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:	928626-002
Policy Effective Date:	June 1, 2019
Policyholder:	RCR Enterprises, LLC
Employer:	RCR Enterprises, LLC
Issue State:	North Carolina

NOTICE TO BUYER: THIS IS A LIMITED BENEFIT HEALTH CERTIFICATE. THIS CERTIFICATE PROVIDES CANCER ONLY COVERAGE AND DOES NOT PAY BENEFITS FOR SICKNESS OR LOSS FROM ANY OTHER CAUSE.

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

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

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

NO RECOVERY FOR PRE-EXISTING DIAGNOSED CANCER — READ CAREFULLY. No benefits will be provided for a Cancer that begins during the first 12 months after the Insured's effective date that is caused or contributed to by a Pre-existing Condition as defined in the Policy.

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

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

Group Cancer Insurance Certificate
Non-Participating

Sun Life Financial®

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1. BENEFIT HIGHLIGHTS

Eligible Classes:	All Full-Time United States Employees working in the United States scheduled to work at least 20 hours per week.
Eligibility Waiting Period:	Until the first of the month coincident with or next following 30 days of employment

1. BENEFIT HIGHLIGHTS

Benefit Coverage Type: Level 1 and Level 2

Covered Benefits

You may be able to select the level of your coverage. If you are eligible to select a level of coverage, the level selected must be the same for both you and your Dependents. Some of the benefits may not apply depending on the level of coverage selected. We will pay the benefits corresponding to the level you selected as shown below.

If you are enrolled for Level 2 benefits, you may reduce your plan of insurance to Level 1 for both you and your Dependents.

Refer to the Covered Cancer Benefits section of this Certificate for additional benefit details. Any limitation or exclusion applies separately to each Insured.

Cancer Losses

	Level 1	Level 2
Cancer Screening: Limited to once per Benefit Year	$50	$75
Hospital Confinement: Limited to 90 days per period of Confinement	$200 per day	$400 per day
Radiation and Chemotherapy:		
Injected Cytotoxic Medications	$300 per Week not to exceed $4,000 per Benefit Year	$1,000 per Week not to exceed $12,000 per Benefit Year
First Prescription Pump Dispensed Cytotoxic Medications	$300 per prescription not to exceed $4,000 per Benefit Year	$1,000 per prescription not to exceed $12,000 per Benefit Year
Refill Pump Dispensed Cytotoxic Medications	$300 per Week not to exceed $4,000 per Benefit Year	$1,000 per Week not to exceed $12,000 per Benefit Year
Oral Cytotoxic Medications	$150 per prescription not to exceed $450 per month	$500 per prescription not to exceed $1,500 per month
Cytotoxic Medications Administration by Any Other Method	$300 per Week not to exceed $4,000 per Benefit Year	$1,000 per Week not to exceed $12,000 per Benefit Year
External Radiation Therapy	$400 per Week not to exceed $4,000 per Benefit Year	$600 per Week not to exceed $12,000 per Benefit Year
Insertion of Interstitial or Intracavity Administration of Radioisotopes or Radium	$450 per Week not to exceed $4,000 per Benefit Year	$750 per Week not to exceed $12,000 per Benefit Year
Oral or I.V. Radiation	$400 per Week not to exceed $4,000 per Benefit Year	$600 per Week not to exceed $12,000 per Benefit Year

1. BENEFIT HIGHLIGHTS

In Hospital Blood and Plasma:	Actual charges up to $50 per day, including fees for administering the blood	Actual charges up to $50 per day, including fees for administering the blood
Outpatient Blood and Plasma:	Actual charges up to $50 per day, including fees for administering the blood	Actual charges up to $50 per day, including fees for administering the blood
Extended Care Facility: Limited to a maximum of 90 days per Benefit Year	$200 per day	$200 per day
Hospice: Limited to a maximum of 100 days per Lifetime	$100 per day	$100 per day
In-hospital Physician Visits: Limited to a maximum of 75 visits	$25 per daily visit	$25 per daily visit
Post-hospital Physician Visits: Limited to once every 6 months not to exceed 5 years after the Diagnosis of Cancer	Not Covered	$50 per visit
Prosthesis:		
Surgically Implanted Devices	$2,000 per device not to exceed a Lifetime maximum of $4,000	$3,000 per device not to exceed a Lifetime maximum of $6,000
Other Devices	$200 per device not to exceed a Lifetime maximum of $400	$300 per device not to exceed a Lifetime maximum of $600
Ambulance Benefit: Limited to 2 one-way trips per period of Confinement, including transportation from one medical facility to another	$250	$250 Ground $2,000 Air
Lodging: Limited to 1 benefit per day not to exceed a maximum of 90 days per Benefit Year	Not Covered	$100 per day
Second Surgical Opinion: Limited to once per surgical procedure	$200	$200
Skin Cancer:		
Biopsy Only	$100	$100
Reconstructive surgery following previous excision of skin Cancer	$250	$250
Excision of skin Cancer without flap or graft	$375	$375
Excision of skin Cancer with flap or graft	$600	$600

Surgery and Anesthesia for Internal Cancer:

Limited to a combined maximum of $2,000 for Level 1 for one operation

Limited to a combined maximum of $7,500 for Level 2 for one operation

Procedure	Level 1 and 2 Anesthesia Benefit	Level 1 and 2 Surgical Benefit
Mandible-Mandibulectomy	$760	$2,300
Misc- Pathological hip fracture	$400	$1,200
Breast – Needle biopsy	$50	$150
Breast – Excisional biopsy	$50	$150
Breast - Lumpectomy	$100	$300
Breast - Mastectomy partial	$100	$300
Breast - Mastectomy simple	$180	$550
Breast - Mastectomy radical	$400	$1,200
Throat - Laryngectomy (without neck dissection)	$365	$1,100
Throat - Laryngectomy (with neck dissection)	$730	$2,200
Throat - Laryngoscopy	$50	$150
Throat - Tracheostomy	$50	$150
Chest - Bronchoscopy	$70	$200
Chest - Thoracentesis	$50	$150
Chest - Thoracostomy	$50	$150
Chest - Thoracotomy	$165	$500
Chest - Pneumonectomy	$400	$1,200
Chest - Lobectomy	$365	$1,100
Chest - Wedge resection	$250	$750
Misc – Venous-catheters/venous port (chemo)	$50	$150
Misc – Bone marrow biopsy or aspiration	$50	$150
Lymphatic – Splenectomy	$225	$675
Lymphatic – Excision or biopsy of a single lymph node	$60	$175
Lymphatic - Lymphadenectomy (bilateral)	$365	$1,100
Lymphatic - Lymphadenectomy (unilateral)	$255	$775
Lymphatic - Axillary node dissection	$215	$650
Chest - Mediastinoscopy	$100	$300
Mouth - Hemiglossectomy	$115	$350
Mouth - Glossectomy	$430	$1,300
Mouth – Resection of palate	$200	$600
Salivary glands - Biopsy	$50	$150
Salivary glands - Parotidectomy	$300	$900
Salivary glands – Radical neck dissection	$730	$2,200
Mouth – Tonsil/Mucous membranes	$290	$875
Esophagus – Resection of esophagus	$305	$925
Esophagus – Esophagoscopy	$50	$150
Stomach – Gastroscopy	$75	$225
Intestines - ERCP	$135	$400
Esophagus – Esophagogastrectomy	$1,155	$3,500
Stomach - Gastrectomy (complete)	$430	$1,300
Stomach - Gastrectomy (partial)	$325	$975
Stomach - Gastrojejunostomy	$265	$800

