Canon Medical Systems USA, Inc.

Group Voluntary Critical Illness

Policy No. R0146035

All Employees

Underwritten by Unum Life Insurance Company of America

March 27, 2018

CERTIFICATE OF COVERAGE

THIS IS A LIMITED BENEFIT CERTIFICATE OF COVERAGE. PLEASE READ IT CAREFULLY.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS OR MINIMUM ESSENTIAL COVERAGE AS DEFINED IN FEDERAL LAW.

You must write Your name in the space provided when You receive this certificate so that it becomes Your Certificate of Coverage. Your coverage effective date is described in the General Provisions section.

Name: _____

Unum Life Insurance Company of America (referred to as Unum) welcomes You as a client.

This is Your Certificate of Coverage as long as You are eligible for coverage and You become insured. You will want to read it carefully and keep it in a safe place.

Unum has written Your Certificate of Coverage in plain English. However, a few terms and provisions are written as required by insurance law. If You have any questions about any of the terms and provisions, please consult Unum. Unum will assist You in any way to help You understand Your benefits.

If the terms and provisions of this Certificate of Coverage (issued to You) are different from the policy (issued to the Policyholder), the policy will govern. The policy may be changed in whole or in part. Only an officer or a registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to the policy. Any other person, including a broker, may not change the policy or waive any part of it.

The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. When making a benefit determination under the policy, Unum has discretionary authority to determine Your eligibility for benefits and to interpret the terms and provisions of the policy.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. and end at 12:00 midnight at the Policyholder's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, ME 04122

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BENEFITS AT A GLANCE

This Critical Illness Policy provides financial protection for You by paying a benefit if You are diagnosed with a specified critical illness. The amount You receive is based on the amount of coverage in effect on the date of diagnosis of a specified critical illness or the date treatment is received according to the terms and provisions of the policy. You also have the opportunity to have coverage for Your Spouse.

EMPLOYER'S ORIGINAL POLICY
EFFECTIVE DATE: January 1, 2011

POLICY YEAR:

January 1, 2011 to January 1, 2019 and each following January 1 to January 1.

POLICY NUMBER: R0146035 CI-0%-01

ELIGIBLE GROUP(S):

All Employees in Active Employment in the United States with the Employer.

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 20 hours per week.

ELIGIBILITY WAITING PERIOD:

For Employees in an eligible group on or before January 1, 2011: None

For Employees entering an eligible group after January 1, 2011: None

REHIRE:

If Your employment ends and You are rehired within 12 months, Your previous work in an eligible group will apply toward the Eligibility Waiting Period. All other policy provisions apply.

CREDIT PRIOR SERVICE:

Unum will apply any period of work with Your Employer toward the Eligibility Waiting Period to determine Your eligibility date.

PAYING FOR COVERAGE:

For You: You must make contributions for Your coverage. Coverage on Your eligible Dependent Children is automatically included with Your coverage.

For Your Spouse: You must make contributions for coverage for Your Spouse.

BENEFIT WAITING PERIOD: 30 days

PRE-EXISTING CONDITION LIMITATION: 12/12

CRITICAL ILLNESS BENEFIT

Face Amount

Employee:	$5,000 - $45,000 in $1,000 increments as applied for by You and approved by Unum.
Spouse, if Covered:	$5,000 - $30,000 in $1,000 increments as applied for by You and approved by Unum.
Dependent Child(ren):	25% of Employee Face Amount

Critical Illnesses	Percentage of Face Amount
Base Covered Conditions	
Benign Brain Tumor Initial Diagnosis Benefit	100%
Blindness Initial Diagnosis Benefit	100%
Coma as the Result of Severe Traumatic Brain Injury Initial Diagnosis Benefit	100%
Coronary Artery Bypass Surgery Initial Diagnosis Benefit	25%
End Stage Renal (Kidney) Failure Initial Diagnosis Benefit	100%
Heart Attack (Myocardial Infarction) Initial Diagnosis Benefit	100%
Major Organ Failure Initial Diagnosis Benefit	100%
Permanent Paralysis as the result of a Covered Accident Initial Diagnosis Benefit	100%
Stroke Initial Diagnosis Benefit	100%
Cancer Conditions	
Cancer Initial Diagnosis Benefit	100%
Carcinoma in Situ Initial Diagnosis Benefit	25%
Additional Critical Illnesses for Dependent Children	
Cerebral Palsy Initial Diagnosis Benefit	100%
Cleft Lip or Palate Initial Diagnosis Benefit	100%
Cystic Fibrosis Initial Diagnosis Benefit	100%
Down Syndrome Initial Diagnosis Benefit	100%
Spina Bifida Initial Diagnosis Benefit	100%

Critical Illness Benefit Reduction
Any coverage in force prior to the Insured's 70th birthday will be reduced on the Policy Anniversary Date following the Insured's 70th birthday. The Insured's Face Amount will be reduced to 50% of the Face Amount the Insured had prior to the Policy Anniversary Date. Any coverage in force after the Policy Anniversary Date following the Insured's 70th birthday will not be subject to a benefit reduction on subsequent Policy Anniversary Dates.

