cancer (covered or excluded under this insurance).

Although the Insured's insurance for Cancer or Non-Life Threatening Cancer terminates, insurance for all other Covered Conditions remains in force.

This information described above must be reported to us within 6 months of the date of Diagnosis. If this information is not provided, we have the right to deny any claim for Cancer or Non-Life Threatening Cancer or any Critical Illness caused by any cancer or its Treatment.

If an Insured's Critical Illness insurance ends and the Insured is covered again under this benefit, we will use the latest date the Insured's insurance began when applying the Non-Life Threatening Cancer Benefit Waiting Period.

OTHER CONDITIONS CATEGORY

Benign Brain Tumor means a confirmed Diagnosis of a non-malignant tumor located in the cranial vault and limited to the brain, meninges, 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:
Benign Brain Tumor does not include pituitary adenomas less than 10 mm. in diameter.

Benign Brain Tumor Benefit Waiting Period:
No benefit will be payable for Benign Brain Tumor and the Insured’s insurance for Benign Brain Tumor will terminate if, within 30 days following the later of:

- the date we receive enrollment information for the person's insurance; and
- the effective date of the person's insurance,

the Insured has any of the following:

a. signs, symptoms or investigations, that lead to Diagnosis of Benign Brain Tumor (covered or excluded under this insurance), regardless of when the Diagnosis is made, or
b. a Diagnosis of Benign Brain Tumor (covered or excluded under this insurance).

Although the Insured’s insurance for Benign Brain Tumor terminates, insurance for all other Covered Conditions remains in force.

This information described above must be reported to us within 6 months of the date of Diagnosis. If this information is not provided, we have the right to deny any claim for Benign Brain Tumor or any Critical Illness caused by Benign Brain Tumor or its Treatment.

If an Insured’s Critical Illness insurance ends and the Insured is covered again under this benefit, we will use the latest date the Insured’s insurance began when applying the Benign Brain Tumor Benefit Waiting Period.

Coma means a confirmed Diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less. The Diagnosis of coma must be made by a Specialist Physician.

Exclusions:
Coma does not include any of the following:
- a medically induced coma; or
- a coma which results directly from alcohol or drug use.

Major Organ Failure means a confirmed Diagnosis by a Specialist Physician of the irreversible end-stage failure of bone marrow, kidney, liver or lung, and:

- for kidney failure only, in the absence of a listing on UNOS, ongoing dialysis (either hemo or peritoneal) on a permanent basis, shall be conclusive proof of irreversible end-stage kidney failure; or
- for all organs listed above, a transplant is recommended as soon as an appropriate donor is located, and the Insured
  - is either listed with the United Network of Organ Sharing (UNOS); or
  - a suitable donor is found without a UNOS listing.

Proof of Major Organ Failure requires:

- submission of medical records documenting major organ failure from a Specialist Physician; and
- except for kidney failure on dialysis, documentation of either:
  - a listing with the United Network of Organ Sharing (UNOS); or
  - that a suitable donor has been found without a UNOS listing.

Major Organ Failure will be deemed to have occurred:

- for kidney failure only, in the absence of a listing on UNOS, ongoing dialysis (either hemo or peritoneal) on a permanent basis, shall be conclusive proof of irreversible end-stage kidney failure, or
- for all organs listed above, the date that the Insured
  - is either listed with the United Network of Organ Sharing (UNOS); or
  - a suitable donor is found without a UNOS listing.

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; and
- autologous bone marrow transplant in which the Insured's own bone marrow is used.

Paralysis for the purposes of the Policy means total and irrecoverable loss of function of two or more limbs as a result of injury to or disease of the spinal cord. The loss must be present for a continuous period of at least 90 days and be expected to be permanent. Limb is defined as the complete arm or the complete leg. The Diagnosis of paralysis must be made by a Specialist Physician.

Severe Burns means a confirmed Diagnosis of third-degree burns over at least 20% 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 confirmed Diagnosis of nonprogressive, neurological defect affecting muscle control. Diagnosis for Cerebral Palsy must be made by a Specialist Physician.

Complex Congenital Heart Disease means a confirmed Diagnosis of 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 life-saving, open heart surgery to survive.