1. BENEFIT HIGHLIGHTS

Procedure	Level 1 and 2 Anesthesia Benefit	Level 1 and 2 Surgical Benefit
Intestines - Resection of small intestine	$305	$925
Intestines - Colectomy	$265	$800
Intestines - Ileostomy	$250	$750
Intestines - Colostomy/or revision of	$200	$600
Intestines - Excision on rectum for biopsy	$70	$200
Intestines - Abdominal-perineal resection	$400	$1,200
Intestines - Proctosigmoidoscopy	$50	$150
Intestines – Sigmoidoscopy	$50	$150
Intestines – Colonoscopy (does not include virtual or CT Colonography)	$85	$250
Liver – Needle biopsy	$50	$150
Liver – Wedge biopsy	$175	$525
Liver – Resection of liver	$1,090	$3,300
Abdomen - Cholecystectomy	$250	$750
Pancreas - Pancreatectomy	$400	$1,200
Pancreas - Whipple procedure	$1,520	$4,600
Pancreas - Jejunostomy	$530	$1,600
Abdomen – Exploratory laparotomy	$175	$525
Abdomen – Paracentesis	$50	$150
Kidney –Nephrectomy (simple)	$300	$900
Kidney - Nephrectomy (radical)	$530	$1,600
Bladder - Cystectomy (partial)	$250	$750
Bladder - Cystectomy (complete)	$1,485	$4,500
Bladder - Cystectomy (with ureteroileal conduit)	$1,815	$5,500
Prostate - Cystoscopy	$50	$150
Bladder – Cystoscopy	$50	$150
Bladder - (TUR) transurethral resection bladder tumors	$135	$400
Prostate – (TUR) transurethral resection prostate	$265	$800
Penis – amputation, partial	$175	$525
Penis – amputation, complete	$265	$800
Penis - amputation, radical	$430	$1,300
Testis - Orchiectomy (unilateral)	$110	$325
Testis - Orchiectomy (bilateral)	$165	$500
Prostate – Needle biopsy	$50	$150
Prostate – Radical prostatectomy	$565	$1,700
Vulva - Vulvectomy (partial)	$190	$575
Vulva - Vulvectomy (radical)	$235	$700
Female Reproductive - Colposcopy	$50	$150
Female Reproductive - D & C	$60	$175
Female Reproductive - Abdominal hysterectomy/uterus only	$400	$1,200
Female Reproductive - Uterus, tubes & ovaries with total pelvic exenteration	$1,650	$5,000
Female Reproductive - Vaginal hysterectomy/uterus only	$330	$1,000
Female Reproductive - Oophorectomy	$190	$575
Female Reproductive - Uterus, tubes & ovaries	$500	$1,500
Thyroid - Thyroidectomy (partial: one lobe)	$265	$800
Thyroid - Thyroidectomy (total: both lobes)	$430	$1,300
Brain - Burr holes not followed by surgery	$200	$600
Brain - Exploratory craniotomy	$695	$2,100
Brain - Excision brain tumor	$1,090	$3,300
Brain - Ventriculoperitoneal shunt	$530	$1,600

1. BENEFIT HIGHLIGHTS

Procedure	Level 1 and 2 Anesthesia Benefit	Level 1 and 2 Surgical Benefit
Spine - Cordotomy	$430	$1,300
Spine - Laminectomy	$1090	$3,300
Eye - Enucleation	$265	$800
Soft Tissue Tumor (sarcoma) - Simple biopsy	$15	$50
Soft Tissue Tumor (sarcoma) - Simple tumor extraction without graft	$125	$375
Soft Tissue Tumor (sarcoma) - Complex excision with reconstructive surgery	$200	$600
Soft Tissue Tumor (sarcoma) - Skin graft following complex excision	$330	$1,000
Soft Tissue Tumor (sarcoma) - Limb amputation	$665	$2,000
Radium Implants - Insertion	$365	$1,100
Radium Implants - Removal	$200	$600

	Level 1	Level 2
First Occurrence: Limited to once per Lifetime	Not Covered	$5,000
Alternative Care:		
Integrative Assessment and Education Benefit Limited to a one time benefit	Not Covered	$150
Palliative Care Benefit Limited to 20 visits per Benefit Year Lifetime maximum of 2 Benefit Years	Not Covered	$50 per visit
Lifestyle Benefit Limited to 20 visits per Benefit Year Lifetime maximum of 2 Benefit Years	Not Covered	$50 per visit
Experimental Treatment:		
Oral, Injected or Pump Dispensed Medications	Not Covered	$150 per day $1,050 per month
Medical Imaging: Limited to twice per Benefit Year	Not Covered	$100
National Cancer Institute Evaluation/Consultation: Limited to once per Lifetime	Not Covered	$500
Anti-nausea:	Not Covered	$100 per month

1. BENEFIT HIGHLIGHTS

Bone Marrow Transplant: Limited to once per Lifetime*	Not Covered	$10,000 for each Insured $1,500 to the bone marrow donor
Stem Cell Transplant: Limited to once per Lifetime*	Not Covered	$2,500
*Benefits will only be paid once per Lifetime for either a Bone Marrow Transplant or Stem Cell Transplant, not both.		
Immunotherapy:	Not Covered	$450 per month not to exceed a Lifetime maximum of $3,500
Home Health Care: Limited to a maximum of 10 visits after any period of Confinement not to exceed a maximum of 30 visits per Benefit Year	Not Covered	$50 per visit
Nursing Services: Limited to 30 days per Benefit Year	Not Covered	$125 per day
Transportation: Limited to 3 round trips per Benefit Year	Not Covered	$500 per round trip
Reconstructive Surgery:		
Breast Symmetry (modification of the non-cancerous breast performed within 5 years of reconstructing the cancerous breast)	Not Covered	$350
Breast Reconstruction	Not Covered	$700
Facial Reconstruction	Not Covered	$700
Breast Transverse Rectus Abdominis Myocutaneous (TRAM) Flap	Not Covered	$2,500
In addition, we will pay 30% of the amounts shown above for Anesthesia during these procedures.		
Outpatient Hospital Surgical: Limited to 3 days per procedure	Not Covered	$250 per day

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

2. DEFINITIONS

Accredited Practitioner means a Naturopathic Physician, Ayurvedic Practitioner, Acupuncturist, Bio-feedback Practitioner, Hypnotherapist, or Massage Therapist who is licensed (if applicable) under the laws of the state where Treatment is received as qualified to treat the type of condition for which a claim is made. If licensed, the practitioner must be practicing within the scope of his or her license.

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 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.

You are 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.

Acupuncture means a therapy that involves puncture with long thin needles into established body points for symptom relief or for Anesthesia.

Acupuncturist means an Accredited Practitioner who has been trained and certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). He or she may be called "Diplomat in Acupuncture (NCCAOM)" or represented as "National Board Certified in Acupuncture (NCCAOM)" and is currently licensed, if required, in the state that he or she practices.

Ambulatory Surgical Center means a licensed or accredited facility that provides medical or surgical intervention requiring care for immediate (day of procedure), pre-procedure and immediate post-procedure care. The total length of care is less than 24 hours. A Physician must be directly involved in the care.

Anesthesia means the administration of anesthetic drugs used during a medical or surgical procedure.

Ayurvedic Medicine means a practice of health promotion, disease prevention, and personal growth that includes physical, psychological and spiritual aspects. Ayurvedic practices are intended to promote well being and reduce stress and may include yoga, meditation, massage, dietary changes and herbs.

Ayurvedic Practitioner means an Accredited Practitioner who has been certified through the American Association of Drugless Accredited Practitioners for Ayurvedic Medicine.

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

Bio-feedback means a therapy that trains and uses the mind to control body functions that are typically regulated automatically such as muscle tension, heart rate, blood pressure or temperature.