MAMMOGRAPHY BENEFIT

Mammography Benefit Amount $200

SOME LOSSES MAY NOT BE COVERED UNDER THIS POLICY.

OTHER FEATURES

Portability

The above items are only highlights of this Policy. For a full description of Your coverage, continue reading Your Certificate of Coverage.

CLAIM INFORMATION

Notice of Claim. Notice of claim should be sent to Unum within 90 days after the Date of Diagnosis for which a benefit is claimed or the date of Covered Loss for which a benefit is claimed, or as soon as is reasonably possible. If notice is not reasonably possible to provide within 90 days, it must be given no later than one year after the time notice of claim is required. These time limits will not apply during any time period You or Your authorized representative lacks the legal capacity to give Unum notice of claim. Notice should be sent to Unum at Our home office. If You submit a claim before notification of Unum's decision on any coverage amount requiring Evidence of Insurability, the amount of coverage applicable to the claim will be determined as if Unum's final underwriting decision had been made prior to the Date of Diagnosis or date of Covered Loss.

Claim Forms. When Unum receives a notice of claim, claim forms will be sent for filing proof of claim within 15 days. If claim forms are not sent within 15 days, the proof of claim requirements will be met if We receive a written statement of the nature and extent of the loss as required in the proof of claim section. Claim forms are also available from Your Employer.

Proof of Claim. Proof of claim must include documentation furnished by a Physician and supported by clinical, radiological, histological, pathological, and/or laboratory evidence. It may also include one or more of the following: a Physician's bill, a Hospital bill, or other proof of charges.

If it is not reasonably possible to give proof of claim within 90 days after the Date of Diagnosis for which a benefit is claimed or date of Covered Loss for which a benefit is claimed, it must be given no later than one year after the time proof of claim is required. These time limits will not apply during any time period the Insured or the Insured's authorized representative lacks the legal capacity to give Unum proof of claim.

Time of Payment of Claims. After Unum receives, evaluates and processes proof of claim, Unum will pay any benefits due.

Payment of Claims. Benefits will be paid to You unless such benefits have been assigned. If You are not competent, Unum can pay up to $2,000 to the person or institution that appears to have assumed Your custody and main support. Any accrued benefits unpaid at Your death will be paid to the named beneficiary, if any, otherwise to Your estate. Unum will be discharged to the extent of any such payment made in good faith.

Overpayments. Unum has the right to recover any overpayments due to:

- fraud; and
- any error We make in processing a claim.

You must reimburse Us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount We paid You.

Unpaid Premium. Any unpaid premium due for Your coverage under this policy may be recovered by Us by offsetting against amounts otherwise payable to You, Your

beneficiary, or Your legal representative(s) under this policy, or by other legally permitted means.

Assignment. The rights provided to You by the policy are owned by You, unless You assign Your rights under the policy to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by You, and acceptable to Us in form; and
- a signed or certified copy of the written assignment has been received and registered by Us at Our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the policy provisions before receiving and registering an assignment.

Physical Examinations and Autopsy. We can require that the Insured be examined by a Physician of Our choice at Our expense as often as it is reasonably necessary while a claim is pending. In case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

Legal Actions. You or Your authorized representative can start legal action regarding Your claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required, unless otherwise provided under federal law.

GENERAL PROVISIONS

ELIGIBILITY FOR COVERAGE

Employee

If You are working for Your Employer in an eligible group, You are eligible for coverage on the later of:

- the Policy Effective Date; or
- the day after You complete Your Eligibility Waiting Period.

Once You are eligible for coverage, Your coverage will begin in accordance with the provision entitled Coverage Effective Date - Employee.

Dependent Children

If You are covered under this policy, Your Dependent Children are automatically eligible for coverage on the later of:

- the date Your coverage begins; or
- the date You first acquire the Dependent Child.

Coverage for Your Dependent Children will begin in accordance with the provision entitled Coverage Effective Date - Dependent Children.

Spouse

When You become eligible and apply for coverage or are covered under the policy, You are also eligible to apply for coverage on Your Spouse. You may not apply for coverage for Your Spouse if Your Spouse is covered as an Employee.