It also means any one of the following specific conditions that require life-saving, open heart surgery to survive:
- aortic stenosis;
- atrial septal defect;
- discrete subvalvular aortic stenosis;
- pulmonary stenosis; or
- ventricular septal defect.

The Diagnosis of Complex Congenital Heart Disease must be made and the surgery must be recommended by a Specialist Physician and supported by cardiac imaging acceptable to us.

Cystic Fibrosis, also known as mucoviscidosis, means the confirmed Diagnosis of a recessive genetic disease affecting most critically the lungs and also the pancreas, liver, and intestine. It is characterized by abnormal transport of chloride and sodium across the epithelium leading to thick viscous secretions. The Diagnosis of cystic fibrosis must be made by a Specialist Physician.

Type 1 Diabetes Mellitus means a confirmed Diagnosis where the Insured has total insulin deficiency and continuous dependence on exogenous insulin for survival. Dependence on insulin must persist for a continuous period of at least three months. The Diagnosis of type 1 diabetes mellitus must be made by a Specialist Physician.

Muscular Dystrophy means a confirmed Diagnosis of one of a group of muscle diseases characterized by progressive skeletal muscle weakness, defects in muscle proteins, and the death of muscle cells and tissue. The confirmed Diagnosis of Muscular Dystrophy must be made by a Specialist Physician.

Childhood Conditions Benefit Waiting Period:
No benefit will be payable for any Childhood Condition and the Insured's insurance for such Childhood Condition will terminate if, within 30 days following the effective date of the Dependent Child's insurance, the Dependent Child has any of the following:

a. signs, symptoms or investigations, that lead to Diagnosis of such Childhood Condition (covered or excluded under this insurance), regardless of when the Diagnosis is made, or
b. a Diagnosis of such Childhood Condition (covered or excluded under this insurance).

Although the Insured's insurance for such Childhood Condition terminates, insurance for all other Covered Conditions remains in force.

This information described above must be reported to us within 6 months of the date of Diagnosis. If this information is not provided, we have the right to deny any claim for a Childhood Condition or any Critical Illness caused by a Childhood Condition or its Treatment.

The Childhood Conditions Benefit Waiting Period does not apply when newborn children, newly placed foster children or newly adopted children are added to your Dependent Children Insurance.

If an Insured's Critical Illness insurance ends and the Insured is covered again under this benefit, we will use the latest date the Insured's insurance began when applying the Childhood Conditions Benefit Waiting Period.

8. LIMITATIONS AND EXCLUSIONS

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:

- intentionally self-inflicted injuries;
- elective plastic or cosmetic surgery;
- active military duty;
- participation in war, declared or undeclared, or any act of war;
- 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;
- being legally intoxicated or under the influence of any narcotic unless taken on the advice of a Physician and taken as prescribed; or
- improper or illegal use of inhalants or huffing.

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.

Pre-Existing Condition means during the 3 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, 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.

What are the maximum benefits payable under this Certificate?
We will only pay one benefit for each Covered Condition shown in the Benefit Highlights. We will not pay more than an aggregate of 100% of the benefits payable for all Covered Conditions in the same Category as shown in the Benefit Highlights. We will not pay more than an aggregate of 200% of the benefits payable for all the Covered Conditions in all Categories shown in the Benefit Highlights.

What happens if you are rehired by your Employer?
If you are rehired by your Employer within 12 months from the day your employment ends your insurance will resume and will be identical to the insurance in effect just prior to your termination of employment including any partially satisfied Eligibility Waiting Period and Pre-Existing Condition limitation, subject to all terms and conditions of the Policy.

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 calendar year during which you or your insured Spouse has any one of the following wellness screening tests performed:

- Breast Cancer Screening (clinical breast exam, mammography, MRI, thermography, ultrasound)
- Colorectal Cancer Screening (fecal occult blood test, colonoscopy, sigmoidoscopy)
- 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)
- Electrocardiogram (ECG)-resting or stress

What is the amount of the wellness screening benefit?
We will pay you $100 each calendar year if any one of the wellness screening tests described in this Certificate is performed for you. We will pay you $100 each calendar year if any one of the wellness screening tests described in this Certificate is performed for your insured Spouse.