Bio-feedback Practitioner means an Accredited Practitioner who has a bachelor's degree in a health related profession, such as a degree in medicine, osteopathy or Naturopathic medicine and who has received certification from the Biofeedback Society of America and is currently licensed in the state that he or she practices.

2. DEFINITIONS

Bone Marrow Transplant means a procedure in which a patient's bone marrow is replaced with cellular elements to reconstitute the bone marrow. It may be preceded by chemotherapy, radiotherapy or other Treatments which cause residual bone marrow to be destroyed. The collection of stem cells or other peripheral blood cells and their later reinfusion is not a Bone Marrow Transplant.

Cancer means the Insured has been Diagnosed with a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells in any part of the body. This includes leukemia, Hodgkin's disease, lymphoma, sarcoma, malignant tumors, myelodysplastic blood disorder, myeloprolifertive blood disorders and melanoma. Cancer includes carcinomas in situ (in the natural or normal place, confined to the site of origin without having invaded neighboring tissue). Pre-malignant conditions or conditions with malignant potential, such as myelodysplastic and myeloproliferative disorders, leukoplakia, hyperplasia, and nonmalignant skin lesions will not be considered Cancer.

Chemotherapy means chemotherapeutic medications prescribed by a Physician for Diagnosed Cancer and that cause cell damage primarily by targeting cell growth. These medications do not include Immunotherapy.

Clinic means an institution, building or part of a building where Outpatients receive Treatment for Diagnoses.

Confined or Confinement means on the advice of a Physician, the assignment of a person to a bed as a resident inpatient in a Hospital for not less than 24 continuous hours. There must be a charge for room and board.

Contributory means you pay all or part of the premium.

Cytotoxic means chemotherapeutic medications prescribed by a Physician for Diagnosed Cancer and that cause cell damage primarily by targeting cell growth. These medications do not include Immunotherapy, hormones, or hormone antagonists.

Dependent means your insured Spouse and Dependent Children.

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

Dependent Child includes:

- your step-child;
- a child for whom coverage is required pursuant to a Qualified Medical Child Support Order or other court or administrative order;
- your grandchild who is a dependent for federal income tax purposes at the time application for coverage for such child is made;
- a foster child placed with you by a licensed agency;
- a child for whom you have or your Spouse has legal guardianship of the child's person;
- your adopted child, including any child placed with you for adoption, regardless of whether or not the adoption decree is final;
- a child of your Spouse.

If an unmarried child is age 26 or older and is:

- incapable of self-sustaining employment because of a mental or physical handicap; and
- chiefly dependent on you for support;

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

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

2. DEFINITIONS

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; or
  - is a full-time student attending school outside of 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. If a pathological Diagnosis cannot be made but the medical evidence substantially documents the Diagnosis of Cancer and the Insured receives a definitive Treatment for Cancer, the Diagnosis of Cancer will be accepted. If the pathological Diagnosis of Cancer is made postmortem, the Diagnosis will be accepted retroactively beginning with the date of the terminal Hospital admission for not less than 45 days prior to the date of death.

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 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;
- who is a U.S. citizen or a U.S. resident;
- scheduled to work at least the minimum hours shown in the Benefit Highlights;
- paid regular earnings in accordance with applicable state and federal wage and hour laws; and
- has a legitimate federal tax identification number.

Employee does not include a seasonal or temporary employee whose annual work schedule is less than 12 months during a calendar year.

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

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

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

Extended-care Facility means an accredited medical institution that provides prolonged skilled nursing or medical care including a skilled nursing facility, a rehabilitation unit or facility, a transition care unit or any bed designated as a swing bed, or to a section of the Hospital used in that manner as approved by Medicare. It does not include any institution which is primarily for the care and Treatment of mental disease.

2. DEFINITIONS

Family Member means: (a) your Spouse, civil union partner or domestic partner and (b) the following relatives of you or your Spouse, civil union partner or domestic partner: (1) parent; (2) grandparent; (3) child; (4) grandchild; (5) brother; (6) sister; (7) aunt; (8) uncle; (9) first cousin; (10) nephew or niece. This includes adopted, in-law and step-relatives.

Family Status Change means one of the following events:

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

Hospice means an organization that provides medical services in an Inpatient, Outpatient or home setting to support and care for persons who are terminally ill with a life expectancy of 6 months or less as certified by a Physician. A Hospice must meet all of the following requirements:

- Comply with all state licensing requirements.
- Be Medicare certified and/or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
- Provide a Treatment plan and services under the direction of a Physician.
- An Inpatient Hospice facility must meet all of the following requirements in addition to the requirements above:
    - Be a dedicated unit within an Acute Medical Facility or a Subacute Rehabilitation Facility or a separate facility that provides Hospice services on an Inpatient basis.
    - Be licensed by the state in which the services are rendered to provide Inpatient Hospice services.
    - Be staffed by an on call Physician 24 hours per day.
    - Provide nursing services supervised by an on duty registered nurse 24 hours per day.
    - Maintain daily clinical records.
    - Admit patients who have a terminal illness.
    - Not provide patients with services that involve active intervention for the terminal illness although ongoing care for comorbid conditions and Palliative Care for the terminal illness may be provided.

Hospital means a facility licensed in the applicable jurisdiction, including a State tax-supported institution, that provides medical care and Treatment to sick and injured persons on an Inpatient basis with 24 hour nursing service by or under the supervision of a Physician. Hospital does not include: (1) a rest home; (2) a skilled nursing facility; (3) an extended care facility; (4) a place of convalescence; (5) rehabilitative care; (6) custodial care; or (7) a place primarily for the Treatment of drug addiction or alcoholism.

Hypnotherapist means an Accredited Practitioner who has been certified by the American Board of Hypnotherapy or the American Clinical Board of Hypnotherapy.

Hypnosis means a change in a person's conscious awareness, induced by another person, which may alter memory and consciousness, increase susceptibility to suggestion, and bring about responses and ideas that may be considered unusual.

2. DEFINITIONS

Immunotherapy means Treatments intended to improve the immune system by providing antibodies, colony stimulating factors, or immunoglobulins or the equivalent for the purpose of treating Cancer.

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.

Inpatient means a patient who is admitted to a Hospital for an Injury or Sickness.

Insured means any person covered under the Policy.

Internal Cancer means a Cancer contained within the body. Internal Cancers do not include Cancers of the skin except for malignant melanoma skin cancer which must be greater than 1.0 in thickness unless it is ulcerated or accompanied by lymph node or distant metastasis.

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

Layoff means that you are temporarily not Actively at Work for a period of time your Employer agreed to in Writing. Your normal vacation time is not considered a temporary Layoff.

Leave of Absence means that you are temporarily not Actively at Work for a period of time your Employer agreed to in Writing. Your normal vacation time is not considered a temporary Leave of Absence.

Lifetime means the period of time you or your Dependent is alive.

Massage Therapist means an Accredited Practitioner who is a graduate of a program accredited by the American Massage Therapy Association and has completed the National Certification Exam.

Massage Therapy means the manipulation of the soft tissue of the body with the objective of normalizing the tissue. Forms of Massage Therapy are limited to sports massage, manual lymph drainage, Swedish massage, deep tissue massage, and neuro-muscular massage.

Mental Illness means a mental disorder as listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, as published by the American Psychiatric Association. A Mental Illness, as so defined, may be related to or be caused by physical or biological factors, or result in physical symptoms or expressions.

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.

2. DEFINITIONS

Naturopathic Physician means an Accredited Practitioner who has graduated from a four year naturopathic medical school, which is accredited by the Council on Naturopathic Medical Education.

Naturopathic Treatment means the services and Treatments used by a Naturopathic Physician in the course of Treatment for a covered illness.