The date Your Spouse is eligible for coverage is the later of:

- the date Your coverage begins; or
- the date You first acquire a Spouse.

Once Your Spouse is eligible for coverage, Your Spouse's coverage will begin in accordance with the provision entitled Coverage Effective Date - Spouse.

COVERAGE EFFECTIVE DATE

Employee

You may apply for coverage based on the benefits available as shown in the Benefits at a Glance during a Scheduled Enrollment Period. Evidence of Insurability is required for any amount of coverage.

If You are eligible for coverage on the Policy Effective Date and apply during the initial Scheduled Enrollment Period, Your coverage will begin at 12:01 a.m. on the later of:

- the Policy Effective Date, if Your Evidence of Insurability is approved prior to the Policy Effective date; or

- the first of the month following the date Unum approves Your Evidence of Insurability.

If You are eligible for coverage after the Policy Effective Date or if You do not apply for coverage when You are first eligible, You can apply for coverage during a subsequent Scheduled Enrollment Period. Coverage on You will begin at 12:01 a.m. on the later of:

- the first of the month following the end of the Scheduled Enrollment Period; or
- the first of the month following the date Unum approves Your Evidence of Insurability.

If You are absent from work on the date Your coverage would normally begin due to Injury, Sickness, temporary Layoff or Leave of Absence, Your coverage will begin on the date You return to Active Employment.

Dependent Children

Coverage for Your Dependent Children will begin on the later of:

- the date Your coverage begins; or
- the date You first acquire the Dependent Child.

Spouse

When Your Spouse becomes eligible for coverage, You may apply for Spouse coverage based on the benefits available as shown in the Benefits at a Glance during a Scheduled Enrollment Period. Evidence of Insurability is required for any amount of Spouse coverage.

If Your Spouse is eligible for coverage on the Policy Effective Date and You apply for Spouse coverage during the initial Scheduled Enrollment Period, Your Spouse's coverage will begin at 12:01 a.m. on the later of:

- the Policy Effective Date, if Your Spouse's Evidence of Insurability is approved prior to the Policy Effective date; or
- the first of the month following the date Unum approves Your Spouse's Evidence of Insurability.

If Your Spouse is eligible for coverage after the Policy Effective Date, or if You do not apply for Spouse coverage when Your Spouse is first eligible, You can apply for Spouse coverage during a subsequent Scheduled Enrollment Period. Coverage on Your Spouse will begin at 12:01 a.m. on the later of:

- the first of the month following the end of the Scheduled Enrollment Period; or
- the first of the month following the date Unum approves Your Spouse's Evidence of Insurability.

Changes You Make to Your Coverage. You can change Your or Your Spouse's coverage during a Scheduled Enrollment Period. You can apply for additional coverage for You or Your Spouse based on the benefits available as shown in the Benefits at a Glance. Evidence of Insurability is required for any additional coverage. Additional coverage will begin at 12:01 a.m. on the later of:

- the first day of the month following the end of the Scheduled Enrollment Period; or

- the first of the month following the date Unum approves Your or Your Spouse's Evidence of Insurability.

Any additional coverage will be subject to a new Pre-existing Condition Limitation and a new Benefit Waiting Period.

You can decrease Your or Your Spouse's coverage based on the benefits available as shown in the Benefits at a Glance at any time during the Policy Year. A decrease in coverage will begin at 12:01 a.m. on the first of the month following the date You provide notification to Your Employer.

Coverage changes will not affect a Payable Claim that occurs prior to the effective date of the change.

If You are absent from work on the date Your change in coverage would normally begin due to Injury or Sickness any coverage changes will begin on the date You return to Active Employment.

Any changes to Your coverage will affect Your Dependent Children's coverage.

Employer Changes to the Policy

Once Your coverage begins and You are in Active Employment or on a covered Layoff or Leave of Absence, any coverage changes made by Your Employer will take effect at 12:01 a.m. on:

- the effective date of the policy change if Evidence of Insurability is not required; and
- the first of the month following the date Unum approves Your or Your Spouse's application for enrollment or Evidence of Insurability, if Evidence of Insurability is required.

If You are not in Active Employment due to Injury or Sickness, any coverage changes will begin on the date You return to Active Employment.

Coverage changes will not affect a Payable Claim that occurs prior to the effective date of the change.

Termination of Employee Coverage. If You choose to cancel Your coverage under the policy, Your coverage ends on the first of the month following the date You provide notification to Your Employer.