What conditions apply to the wellness screening benefit?
To receive this benefit, you must provide us with Proof that the wellness screening test was performed by a Physician, a Specialist Physician or a duly licensed medical practitioner who is deemed by state or provincial law to be qualified to conduct such test. You must send us such Proof no later than 15 months after the date of the wellness screening test was performed.

10. CLAIMS

How is a claim submitted?
To submit a claim, you or someone on your behalf must send us written Notice and Proof of claim 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 60 days after the date of Diagnosis or within 90 days of the 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?
Proof of claim must be given to us no later than 120 days after the date of Diagnosis or Treatment of the Critical Illness.

If Proof cannot be given within these time limits, 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 Critical Illness;
- the date the Diagnosis and/or Treatment occurred; and
- the cause of the Critical Illness.

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 45 days after receipt of the claim. If we cannot make a decision within 45 days after receiving your claim, we will request a 30 day extension as permitted by U.S. Department of Labor regulations. If we cannot render a decision within the extension period, we will request an additional 30 day extension. Any request for extension will specifically explain:

- the standards on which entitlement to benefits is based;
- the unresolved issues that prevent a decision on the claim; and
- the additional information needed to resolve those issues.

If a period of time is extended because you failed to provide necessary information, the period for making the benefit determination is tolled from the date we send notice of the extension to you until the date on which you respond to the request for additional 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 setting forth:

- 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) following an adverse determination on review;
- the identity of an internal rule, guideline, protocol or other similar criterion, if any, that was relied upon to deny the claim and a copy of the rule, guideline, protocol or criterion or a statement that a copy is available free of charge upon request; and
- the 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 180 days after receiving notice of denial.
You may submit written comments, documents, records or other information relating to your claim for benefits, and may request free of charge copies of all documents, records, and other information relevant to your claim for benefits.

We will review the claim on receipt of the written request for review, and will notify you of our decision within a reasonable time but not later than 45 days after the request has been received. If an extension of time is required to process the claim, we will notify you in writing of the special circumstances requiring the extension and the date by which we expect to make a determination on review. The extension cannot exceed a period of 45 days from the end of the initial period.

If a period of time is extended because you failed to provide information necessary to decide your claim, the period for making the decision on review is tolled from the date we send notice of the extension to you until the date on which you respond to the request for additional information. You will have at least 45 days to provide the specified information.

What if your claim is denied on review?
If we deny all or any part of your claim on review, you will receive a written notice of denial setting forth:

- 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);
- the identity of an internal rule, guideline, protocol or other similar criterion, if any, that was relied upon to deny the claim and a copy of the rule, guideline, protocol or criterion or a statement that a copy is available free of charge upon request;
- 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."; and
- the identity of any medical or vocational experts whose advice was obtained in connection with the appeal, regardless of whether the advice was relied upon to deny the appeal.

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:

1. 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;
2. 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 in item 1; or
3. 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 in items 1, 2, or 3 above, is determined by us, 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 lawful spouse, up to a cumulative amount of $5,000; or
- if you have no lawful spouse, up to a cumulative amount of $5,000 to any one or more of the following relatives in the following order of priority:

    1. your child or children; or
    2. your mother or father.

11. INSURANCE CONTINUATION

While the Policy is in force and subject to the conditions stated in the Policy, your Employer may continue your insurance by paying the required premium to us for any of the following reasons and durations:

- Layoff - for up to 7 months
- Leave of Absence - for up to 7 months
- Reduced Hours - for up to 1 month
- Absence due to injury or sickness - for up to 12 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). You should contact your employer for more details.

12. PORTABILITY

What is portability and when are you eligible?
Portability is an optional benefit that you may elect to continue your insurance for each insured 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; and
- the Policy is still in force; and
- you reside in the United States or Canada; and
- you have not exercised your portability right under a similar certificate issued by us; and
- you are under age 70 at the time insurance terminates.

Your new portable insurance will be provided under an insurance policy we make available for this purpose.

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 portable insurance benefit?
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. Your new portable insurance policy will not provide any benefits beyond those described in the section of this Certificate titled Benefit Provisions. Your new portable insurance may not be identical to your current insurance under the Policy.

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.

When is portability available to your Spouse and when is your Spouse eligible?
Portability is available for your Spouse if all of the following requirements are met:

- you die or Divorce your Spouse;
- the Policy is still in force;
- your Spouse resides in the United States or Canada; and
- your Spouse is under age 70 at the time of your death or Divorce.