Naturopathy/naturopathic means the art, science, philosophy and practice of Diagnosis, Treatment and prevention of illness, using the least invasive, most physiologically supportive method possible. The practice of Naturopathy identifies and treats the cause of an illness or disease rather than the symptoms of an illness and usually includes a plan of prevention that includes education and alteration of mental, emotional, genetic, social, spiritual and other lifestyle factors.

NCI-designated Cancer Center means a facility, having a current National Cancer Institute (NCI) designation, that provides Treatment for or research concerning Cancer.

NCI-listed means a Cancer Treatment protocol that is listed in the National Cancer Institute's (NCI) Physician Data Query (PDQ) or its equivalent. The PDQ is an online database that contains Cancer information summaries, listings of clinical trials, and directories of Physicians and organizations involved in Cancer care.

Outpatient means a patient who is not admitted to a Hospital but instead is cared for elsewhere such as a Physician's office, Clinic, or day surgery center for an Injury or Sickness.

Palliative Care means Treatment or services designed to reduce the severity of a condition or symptoms without curing the underlying disease.

Physician means a person who is operating within the scope of his or her license and is either:

- licensed in the United States or Canada as a medical doctor and authorized to practice medicine and prescribe and administer drugs or to perform surgery; or
- any other duly licensed medical practitioner who is deemed by applicable state or provincial law to have the same authority as a legally qualified medical doctor.

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

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

Policyholder means the entity to which the Policy is issued.

Prior Policy means the group insurance policy(ies) for Cancer Insurance issued to the Policyholder that was in effect immediately prior to the Policy.

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

Prosthesis means the replacement of a missing or defective part by an artificial substitute, such as an artificial extremity, an artificial organ or part.

Sickness means disease or illness, Mental Illness, drug and alcohol illness or pregnancy.

2. DEFINITIONS

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 Physician 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 a partner in a civil union.

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 your Spouse who resides with you while you are on a temporary work assignment outside the United States.

Stem Cell Transplant means the delivery of autologous or allogeneic stem cells to a person who has received chemotherapy or radiation to treat Internal Cancer. This definition does not include allogeneic or autogeneic bone marrow collection and infusion of bone marrow under Anesthesia.

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

Week means a calendar period of seven consecutive days, beginning on 12:00 a.m. Sunday and ending on 11:59 p.m. Saturday.

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

Written or Writing means a record which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

You, Your (you, your) means an Employee who is eligible for insurance under the Policy.

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF EMPLOYEE INSURANCE

When are you eligible for Employee Cancer Insurance?
You are initially eligible for Employee Cancer Insurance on the latest of:

- June 1, 2019;
- the first day of the month coincident with or next following the date your Eligibility Waiting Period ends;
- the date you first are Actively at Work in an Eligible Class.

You are also eligible for Employee Cancer 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 Cancer Insurance?
You must enroll within 90 days of the date you are initially eligible for Employee Cancer Insurance or within 31 days of the date of a Family Status Change or during any Enrollment Period otherwise you will be considered a Late Entrant.

If you refuse your insurance and do not enroll when you are eligible, then you will not be allowed to enroll until the next Enrollment Period.

When does Employee Cancer Insurance start?
Employee Cancer 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;

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.

When can you make changes in Employee Cancer Insurance?
You may request a change in your Employee Cancer Insurance benefit elections during any Enrollment Period while the Policy is in force.

You may also request a change in Employee Cancer 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 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 Cancer Insurance plan as shown in the Benefit Highlights.

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF EMPLOYEE INSURANCE

When does a change in Employee Cancer Insurance start?
If you are Actively at Work, any increase in Employee Cancer Insurance or benefits, for reasons other than a Family Status Change will start on the June 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.

If you are not Actively at Work on that date, any increase in Employee Cancer 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 Cancer Insurance or benefits for reasons other than a Family Status Change will start on the date of change, when you apply for a different coverage option.

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

- the date you apply for such change in Employee Cancer Insurance 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 Cancer 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 Cancer Insurance or benefits due to a Family Status Change will start on the date of your Family Status Change.

Any change in Employee Cancer Insurance will only affect benefits for a Covered Cancer Benefit that occurs after the effective date of the change.

What happens if you are rehired by your Employer?
If you are rehired by your Employer within 12 months of the date your employment ends, your insurance may be reactivated. Your reactivated insurance will:

- be the same insurance for which you were insured prior to termination of employment;
- be subject to all the terms and provisions of the Policy.

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

If you had partially satisfied your Eligibility Waiting Period prior to your termination of employment, your previous time employed with your Employer will count towards completion of your Eligibility Waiting Period. Your Eligibility Date will be the later of the date you are rehired or the day after you complete the Eligibility Waiting Period.

If you are rehired by your Employer 12 months or later after the date your employment terminates, your coverage will not be reactivated. You will be eligible for insurance on the day after you complete a new Eligibility Waiting Period.

You must re-enroll within 31 days of your rehire date.

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

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF EMPLOYEE INSURANCE

When does Employee Cancer Insurance end?
Your Employee Cancer 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 Cancer Insurance or any part of your insurance;
- the date you request in Writing to cancel your Employee Cancer Insurance; or
- the date you die.

Your Employee Cancer Insurance will also end when any of the following occur, but coverage may be extended subject to any allowed continuation as specified in the Insurance Continuation section:

- the date you are no longer in an Eligible Class;
- the date you enter active duty in any armed service;
- the date you retire;
- the date your class is no longer included for insurance; or
- the last day you are Actively at Work, subject to any applicable Portability provision provided.

If your coverage has ended, can it be reinstated?
If your Employee Cancer Insurance ends for any reason other than you have voluntarily terminated your insurance, then your insurance may be reinstated within 12 months from when your insurance ended. To reinstate your insurance, you must submit a Written request within 31 days after you return to being Actively at Work in an Eligible Class. Reinstatement will be effective on the 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, service or Treatment for Cancer occurring between your termination date and your reinstatement effective date will not be considered a Covered Cancer Benefit.

A new Eligibility Waiting Period will not apply.

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

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

4. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE

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

You are also eligible for Spouse Cancer 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 Cancer Insurance?
You must enroll within 90 days of the date you are initially eligible for Spouse Cancer Insurance as long as you are Actively at Work or within 31 days of the date of a Family Status Change or during any Enrollment Period otherwise you will be considered a Late Entrant.

When does Spouse Cancer Insurance start?
Spouse Cancer Insurance starts on the latest of the date:
- you are eligible for Spouse Cancer Insurance;
- you are insured under the Policy for Employee Cancer Insurance; or
- you enroll for Spouse Cancer Insurance and you agree to make any required contribution toward the cost of insurance;

if 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 Cancer Insurance will not start until you resume being Actively at Work.

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

When can you make changes in Spouse Cancer Insurance?
You may request a change in your Spouse Cancer Insurance benefit elections during any Enrollment Period while the Policy is in force.

You may also request a change in Spouse Cancer 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 increase in Spouse Cancer 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 Cancer Insurance plan as shown in the Benefit Highlights.

4. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE

When does a change in Spouse Cancer Insurance start?
If you are Actively at Work, any increase in Spouse Cancer Insurance or benefits, for reasons other than a Family Status Change, will start on the June 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.

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

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

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

If you are Actively at Work, any increase in Spouse Cancer Insurance or benefits due to a Family Status Change will start on the later of:
- the date you apply for such change in Spouse Cancer Insurance and you agree to make any required contribution toward the cost of insurance; or
- the date of your Family Status Change.

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

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

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

Any change in Spouse Cancer Insurance will only affect benefits for a Covered Cancer Benefit that occurs after the effective date of the change.

When does Spouse Cancer Insurance end?
Spouse Cancer 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 Cancer Insurance or any part of your insurance or your Spouse Cancer Insurance;
- the date you request in Writing to cancel your Spouse Cancer Insurance;
- the date you die; or
- the date your Spouse dies.