Otherwise, Your coverage under the policy ends on the earliest of the:

- date this policy is cancelled;
- date You are no longer in an eligible group;
- date Your eligible group is no longer covered;
- date of Your death;
- last day of the period for which You made any required contributions; or
- last day You are in Active Employment unless continued due to a covered Layoff or Leave of Absence or due to an Injury or Sickness.

Coverage on Your Dependent Children ends on the earliest of the date Your coverage under the policy ends or the date a dependent child no longer meets the definition of Dependent Children.

Unum will provide coverage for a Payable Claim which occurs while You are covered under this policy.

Termination of Spouse Coverage. If You choose to cancel Your Spouse's coverage under the policy, coverage for Your Spouse ends on the first of the month following the date You provide notification to Your Employer.

Otherwise, Spouse coverage under the policy ends on the earliest of the:

- date this policy is cancelled;
- date You no longer are in an eligible group;
- date Your eligible group is no longer covered;
- date of Your death;
- last day of the period for which You made any required contributions;
- last day You are in Active Employment unless continued due to a covered Layoff or Leave of Absence or due to an Injury or Sickness;
- date Your coverage under the policy ends;
- date Your Spouse no longer meets the definition of Spouse; or
- date of divorce or annulment.

Unum will provide coverage for a Payable Claim which occurs while Your Spouse is covered under the policy.

Layoff. If You are on a temporary Layoff, and if premium is paid, any Insured will be covered through the end of the month that immediately follows the month in which Your temporary Layoff begins.

Leave of Absence. If You are on a Leave of Absence, other than for family or medical leave, and if premium is paid, any Insured will be covered through the end of the month that immediately follows the month in which Your Leave of Absence begins.

Absence Due to Injury or Sickness. If You are not working due to Injury or Sickness, and if premium is paid, any Insured may continue to be covered subject to the Termination of Employee Coverage provision.

Continuing Coverage while Employee is on Family and Medical Leave of Absence. Unum will continue coverage in accordance with Your Employer's Human Resource policy on family and medical leaves of absence if premium payments continue and Your Employer approved Your leave in writing.

Coverage will be continued until the end of the latest of the leave period:

- required by the Federal Family and Medical Leave Act of 1993 and any amendments;
- required by applicable state law; or
- provided to You for an Injury or Sickness.

If Your Employer's Human Resource policy does not provide for continuation of Your coverage during a family and medical leave of absence, Your coverage will be reinstated when You return to Active Employment.

Unum will not:

- apply a new Eligibility Waiting Period;
- require Evidence of Insurability;
- apply a new Pre-existing Condition Limitation; or
- apply a new Benefit Waiting Period.

Insurance Fraud. Unum wants to ensure You and Your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

Any person who knowingly files a statement of claim containing any false or misleading information may be subject to criminal and civil penalties.

In addition, submission of false information in connection with the claim form may also constitute a crime under federal laws. Unum will pursue any appropriate legal remedies in the event of insurance fraud, including prosecuting under federal mail fraud, federal wire fraud, and/or the federal Racketeer Influenced and Corrupt Organizations Act statutes. Any false statements made herein may be reported to state and federal tax and regulatory authorities as is appropriate.

Contestability of Statements in Application or Evidence of Insurability. Unum considers any statements You make in a signed application or Evidence of Insurability form, or that Your Employer makes in the application process, a representation and not a warranty. If any of the statements You or Your Employer make are not complete and/or not true at the time they are made, We can:

- reduce or deny any claim; or
- cancel Your coverage from the original effective date.

As a basis for doing this, We will use only statements made by the Employer in the application process or statements made by You in a signed application or Evidence of Insurability form.

Except in the case of fraud, Unum can take action only in the first two years any Insured's coverage is in force.

If the Employer gives Unum information about You that is incorrect, Unum will:

- use the facts to decide whether You have coverage under the policy and in what amounts; and
- make a fair adjustment of the premium.

Employer as Agent. For purposes of this policy, the Employer acts on its own behalf or as the Employee's agent. Under no circumstances will the Employer be deemed the agent of Unum.

Communicating with You or Your Employer. Unum may provide notices, information and other communications to You or Your Employer in written, electronic or telephonic form.

Workers Compensation or State Disability Insurance. This policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

Cancellation or Modification of this Policy. This Policyholder Provision applies to Your coverage. This policy can be cancelled by:

- Unum; or
- the Policyholder.

Unum may cancel or modify this policy if:

- the Policyholder does not promptly provide Unum with information that is reasonably required;
- the Policyholder fails to perform any of its obligations that relate to this policy;
- fewer than 10 Employees or less than 5% of those eligible are insured under this policy;
- the premium is not paid in accordance with the provisions of this policy that specify whether the Policyholder, the Employee, or both, pay(s) the premiums;
- the Policyholder does not promptly report to Us the names of any Employees who are added or deleted from the eligible group;
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale or reorganization of the Policyholder and/or its Employees;
- Unum provides 31 days notice at any time after the Initial Rate Guarantee for any reason; or
- Unum is notified of a change in Federal or State Law materially affecting the policy.