Your Spouse's new portable insurance will be provided under an insurance policy we make available for this purpose.

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 is available from your Employer.

What is the Spouse's portable insurance benefit?
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 new portable insurance policy will not provide any benefits beyond those described in the section of this Certificate titled Benefit Provisions. Their new portable insurance may not be identical to your current insurance under the Policy.

Your Spouse may not apply for portable insurance for a Dependent Child whose insurance has not terminated under the Policy due to the 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 ("Previous Plan") with the insurance provided by this Certificate and the Policy ("This Plan"), Continuity of Coverage benefits as stated in this Section may be available to you. These benefits will be available as long as the insurance and level of benefits under the Previous Plan were substantially similar to the insurance provided by this Plan.

What if you are not Actively at Work when your Employer replaces your Previous Plan with This Plan?
You will be covered under This Plan if you are not Actively at Work on January 1, 2018: if:

- you were insured under the Previous Plan on the day before January 1, 2018;
- you are a member of an Eligible Class;
- premiums for you are paid up to date; and
- you are not receiving or eligible to receive benefits under the Previous Plan.

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

- the benefit payable under This Plan; or
- the benefit payable under the Previous Plan.

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

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

Do benefit waiting periods apply when your Employer replaces your Previous Plan with This Plan?
We will apply any period of time satisfied under the Previous Plan to meet the requirements of any benefit waiting period toward the satisfaction of the period of time required by This Plan's benefit waiting periods.

14. GENERAL PROVISIONS

ALTERATION

Who can alter this Certificate?
The only persons with the authority to alter or modify this Certificate 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 benefits 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 connection with the Policy or delays in keeping records for the Policy whether by us, the Policyholder, or the Employer:

- will not terminate insurance that would otherwise have been effective.
- will not continue insurance that would otherwise have ceased or should not have been in effect.

If appropriate, a fair adjustment of premium will be made to correct the error, subject to the "Limit of Premium Refunds" section.

This provision does not apply to benefit administration errors by the Policyholder or the Employer which results 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 continuation or portability options.

CONFORMITY WITH STATUTES

What is the effect of Conformity with Statutes?
If any provision of the Policy is in conflict with any applicable law, the provisions of Policy will be automatically amended to meet the minimum requirements of the law and to reflect updated statutory references.

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 own expense, have the right to have any person whose Critical Illness is the basis of a claim:

- examined by a Physician, Specialist Physician, other health professional or vocational expert of our choice; and/or
- interviewed by an authorized representative.

This right may be used as often as reasonably required.

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.

MISSTATEMENT OF FACTS

What happens if there is a misstatement of facts in the administration of the Policy?
If relevant facts about the Employee relating to this insurance are not accurate:

- a fair adjustment of premium will be made, subject to the "Limit of Premium Refunds" section; and
- the true 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.

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 6 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.

NOTICE

How are required notices provided?
Any obligation we may have to give written notice will be satisfied by sending such notice to the last known address of the person or institution entitled to such notice.

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 all Policy requirements must be satisfied.

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.

REINSTATEMENT

What are your rights for reinstatement of insurance?

If your insurance ends for any reason other than you have received the maximum benefits payable under the Policy or you have voluntarily terminated your insurance, then you may apply to reinstate your insurance within 12 months from when your insurance ended. To reinstate your insurance, you must apply 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:

- we approve your application for reinstatement;
- we approve any required Evidence of Insurability;
- you agree to make any required contribution toward the cost of your insurance; and
- you return to being Actively at Work.

New benefit waiting periods will apply upon reinstatement.

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 to your estate representative.

SUN LIFE ASSURANCE COMPANY OF CANADA

RECURRENCE BENEFIT RIDER

This rider is part of the Certificate to which it attaches and is effective on January 1, 2018. It is part of, and subject to, the other terms and conditions of the Certificate. If the terms of this rider and the Certificate conflict, then this rider's provisions will control.

What is the recurrence benefit?
Except as stated below, we will pay you a lump-sum benefit each time any eligible Insured is Diagnosed with a Covered Condition for which we previously paid a benefit. Such Diagnosis must be for a new event while this rider is in effect and not a re-diagnosis of the Covered Condition for which we previously paid a benefit.