Your Spouse Cancer Insurance will also end when any of the following occur, but coverage may be extended subject to any allowed continuation as specified in the Insurance Continuation section:
- the date you are no longer in an Eligible Class;
- the date you are no longer insured under the Policy;
- the date your Spouse no longer meets the definition of Spouse as described in this Certificate;
- the date your Spouse enters active duty in any armed service;
- the date you retire;
- the date your class is no longer included for insurance; or
- the last day you are Actively at Work, subject to any applicable Portability provision provided.

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

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

- June 1, 2019; or
- the date you are eligible for Employee Cancer Insurance; or
- the date you acquire your Dependent Children.

You are also eligible for Dependent Children Cancer 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 Cancer Insurance?
You must enroll within 90 days of the date you are initially eligible for Dependent Children Cancer Insurance as long as you are Actively at Work on that date or within 31 days of the date of a Family Status Change or during any Enrollment Period otherwise you will be considered a Late Entrant. However, if you enroll a Dependent Child pursuant to a court or administrative order, such Dependent Child will not be subject to this requirement.

When does Dependent Children Cancer Insurance start?
Dependent Children Cancer Insurance starts on the latest of the date:

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

if you are Actively at Work on that date and your Dependent Children are not confined on that date.

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

If your Dependent Children are Confined on the date your Dependent Children Cancer Insurance would normally start, your Dependent Children Cancer Insurance will not start until your Dependent Children are no longer Confined. Confinement does not apply to a newborn child, newly placed foster child or a newly adopted child.

When can you make changes in Dependent Children Cancer Insurance?
You may request a change in your Dependent Children Cancer Insurance benefit elections during any Enrollment Period while the Policy is in force.

You may also request a change in Dependent Children Cancer 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 increase in Dependent Children Cancer 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 Cancer Insurance plan as shown in the Benefit Highlights.

When does a change in Dependent Children Cancer Insurance start?
If you are Actively at Work, any increase in Dependent Children Cancer Insurance or benefits, for reasons other than a Family Status Change, will start on the June 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.

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

If your Dependent Child is Confined on that date, your increase in Dependent Children Cancer 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 Cancer 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 Cancer Insurance or benefits for reasons other than a Family Status Change will start on the date of change, when you apply for a different coverage option.

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

- the date you apply for such change in Dependent Children Cancer Insurance and you agree to make any required contribution toward the cost of insurance; or
- the date of your Family Status Change.

If your Dependent Child is Confined on that date, your increase in Dependent Children Cancer 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 due to a Family Status Change in Dependent Children Cancer 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 Cancer Insurance or benefits due to a Family Status Change will start on the date of your Family Status Change.

Any change in insurance for your Dependent Children will only affect benefits for a Covered Cancer Benefit that occurs after the effective date of the change.

How can you add a child or children to your Dependent Children Cancer 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 Cancer 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 Cancer 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 Cancer 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 Cancer Insurance.

If you are covered under the Policy and have Dependent Children Cancer 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.

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

When does Dependent Children Cancer Insurance end?

Dependent Children Cancer 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 Cancer Insurance or any part of the insurance;
- the date you request in Writing to cancel your Dependent Children Cancer Insurance;
- the date you die; or
- the date your Dependent Child dies.

Your Dependent Children Cancer 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 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;
- 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. COVERED CANCER BENEFITS

We will pay the Covered Benefit amounts shown in the Benefit Highlights if the Insured is Diagnosed with Cancer and receives services or Treatment for Cancer while covered under the Policy. Any benefits are subject to the provisions of the Policy.

Some of the benefits described in the Policy may not apply depending on the level of coverage selected. A covered loss must occur while the Insured is covered under the Policy. A Covered Benefit is subject to the limitations and exclusions described in this certificate. Any required premiums must continue to be paid, either under the Policy or under the group portability policy, if eligible, for benefits to be paid.

If any of the benefits below require a charge and the Insured is not charged because the facility is a United States government facility, then we will pay the Covered Benefit amounts shown in the Benefit Highlights.

Cancer Screening

We will pay the Cancer Screening amount shown in the Benefit Highlights if you provide proof satisfactory to us that you or your Dependent was tested for Internal Cancer and charged for undergoing a 1) colonoscopy, 2) CA 125 test, 3) chest x-ray, 4) flexible sigmoidoscopy, 5) mammogram, 6) pap smear, 7) biopsy, 8) PSA, 9) CT scans or MRI scans, 10) BRCA testing, or 11) Hemocult stool specimen while covered under the Policy. We will pay this benefit only once per Benefit Year for each Insured regardless of whether multiple tests are performed. The benefit will be paid even if Internal Cancer is not Diagnosed. In order to receive this benefit, you must submit proof that the Internal Cancer screening test was performed by providing us with documentation from your Physician.

Hospital Confinement

We will pay the Hospital Confinement amount shown in the Benefit Highlights for each day during a period of Confinement in which you or your Dependent is Confined as an Inpatient for the Treatment of Internal Cancer. This benefit is limited to 90 days per period of Confinement.

Radiation and Chemotherapy

If the Insured receives Cytotoxic medications or radiation administered by medical personnel in a Hospital, Clinic or Physician's office as Internal Cancer Treatment for the purpose of changing or destroying abnormal tissue, then we will pay the Radiation and Chemotherapy benefits described below.

If the Insured receives and is charged for an injected Cytotoxic medication (approved by the FDA or NCI-listed) as Internal Cancer Treatment for the purpose of destroying or changing abnormal tissue, then we will pay the amount shown in the Benefit Highlights for each Week in which the Insured receives such Treatment, not to exceed the maximum per Benefit Year shown in the Benefit Highlights for all medications.

If the Insured receives and is charged for Cytotoxic Internal Cancer Treatment medications (approved by the FDA or NCI-listed) dispersed by a pump or implant for the purpose of destroying or changing abnormal tissue, then we will pay the amount shown in the Benefit Highlights for the first prescription and for each Week in which the Insured receives a pump refill, not to exceed the maximum per Benefit Year shown in the Benefit Highlights. This benefit is in addition to Surgical/Anesthesia benefits that may also be available for installing or removing the device. Benefits are not based on the number of days of continuous infusion of the medications pumped.

If the Insured receives and is charged for Cytotoxic Internal Cancer Treatment medications (approved by the FDA or NCI-listed) administered orally at any location, we will pay the amount shown in the Benefit Highlights for each prescription not to exceed the maximum per month shown in the Benefit Highlights for all prescriptions.

If the Insured receives and is charged for external radiation Internal Cancer Treatment therapy administered for the purpose of destroying or changing abnormal tissue, we will pay the amount shown in the Benefit Highlights for each Week the external radiation is administered not to exceed the maximum per Benefit Year shown in the Benefit Highlights. Benefits will not be based on the length of time the radium or radioisotope stays in the body.

If the Insured is charged for the insertion of interstitial or intracavity administration of radioisotopes or radium Internal Cancer Treatments for the purpose of destroying or changing abnormal tissue, we will pay the amount shown in the Benefit Highlights for each Week in which an insertion is performed, not to exceed the maximum per Benefit Year shown in the Benefit Highlights. This benefit is in addition to surgical/Anesthesia benefits which may also be available for insertion or removal of radiation delivery devices.

If the Insured receives and is charged for Cytotoxic Internal Cancer Treatment medications (approved by the FDA or NCI-listed) administered by any other method or radiation (approved by the FDA or NCI-listed) administered orally or intravenously (I.V.), we will pay benefits for each W*eek* in which the Insured receives such Treatment, not to exceed the maximum per Benefit Year shown in the Benefit Highlights.