If Unum cancels or modifies this policy, for any of the reasons listed above, a written notice will be delivered to the Policyholder at least 31 days prior to the cancellation date or modification date. The Policyholder may cancel this policy if the modifications are unacceptable.

If any premium is not paid during the 31 day Grace Period, this policy will cancel automatically at the end of the Grace Period. The Policyholder is liable for premium for coverage during the Grace Period. The Policyholder must pay Us all premiums due for the full period this policy is in force. In the event of termination, this policy may be reinstated only as agreed upon by Unum and the Policyholder. If Unum agrees to reinstate this policy, such reinstatement will not constitute waiver of the termination provision in the future.

The Policyholder may cancel this policy by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Policyholder and Unum agree, this policy can be cancelled on an earlier date. If Unum or the Policyholder cancels this policy, coverage will end at 12:00 midnight on the last day of coverage.

If this policy is cancelled, the cancellation will not affect a Payable Claim.

BENEFIT INFORMATION

CRITICAL ILLNESS BENEFIT

Benefits for Cancer and Carcinoma in Situ, as defined in this Critical Illness Benefit, are based on diagnosis and not treatment. Cancer will be covered at 100% of the Face Amount and Carcinoma in Situ will be covered at 25% of the Face Amount, subject to the terms of coverage. The extent of treatment recommended, including but not limited to surgery, chemotherapy and/or radiation, will not affect the benefit amount.

Examples

A 50-year old has a $50,000 Face Amount. At age 60, she discovers a lump in her breast. Benefits are calculated as follows:

If the lump is malignant and meets the definition of Cancer: $50,000 Face Amount x 100% = $50,000

If the lump is malignant and meets the definition of Carcinoma in Situ: $50,000 Face Amount x 25% = $12,500

If the lump is benign, it will not meet the definition of Cancer or Carcinoma in Situ and no coverage is provided.

Definitions

Benign Brain Tumor means a non-cancerous brain tumor confirmed by the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination. The tumor must result in persistent neurological deficits including but not limited to:

- loss of vision;
- loss of hearing; or
- balance disruption.

For the purposes of this policy, the following are not considered Benign Brain Tumors:

- tumors of the skull;
- pituitary adenomas; and
- germanomas.

We will not pay for Benign Brain Tumors for individuals diagnosed with any of the following conditions prior to the Insured's coverage effective date:

- Neurofibromatosis I;
- Neurofibromatosis II;
- Von Hippel Lindau;
- Tuberous Sclerosis;
- Li Fraumani Syndrome;
- Cowden Disease; or
- Turcot Syndrome.

Blindness means clinically proven irreversible reduction of sight in both eyes certified by an ophthalmologist with:

- sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (Snellen or E-Chart Acuity); or
- visual field restriction to 20° or less in both eyes.

Cancer means a disease which is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells. The following are not to be construed as Cancer for the purposes of this policy:

- pre-malignant conditions or conditions with malignant potential;
- Carcinoma in Situ;
- Basal cell carcinoma and squamous cell carcinoma of the skin, unless metastatic disease develops; or
- melanoma that is diagnosed as Clark's Level I or II or Breslow less than .75 mm or melanoma in situ.

Carcinoma in Situ means a malignant tumor which has not yet become invasive but is confined only to the superficial layer of cells from which it arose (i.e. malignant cells confined to the epithelium without penetration of the basement membrane). The following are not to be construed as Carcinoma in Situ for the purposes of this policy:

- pre-malignant conditions or conditions with malignant potential;
- Basal cell carcinoma and squamous cell carcinoma of the skin; or
- melanoma or melanoma in situ.

Cerebral Palsy means a group of disorders of the development of movement and posture causing activity limitation, that are attributed to progressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of cerebral palsy are often accompanied by disturbances of sensation, cognition, communication, perception, and/or behavior and/or by a seizure disorder.

Cleft Lip or Palate means there is a definite clinical diagnosis of either cleft lip or cleft palate. A cleft lip appears as a narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose. A cleft palate is an opening between the roof of the mouth and the nasal cavity.

This policy covers clefts occurring on one side of the mouth (unilateral clefting) or on both sides of the mouth (bilateral clefting).