No benefit will be payable for any Childhood Conditions.

No benefit will be payable for Coronary Artery Disease.

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.

What conditions apply to the recurrence benefit?
We will pay this benefit only if the date of the new event and subsequent Diagnosis is more than 12 months after the date of the prior Diagnosis of the applicable Covered Condition.

The recurrence benefit for Cancer and Non-Life Threatening Cancer is payable only when:

- there is a Diagnosis of a new Cancer; or
- after the end of all primary treatment for the prior Cancer,
    - a recurrence of the prior Cancer occurs; and
    - the Insured had no evidence of Cancer for any period of at least 12 months prior to the subsequent Diagnosis.

The recurrence benefit for Major Organ Failure and End Stage Heart Failure is payable only if:

- the first failure is corrected by a transplant and the transplant irreversibly failed; and;
- the Insured goes on a waiting list with UNOS as a result of such failure; or
- for end-stage kidney failure, ongoing dialysis on a permanent basis shall be conclusive proof of irreversible failure of the transplanted kidney.

What is the maximum benefit payable under this rider?
We will pay the recurrence benefit for an Insured only once for each applicable Covered Condition. We will not pay more than an aggregate of 100% of the benefit payable for all Covered Conditions in the same Category as shown in the Benefit Highlights. We will not pay more than an aggregate of 200% of the benefit payable for all the Covered Conditions in all Categories shown in Benefit Highlights.

Can you continue the recurrence benefit?
You may continue the recurrence benefit with any insurance continued under the Insurance Continuation and Portability provisions.

When does this rider end?
This rider will end on the earliest of the following to occur:

- the date the Employer elects to terminate this rider;
- the date all benefits paid under the rider reach the maximum amount payable as described herein; and
- the date the Policy terminates.

Dean A. Connor
President and Chief Executive Office

SUN LIFE ASSURANCE COMPANY OF CANADA

Group Critical Illness Insurance Certificate

Critical Illness and Cancer

Non-Participating

Bronson Healthcare Group, Inc. Employee Benefit Plan (The Plan) has been established to provide welfare benefits for its employees.

The Employee Retirement Income Security Act of 1974 (ERISA) requires that the Plan Administrator provide you with a Summary Plan Description which discloses required information about the employee benefit plan. The following section entitled "Summary Plan Description" is not part of the Group Insurance Policy. The information in the Summary Plan Description is provided by the Policyholder and is included in this Booklet/Certificate for your convenience. Sun Life Assurance Company of Canada assumes no responsibility for the accuracy or sufficiency of the information in the Summary Plan Description.

SUMMARY PLAN DESCRIPTION

Plan Sponsor: Bronson Healthcare Group, Inc.
601 John Street
Kalamazoo, MI 49007

Plan Administrator: Bronson Healthcare Group, Inc.
601 John Street
Kalamazoo, MI 49007

The Plan Administrator has authority to control and manage the operation and administration of the Plan.

Agent for Service of Legal Process:

Bronson Healthcare Group, Inc.
601 John Street
Kalamazoo, MI 49007

Employer Identification Number (EIN): 38-2418383

Plan Number: 501

End of Plan Year: December 31st

Type of Administration: The Plan is administered by the Plan Administrator. The benefits provided by the Group Insurance Policy issued by Sun Life Assurance Company of Canada are included in the Plan.

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

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

Contributions: The cost of your benefits under the Plan is paid for by your employer and (if applicable) includes the cost of any insurance premiums contributed by you.

Funding: Sun Life provides the Plan Administrator with certain insurance benefits in connection with the Plan. Those insurance benefits are described in your Booklet/Certificate.

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

If your claim for benefits is denied in whole or in part, you will receive a written notice within the time required by ERISA from the date you filed your claim, stating the reasons why your claim was denied. You will then have the right, upon

written notice from you or your authorized representative, to review that claim denial. The claim denial notice will include the name and address of the person you may ask for such a review. Additional information about claims submitted and review procedures may be obtained by contacting your Plan Administrator.

Your Rights under ERISA:

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

Receive Information About Your Plan and Benefits

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

Assistance with Your Questions

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