We will not pay benefits for Treatment planning, therapeutic devices, Immunotherapy, laboratory tests, diagnostic x-rays, dosimetry or simulation associated with these procedures.

We will not pay benefits under this provision for Internal Cancer Treatment administered on the same day as Treatments covered by the Experimental Treatment benefit. However, if the Insured is eligible for both the Radiation and Chemotherapy benefit and the Experimental Treatment benefit on the same day, then we will pay the higher benefit.

In-hospital Blood and Plasma

For each day the Insured, while Confined as an Inpatient in a Hospital for Internal Cancer Treatment, receives blood and/or plasma, we will pay the In-hospital Blood and Plasma amount shown in the Benefit Highlights.

Outpatient Blood and Plasma

For each day the Insured receives Outpatient blood and/or plasma transfusions in a Physician's office, Clinic, Hospital, or Ambulatory Surgical Center, we will pay the Outpatient Blood and Plasma amount shown in the Benefit Highlights. These transfusions must be directly related to Internal Cancer Treatment.

Extended-care Facility

If we make payments under the Hospital Confinement Benefit for the Insured and the Insured is thereafter Confined due to Internal Cancer to an Extended-care Facility, then we will pay the Extended-care Facility amount shown in the Benefit Highlights. We will pay for each day of Confinement in an Extended-care Facility that is within 30 days of Confinement for Internal Cancer. Benefits are payable each Insured for a maximum period of 90 days per Benefit Year.

This benefit will not be paid for any day that a benefit is paid under the Hospital Confinement provision of the Policy. Confinements in an Extended-care Facility must begin no later than 30 days after the end of Confinement.

Hospice

We will pay the Hospice amount shown in the Benefit Highlights per day the Insured receives Hospice care not to exceed a maximum of 100 days during each Insured’s Lifetime.

Benefits will be paid provided the Insured’s Physician gives a statement in Writing that the Insured is terminally ill as a result of Internal Cancer, that it is no longer appropriate to intervene with medical therapies to try to cure the Internal Cancer, and the Insured’s medical prognosis is a life expectancy of less than 6 months.

This benefit is not payable for the same day the Extended-care Facility Benefit, the Home Health Care Benefit or the Hospital Confinement Benefit is payable. However, if the Insured is eligible for the Hospice benefit, the Extended-care Facility benefit, the Home Health Care benefit and the Hospital Confinement benefit on the same day, then we will pay the highest benefit.

In-hospital Physician Visits

While the Insured is Confined for Internal Cancer Treatment, we will pay the In-hospital Physician Visits amount shown in the Benefit Highlights for each day the Insured is visited by a Physician for Internal Cancer Treatment other than the operating surgeon not to exceed a maximum of 75 visits.

Post-hospital Physician Visits

If the Insured visits the Physician after being released from a Hospital, we will pay the Post-hospital Physician Visits amount shown in the Benefit Highlights per Physician visit once every 6 months not to exceed 5 years after the Diagnosis of Internal Cancer for the purpose of ongoing Cancer evaluation.

Prosthesis

We will pay the Prosthesis amount shown in the Benefit Highlights for each surgically implanted Prosthetic device not to exceed a Lifetime maximum amount shown in the Benefit Highlights for each Insured, if, as a direct result or consequence of surgical Treatment of Internal Cancer, the Insured receives an implantable Prosthetic device, or other non-implantable Prosthetic devices as the result of Internal Cancer Treatment.

If as a direct result or consequence of Treatment for Internal Cancer, the Insured receives non-implantable Prosthetic devices such as voice boxes, hairpieces or removable breast Prosthesis, we will pay the Prosthesis amount shown in the Benefit Highlights for each non-implantable device up to the Lifetime maximum amount shown in the Benefit Highlights for each Insured. The Prosthesis Benefit does not include coverage for a Breast Transverse Rectus Abdominis Myocutaneous (TRAM) Flap procedure as listed under the Reconstructive Surgery Benefit.

Ambulance

We will pay the Ambulance amount shown in the Benefit Highlights if a licensed professional ambulance is used to transport the Insured to a Hospital where the Insured is Confined as an Inpatient for Internal Cancer Treatment. This benefit is limited to two one-way trips per period of Confinement, including transportation from one medical facility to another.

Lodging

If the Insured or his/her adult family companion stays in a hotel while the Insured is receiving Internal Cancer Treatment at a Hospital or Clinic more than 100 miles from the Insured's residence, we will pay the Lodging amount shown in the Benefit Highlights per day not to exceed a maximum of 1 benefit per day and 90 days per Benefit Year. We will not pay for any day that a hotel charge is incurred if a stay begins, if either more than 24 hours prior to Treatment or more than 24 hours after Treatment.

Second Surgical Opinion

If a Physician has Diagnosed the Insured with Internal Cancer requiring surgery and a second surgical opinion is obtained, we will pay the Second Surgical Opinion amount shown in the Benefit Highlights when the Insured obtains a second surgical opinion from a different Physician regarding the Internal Cancer surgery.

This benefit will be paid only once per surgical procedure and will not be payable for the same day that a National Cancer Institute Evaluation/Consultation Benefit is payable. However, if the Second Surgical Opinion Benefit under this provision is payable the same day that a National Cancer Institute Evaluation/Consultation Benefit is payable, then we will pay the higher benefit.

Skin Cancer

We will pay the Skin Cancer amount shown in the Benefit Highlights if a biopsy, reconstructive surgery following previous excision of skin Cancer, excision of skin Cancer without flap or graft and excision of skin Cancer with flap or graft for Diagnosed skin Cancer is performed. The amount shown in the Benefit Highlights includes the amount payable for Anesthesia services.

6. COVERED CANCER BENEFITS

Surgery and Anesthesia for Internal Cancer

If a Physician performs one of the procedures shown in the Benefit Highlights for the purpose of treating Internal Cancer Diagnosed in the Insured, we will pay the Surgery and Anesthesia for Internal Cancer amounts shown in the Benefit Highlights, provided the total combined benefits payable under this provision for one operation is limited to the maximum shown in the Benefit Highlights. The Benefit Highlights of Operations shall not apply to surgery for skin Cancer, which will be covered only under the Skin Cancer Benefit. Similarly, the Benefit Highlights of Operations shall not apply to reconstructive surgery, which will be covered only under the Reconstructive Surgery Benefit.

If more than one surgical procedure is performed through the same incision, benefits will be paid for only one procedure based upon the highest eligible benefit.

First Occurrence

When the Insured is Diagnosed for the first time as having Internal Cancer, we will pay the First Occurrence amount shown in the Benefit Highlights for the First Occurrence Benefit.

This benefit will be paid for each Insured only once per Lifetime.

Alternative Care

The following benefits will only be payable upon the Diagnosis of Internal Cancer. We will require that the Cancer Diagnosis be re-confirmed on a regular basis, either by proof of on-going Treatment, or by a Physician's certification.

- **Integrative Assessment and Education Benefit:** A one-time benefit per Diagnosis of Internal Cancer amount shown in the Benefit Highlights is payable for assessment/education services performed by an Accredited Practitioner.

- **Palliative Care Benefit:** We will pay the amount shown in the Benefit Highlights for each visit to an Accredited Practitioner, for up to 20 visits per Benefit Year for a Lifetime maximum of 2 Benefit Years for Acupuncture, Massage Therapy, Bio-feedback and Hypnosis.

- **Lifestyle Benefit:** We will pay the amount shown in the Benefit Highlights for each visit for up to 20 visits per Benefit Year for a Lifetime maximum of 2 Benefit Years to an Accredited Practitioner for the following types of alternate care: smoking cessation, Yoga, meditation, relaxation techniques, Tai-Chi and nutritional counseling.