Clinical Diagnosis of Cancer or Carcinoma in Situ is based on the study of symptoms. We will pay benefits for a Clinical Diagnosis only if:

- there is medical evidence to support a positive diagnosis of Cancer or Carcinoma in Situ; and
- the diagnosis is made by a qualified Physician whose positive diagnosis of malignancy is consistent with professional medical standards of care for Cancer or Carcinoma in Situ.

Coma as the Result of Severe Traumatic Brain Injury means a coma resulting from a severe traumatic brain Injury that results in a continuous state of profound

unconsciousness lasting for a period of 14 or more consecutive days, characterized by the absence of:

- eye opening;
- verbal response; and
- motor response.

The condition must require intubation for respiratory assistance.

Coronary Artery Bypass Surgery means Heart Disease or Angina that has been clinically diagnosed and requires the Insured to undergo Coronary Artery Bypass Surgery, which is a surgical procedure to bypass a narrowing or blockage of one or more coronary arteries utilizing venous or arterial grafts. Coronary Artery Bypass Surgery does not include percutaneous coronary intervention (balloon angioplasty, stent implantation or related procedures to increase the flow of blood through the coronary arteries).

Covered Accident is an accident which:

- occurs on or after the coverage effective date;
- occurs while coverage is in force; and
- is not excluded by name or specific description in the Certificate of Coverage.

Critical Illness(es) means Benign Brain Tumor, Blindness, Cancer and Carcinoma in Situ, Coma as the Result of Severe Traumatic Brain Injury, Coronary Artery Bypass Surgery, End Stage Renal (Kidney) Failure, Heart Attack (Myocardial Infarction), Major Organ Failure, Permanent Paralysis as the result of a Covered Accident, and Stroke as defined in this policy. For Dependent Children, Critical Illness also means Cerebral Palsy, Cleft Lip or Palate, Cystic Fibrosis, Down Syndrome and Spina Bifida.

Cystic Fibrosis means a definite diagnosis of Cystic Fibrosis by a licensed pediatrician or pulmonologist where the Dependent Child has chronic lung disease and pancreatic insufficiency. The diagnosis of Cystic Fibrosis made via a sweat test should be based upon sweat chloride concentrations greater than 60 mmol/L.

Date of Diagnosis for Critical Illness is:

- for Benign Brain Tumor, the date of diagnosis of the Benign Brain Tumor by examination of tissue (biopsy or surgical excision) or specific neuroradiological examination;
- for Blindness, the date the ophthalmologist makes an accurate certification of blindness as defined in the Blindness definition;
- for Cancer or Carcinoma in Situ, the date the tissue specimen, blood samples and/or titer(s) are taken on which the diagnosis of Cancer or Carcinoma in Situ is based;
- for Cerebral Palsy, defined as a group of disorders of the development of movement and posture causing activity limitation, that are attributed to progressive disturbances that occurred in the developing fetal or infant brain, the date of diagnosis of Cerebral Palsy is the date a licensed pediatrician or neurologist diagnoses Cerebral Palsy after live birth;
- for Cleft Lip or Palate, the date of diagnosis of Cleft Lip or Palate (unilateral or bilateral clefting) by Physician after live birth;

- for Coma as the Result of Severe Traumatic Brain Injury, the date a Physician confirms a Coma as the Result of Severe Traumatic Brain Injury lasting 14 or more consecutive days;
- for Coronary Artery Bypass Surgery, the date the Coronary Artery Bypass Surgery occurs;
- for Cystic Fibrosis, the date of diagnosis where Cystic Fibrosis has been definitively confirmed and established via a sweat test with sweat chloride concentrations greater than 60 mmol/L after live birth;
- for Down Syndrome, the date of diagnosis of Down Syndrome through the study of the 21st chromosome revealing Trisomy 21, Translocation or Mosaicism after live birth;
- for End Stage Renal (Kidney) Failure, the date the Insured's Physician recommends the Insured begin renal dialysis;
- for Heart Attack (Myocardial Infarction), the date that the ischemic death of a portion of the heart muscle occurred based on the criteria listed under the Heart Attack (Myocardial Infarction) definition;
- for Major Organ Failure, the date that the Insured is placed on the UNOS list for transplantation;
- for Permanent Paralysis as the result of a Covered Accident, the date a Covered Accident occurred which caused Permanent Paralysis continuing for a period of 90 consecutive days as confirmed by the attending Physician or immediately if the spinal cord is completely and irreparably transected;
- for Spina Bifida, the date of diagnosis of Meningocele or Myelomeningocele Spina Bifida by a Physician familiar with the diagnosis and/or treatment of Spina Bifida after live birth;
- for Stroke, the date a Stroke occurred based on neuroimaging consistent with an acute or subacute abnormality or other neurodiagnostic study and presence of neurological deficits persisting for a period of 30 days or greater.