Experimental Treatment

If a Physician prescribes experimental Treatments for the purpose of destroying or changing abnormal tissue, and the Treatment is administered by medical personnel in a Physician's office, Clinic or Hospital, we will pay the Experimental Treatment amount shown in the Benefit Highlights for each day the Treatment is administered by these medical personnel. All Treatments must be NCI-listed as viable experimental Treatment for Internal Cancer.

We will not pay benefits under this provision for laboratory tests, Immunotherapy, diagnostic x-rays, and therapeutic devices or other procedures related to these Treatments. We will not pay benefits under this provision for the same day the Radiation and Chemotherapy Benefit is payable. However, if the Insured is eligible for both the Experimental Treatment benefit and the Radiation and Chemotherapy benefit on the same day, then we will pay the higher benefit.

Medical Imaging

If, after an initial Diagnosis of Internal Cancer, a follow-up evaluation is performed using any imaging test as directed by a Physician (except breast mammography and breast ultrasound), we will pay the Medical Imaging amount shown in the Benefit Highlights. We will only pay this benefit twice per Benefit Year provided the Insured is charged for and these procedures are performed when the Insured is an Outpatient.

National Cancer Institute Evaluation/Consultation

If the Insured is Diagnosed with Internal Cancer by a Physician and an evaluation or consultation is obtained at an NCI-designated Cancer center strictly to determine the appropriate course of Cancer Treatment, we will pay the National Cancer Institute Evaluation/Consultation amount shown in the Benefit Highlights upon such evaluation or consultation. This benefit is payable only once per Lifetime for each Insured and is not payable for the same day the Second Surgical Opinion Benefit is payable. However, if the Insured is eligible for both the National Cancer Institute Evaluation/Consultation benefit and the Second Surgical Opinion benefit on the same day, then we will pay the higher benefit. The Transportation and Lodging benefits will apply for this evaluation or consultation provided the requirements under those benefits are met.

Anti-nausea

If a Physician prescribes drugs to control nausea related to chemotherapy or radiation Internal Cancer Treatments, we will pay the Anti-nausea amount shown in the Benefit Highlights for each month during which the Insured receives and is charged for the drugs. This benefit will be paid as long as the Insured is receiving radiation or chemotherapy Treatments and prescribed drugs to control nausea.

Bone Marrow or Stem Cell Transplant

If the Insured receives and is charged for a Bone Marrow Transplant as a result of Internal Cancer, we will pay the Bone Marrow Transplant amount shown in the Benefit Highlights for each Insured and the amount shown in the Benefit Highlights to the bone marrow donor. If the Insured receives and is charged for a peripheral Stem Cell Transplant procedure to treat Internal Cancer, then we will pay the Stem Cell Transplant amount shown in the Benefit Highlights. We will pay benefits under this provision only once during each Insured's Lifetime for either a Bone Marrow Transplant or a Stem Cell Transplant, not both.

Immunotherapy

If a Physician prescribes Immunotherapy as a Treatment for Internal Cancer and the Insured is charged for such Treatment, then we will pay the Immunotherapy amount shown in the Benefit Highlights per month that the Insured is charged for such Treatments, up to the Lifetime maximum shown in the Benefit Highlights. We will not pay benefits under this provision for the same Treatment under either the Radiation and Chemotherapy benefit or the Experimental Treatment benefit. However, if the Insured is eligible for the Immunotherapy benefit, the Radiation and Chemotherapy benefit and the Experimental Treatment benefit on the same day, then we will pay the highest benefit.

Home Health Care

If, after the Insured is released from Confinement due to Internal Cancer, the attending Physician prescribes home health care or health support services and these services begin within 7 days of the Insured's release from Confinement, we will pay the Home Health Care amount shown in the Benefit Highlights for each home health visit up to a maximum of 10 visits after any period of Confinement, but no more than 30 visits per Benefit Year.

To receive this benefit, the prescribing Physician must certify that the Insured would need to be Confined if home health care visits were not available to give the Insured necessary care and Treatment.

We will pay benefits under this provision only if the home health care and health supportive services providers are licensed or certified and as qualified as caregivers providing comparable services at a Hospital or other appropriate medical facility. This benefit will not be paid for any day that a benefit is paid under the Hospice Benefit. If the Home Health Care Benefit under this provision is payable the same day that a Hospice Benefit is payable, then we will pay the higher benefit.

Nursing Services

If the attending Physician prescribes for the Insured while Confined for Internal Cancer the services of private nurses, in addition to those ordinarily provided by a Hospital, then we will pay the Nursing Services amount shown in the Benefit Highlights per day for up to 30 days per Benefit Year that the Insured is charged for such additional full time care. Care must be provided by a licensed registered graduate nurse or licensed practical or vocational nurse, but not by a Family Member.

Transportation

We will pay the Transportation amount shown in the Benefit Highlights upon completion of a round trip to transport the Insured to a Hospital or Clinic more than 100 miles away from the Insured's residence if the purpose of the trip is to obtain Internal Cancer Treatment prescribed by the Insured's local attending Physician. We will pay this benefit only for each Insured's transportation. However, we will pay this benefit for commercial travel by bus, train or airplane for a parent or guardian if the medical care is for a Dependent Child and he or she is accompanied by a parent or guardian. Each Insured is limited to 3 round trips per Benefit Year each Insured including trips in which the Dependent Child is accompanied by a parent or guardian. This benefit does not apply to transportation by ambulance to or from any Hospital.

Reconstructive Surgery

We will pay the Reconstructive Surgery amount shown in the Benefit Highlights for the Insured for Internal Cancer related reconstructive surgery listed below:

- Breast Symmetry (modification of the non-cancerous breast performed within 5 years of reconstructing the cancerous breast)
- Breast Reconstruction
- Facial Reconstruction
- Breast Transverse Rectus Abdominis Myocutaneous (TRAM) Flap

In addition, we will pay 30% of the Reconstructive Surgery amounts shown in the Benefit Highlights for Anesthesia during these procedures.

6. COVERED CANCER BENEFITS

Outpatient Hospital Surgical

We will pay the Outpatient Hospital Surgical amount shown in the Benefit Highlights per day not to exceed 3 days per procedure if the Insured is Diagnosed with Internal Cancer and a Physician performs a surgical procedure on the Insured and the procedure is performed on an Outpatient basis in a hospital (including an Ambulatory Surgical Center, but not a Physician's office.

Only surgeries for Internal Cancer qualify for this benefit. We will not pay this benefit if the Insured is Confined on the same day.

7. EXCLUSIONS AND LIMITATIONS

What exclusions apply to the benefits payable?
In addition to the exclusions stated in the Covered Cancer Benefits section of this Certificate, we will not pay any benefit that is caused by, contributed to in any way, or resulting from any Cancer Diagnosed outside the United States or Canada without confirmation of the Diagnosis by a Physician who practices in the United States or Canada; or any service, Treatment or Confinement outside the United States or Canada.

We will not pay a benefit for any Cancer that is due to or results from:
- services or Treatment not included in the Covered Cancer Benefits;
- 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);
- active military duty;
- intentionally self-inflicted injuries while sane or insane;
- services or Treatment for which the Insured is not charged, unless there is no charge because the facility is a United States government facility;
- services or Treatment provided by a Family Member;
- services or Treatment for premalignant conditions;
- services or Treatment for conditions with malignant potential;
- services or Treatment for non-cancer illnesses;
- elective plastic or cosmetic surgery.