Down Syndrome means diagnosis of Down Syndrome through study of the 21st chromosome. Diagnosis must be confirmed by a licensed pediatrician or another Physician familiar with Down Syndrome diagnosis.

Down Syndrome includes:

- Trisomy 21 - An individual has three instead of two number 21 chromosomes.
- Translocation - An extra part of the 21st chromosome is attached to another chromosome.
- Mosaicism - The individual has an extra 21st chromosome in only some of the cells but not all of them. The other cells have the usual pair of 21st chromosomes.

End Stage Renal (Kidney) Failure means chronic irreversible failure of the function of both kidneys such that regular hemodialysis or peritoneal dialysis is required to sustain life.

Heart Attack (Myocardial Infarction) means there is an identifiable clinical event consistent with a heart attack:

- which is defined as having two of the following three:

  - typical chest pain;
  - electrocardiographic (EKG) changes indicative of Myocardial Infarction; in the case of Myocardial Infarction associated with percutaneous coronary intervention (balloon

angioplasty, stent implantation, and related procedures to increase the flow of blood through the coronary arteries), evolving ST elevations or new Q wave changes must be documented and included as one of the criteria on establishing a diagnosis; or
- elevation of biochemical markers of myocardial necrosis;

- and that results in some permanent functional loss of heart contraction detectable by a regional contraction abnormality study on an imaging study.

In the event of death, an autopsy confirmation and/or death certificate identifying Myocardial Infarction as the cause of death will be accepted.

Major Organ Failure means diagnosis of major organ failure of the liver, both lungs, pancreas, or heart resulting in the Insured being placed on the UNOS (United Network for Organ Sharing) list for a transplant.

If an Insured is on the UNOS list for a combined transplant (example: heart and lung); a single benefit will be paid.

Only one Major Organ Failure benefit will be paid per Insured.

Pathological Diagnosis of Cancer or Carcinoma in Situ is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a qualified Physician whose positive diagnosis of malignancy is in keeping with the professional medical standards of care for Cancer or Carcinoma in Situ.

Permanent Paralysis as the Result of a Covered Accident means the complete and permanent loss of the use of two or more limbs through paralysis for a continuous period of 90 days as confirmed by a Physician.

In the case of a transected spinal cord with supporting clinical and radiological evidence and no expectation of return of function, the continuous 90 days requirement specified above is waived.

Spina Bifida means a confirmed diagnosis of either of the following types of Spina Bifida:

- Meningocele - The protective coatings (meninges) come through the open part of the spine like a sac that is pushed out. Cerebrospinal fluid is in the sac and there is usually no nerve damage. Individuals may suffer minor disabilities. New problems can develop later in life; or
- Myelomeningocele - This occurs when the meninges (protective covering of the spinal cord) and spinal nerves come through the open part of the spine. This is the most serious type of Spina Bifida, which causes nerve damage and more severe disabilities.

Diagnosis must be made by a licensed Physician familiar with Spina Bifida.

This policy excludes spina bifida occulta.

Stroke means a cerebrovascular incident including infarction of brain tissue, cerebral and subarachnoid hemorrhage, cerebral embolism and cerebral thrombosis. The diagnosis must be supported by:

- evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the event; and
- confirmatory neuroimaging studies consistent with the diagnosis of a new Stroke.

The following are not to be construed as a Stroke for purposes of this policy:

- transient ischemic attack;
- brain Injury related to trauma or infection;
- brain Injury associated with hypoxia, anoxia or hypotension;
- vascular disease affecting the eye or optic nerve; and
- ischemic disorders of the vestibular system.

In the event of death, an autopsy confirmation and/or death certificate identifying Stroke as the cause of death will be accepted.

Benefit Payment Conditions for Critical Illness

If, while the Insured's coverage is in force, the Insured is diagnosed with a Critical Illness by a Physician, Unum will pay a benefit subject to the benefit payment conditions listed below and the Critical Illness Benefit Reduction provision. Once a Critical Illness has been diagnosed and an Initial Diagnosis Benefit has become payable for that Critical Illness, an Initial Diagnosis Benefit for a separate and subsequently diagnosed Critical Illness will not be payable unless that subsequently diagnosed Critical Illness is medically unrelated to the previously diagnosed Critical Illness and separated by a period of 90 days. Only one Initial Diagnosis Benefit will ever be paid per Critical Illness per Insured.