What limitations apply to the benefits payable?
In addition to the limitations stated in the Covered Cancer Benefits section of this Certificate, we will not pay any benefit for any Cancer 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 12 months prior to any Insured's effective date of insurance or the effective date of an increase in any Insured's amount of insurance, any condition for which any Insured:
- received medical Treatment, consultation, advice, care or services, including diagnostic measures for the condition, 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. CLAIM PROVISIONS

How is a claim submitted?
To submit a claim, you or someone on your behalf must send us Written notice and Proof of claim on our form within the time limits specified. Your Employer has the Notice and Proof of claim forms.

NOTICE OF CLAIM

When does Written notice of claim have to be submitted?
Written notice of claim must be given to us no later than 90 days after the Insured's date of loss.

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 Insured's date of loss.

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 you are legally incompetent.

What is considered Proof of claim?
Proof of claim must consist of at least the following information:
- a description of the loss;
- the date the loss occurred;
- the cause of the loss;
- hospital records, physician records, x-rays, narrative reports, or lab, toxicology or other diagnostic testing materials as appropriate for the Treatment of Cancer; and
- any other information we may require to make a claim determination.

We may require as part of the Proof, authorizations to obtain medical and non-medical information. Proof must be satisfactory to us. Failure to provide the requested Proof may result in the denial of your claim.

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.

8. CLAIM PROVISIONS

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 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.

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.

8. CLAIM PROVISIONS

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;
- 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 following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Insurance regulatory agency."

To whom are benefits payable?

We will pay you if your Proof of claim is satisfactory to us, except in the following situations:

- you are a minor. In such case, claim may be made by your duly appointed guardian, conservator or committee and we will pay to such person or persons;
- due to physical or mental incapacity, you cannot, in our judgment, give us a valid receipt for payments. In such case, claim may be made as described above; or
- you die before we pay you. In such case, claim may be made by your executor or the administrator of your estate and we will pay to such person or persons.

If we do not pay you and claim is not made by the appropriate person designated above, we may, at our option, make payments under either or both Methods A or B below. Any decision to pay any benefits, prior to the appointment of the appropriate person designated (as shown above), is solely at our discretion, and we may choose to pay no amounts under any circumstances until such appropriate person is formally appointed.

Method A: We may pay up to the sum of $3,000 to any individual or entity we determine has incurred or paid expenses as a result of funeral services provided to or on your behalf. If we pay such a benefit, we will not have to pay that benefit amount again and the total benefit due under the Policy shall be reduced by the amount paid under this provision.

Method B: We may pay the whole or any part of such benefit:

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

9. 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:

- Sickness or Injury – up to 12 months
- Layoff – up to 3 months
- Leave of Absence – 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.

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.

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

10. PORTABILITY

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

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

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

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

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

What is the amount of portable insurance?
You may apply for portable insurance for the plan of insurance in force under the Policy on the date your insurance terminates. Your portable insurance policy will not provide any benefits beyond those described in the section of this Certificate titled Covered Cancer Benefits.

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

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

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

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

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

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

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

10. PORTABILITY

What is the amount of your Spouse's portable insurance?
Your Spouse may apply for portable insurance for the plan of Spouse Cancer Insurance and Dependent Children Cancer Insurance in force under the Policy on the date of your death or divorce.

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

When does your Spouse's portable insurance start?
After your death or divorce, your Spouse's portable insurance will start on the later of the following:

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

11. CONTINUITY OF COVERAGE

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

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

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

Any benefit payable will be the benefit payable under Level 1 of This Policy.

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

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

12. GENERAL PROVISIONS

AGENCY

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

ALTERATION

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

ASSIGNMENT

Can benefit payments be assigned?
An Insured cannot assign any of the group cancer insurance benefits.

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.
- 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 Insurance Continuation or Portability options.

CONFORMITY WITH STATUTES

What is the effect of Conformity with Statutes?
If any provision of the Policy conflicts with any applicable law, the provision will be automatically amended to meet the minimum requirements of the law except as otherwise pre-empted by federal law.

DISCHARGE OF OUR RESPONSIBILITY

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

12. GENERAL PROVISIONS

ENTIRE CONTRACT

What is the entire contract?
The following are incorporated in and made part of this Policy:
- any Policy amendments, endorsements or riders;
- the application of the Policyholder;
- the certificate(s); and
- any certificate amendments, endorsements or riders.

The Policy is the entire contract.

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

EXAMINATION

What are our examination rights?
We, at our expense, have the right to have any person with respect to whom a claim has been filed:
- examined by a Physician, other health professional or vocational expert of our choice; and/or
- interviewed by an authorized representative.

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

GRACE PERIOD

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

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

12. GENERAL PROVISIONS

INCONTESTABILITY

What is the Incontestability Provision?
Except for non-payment of premium 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.

INSURER'S AUTHORITY

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

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

LEGAL PROCEEDINGS

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

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

LIMIT OF PREMIUM REFUNDS

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

MISSTATEMENT OF FACTS

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

12. GENERAL PROVISIONS

NON-PARTICIPATING

Does the Policy participate in dividends?
The Policy is non-participating and will not share in any profits or surplus earnings of Sun Life Assurance Company of Canada, and, therefore, no dividends are payable.

PREMIUM PAYMENTS AS EVIDENCE OF INSURANCE

Does the payment of premiums guarantee coverage under the Policy?
The receipt of premiums by us is not a guarantee of insurance. Eligibility for benefits will be determined at the time of claim submission and in order to receive a benefit under the Policy, all Policy requirements must be satisfied.

If we determine that you or your Spouse or your 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.

SUN LIFE ASSURANCE COMPANY OF CANADA

CERTIFICATE ENDORSEMENT

This endorsement is part of the Certificate issued under Policy Number 928626-002 and is effective on June 1, 2019. It is part of, and subject to, the other terms and conditions of the Certificate. If the terms of this endorsement and the Certificate conflict then this endorsement's provisions will control.

For the purposes of this endorsement:

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

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

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

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

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

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

5. Any request or election made under the Prior Policy shall be deemed to have been made under the Policy.

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

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

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

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

Dean A. Connor
President and Chief Executive Officer

SUN LIFE ASSURANCE COMPANY OF CANADA

Group Cancer Insurance Certificate

Non-Participating

RCR Enterprises, LLC Employee Benefit Plan (The Plan) has been established to provide welfare benefits for its eligible employees and their eligible dependents.

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 Plan Administrator who is the Policyholder and is included in this Certificate for your convenience. This Summary Plan Description applies only to the benefits under the Plan to the extent they are funded by the Group Insurance Policy issued by Sun Life Assurance Company of Canada. 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: RCR Enterprises, LLC
425 Industrial Dr
Welcome, NC 27374

Plan Administrator and Named Fiduciary:

RCR Enterprises, LLC
425 Industrial Dr
Welcome, NC 27374

The Plan Administrator has authority to control and manage the operation and administration of the Plan, except that Sun Life Assurance Company of Canada makes all benefit claim determinations under the Group Insurance Policy.

Subsidiaries/Affiliates: Childress Properties, LLC,
Childress Vineyards, LLC,
Childress Winery, LLC,
Yadkin River Angus Farm,
ECR Engines

Agent for Service of Legal Process for the Plan:

RCR Enterprises, LLC
425 Industrial Dr
Welcome, NC 27374

Service of Legal Process for Sun Life:
General Counsel
1 Sun Life Executive Park
Wellesley Hills, MA 02481

Employer Identification Number (EIN): 56-1111649

Plan Number: 503

End of Plan Year: May 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. Sun Life Assurance Company of Canada is the claims administrator for those benefits and has full authority to make all benefit claim determinations.

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

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

Contributions: The cost of the insurance premiums are paid for by you.

Funding: The benefits under the Plan are funded, at least in part, by the Group Insurance Policy issued by Sun Life Assurance Company of Canada. Those insurance benefits are described in your 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 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, if required by ERISA. 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 and if you have exhausted the claims and appeal procedures described in the Certificate, 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.