Unum will pay benefits for the Critical Illnesses listed below if:

- the Date of Diagnosis is while the Insured's coverage is in force under the policy; and
- payment is not precluded by any general or specific exclusion or limitation set forth in this policy or any failure to meet any condition set out in the policy.

If any Dependent Children are insured as more than one Employee's Dependent Children, Unum will only pay benefits under one of the Employee's coverage. You may choose which Employee's coverage that benefits will be paid under by sending Unum written notice of Your choice.

No Benefit Waiting Period or Pre-existing Condition Limitation will be applied for Dependent Children who are born or adopted while You are covered under this policy, and who are continuously covered from the date of birth or adoption.

Benign Brain Tumor

Initial Diagnosis Benefit. If the Date of Diagnosis for a Benign Brain Tumor is after the Insured's coverage effective date and Benefit Waiting Period, Unum will pay the Percentage of Face Amount for Benign Brain Tumor shown in the Benefits at a Glance.

Blindness

Initial Diagnosis Benefit. If the Date of Diagnosis for Blindness is after the Insured's coverage effective date and Benefit Waiting Period, Unum will pay the Percentage of Face Amount for Blindness shown in the Benefits at a Glance.

Cancer

Initial Diagnosis Benefit. If the Date of Diagnosis for Cancer is after the Insured's coverage effective date and Benefit Waiting Period, Unum will pay the Percentage of Face Amount for Cancer shown in the Benefits at a Glance.

Carcinoma in Situ

Initial Diagnosis Benefit. If the Date of Diagnosis for Carcinoma in Situ is after the Insured's coverage effective date and Benefit Waiting Period, Unum will pay the Percentage of Face Amount for Carcinoma in Situ shown in the Benefits at a Glance.

Cerebral Palsy

Initial Diagnosis Benefit. If a Dependent Child has a Date of Diagnosis for Cerebral Palsy after the Dependent Child's coverage effective date, Unum will pay the Percentage of Face Amount for Cerebral Palsy shown in the Benefits at a Glance.

Cleft Lip or Palate

Initial Diagnosis Benefit. If a Dependent Child has a Date of Diagnosis for Cleft Lip or Palate after the Dependent Child's coverage effective date, Unum will pay the Percentage of Face Amount for Cleft Lip or Palate shown in the Benefits at a Glance.

Coma as the Result of Severe Traumatic Brain Injury

Initial Diagnosis Benefit. If an Insured has a Date of Diagnosis for Coma as the Result of Severe Traumatic Brain Injury after the Insured's coverage effective date, Unum will pay the Percentage of Face Amount for Coma as the Result of Severe Traumatic Brain Injury shown in the Benefits at a Glance.

Coronary Artery Bypass Surgery

Initial Diagnosis Benefit. If the Date of Diagnosis for Coronary Artery Bypass Surgery is after the Insured's coverage effective date and Benefit Waiting Period, Unum will pay the Percentage of Face Amount for Coronary Artery Bypass Surgery shown in the Benefits at a Glance.

Cystic Fibrosis

Initial Diagnosis Benefit. If a Dependent Child has a Date of Diagnosis for Cystic Fibrosis after the Dependent Child's coverage effective date, Unum will pay the Percentage of Face Amount for Cystic Fibrosis as shown in the Benefits at a Glance.

Down Syndrome

Initial Diagnosis Benefit. If a Dependent Child has a Date of Diagnosis for Down Syndrome after the Dependent Child's coverage effective date, Unum will pay the Percentage of Face Amount for Down Syndrome shown in the Benefits at a Glance.

End Stage Renal (Kidney) Failure

Initial Diagnosis Benefit. If an Insured has a Date of Diagnosis for End Stage Renal (Kidney) Failure after the Insured's coverage effective date and Benefit Waiting Period, Unum will pay the Percentage of Face Amount for End Stage Renal (Kidney) Failure shown in the Benefits at a Glance.

Heart Attack (Myocardial Infarction)

Initial Diagnosis Benefit. If an Insured has a Date of Diagnosis for Heart Attack (Myocardial Infarction) after the Insured's coverage effective date and Benefit Waiting Period, Unum will pay the Percentage of Face Amount for Heart Attack (Myocardial Infarction) shown in the Benefits at a Glance.

Major Organ Failure

Initial Diagnosis Benefit. If an Insured has a Date of Diagnosis for Major Organ Failure after the Insured's coverage effective date and Benefit Waiting Period, Unum will pay the Percentage of Face Amount for Major Organ Failure shown in the Benefits at a Glance.

Permanent Paralysis as the result of a Covered Accident

Initial Diagnosis Benefit. If an Insured has a Date of Diagnosis for Permanent Paralysis as the result of a Covered Accident after the Insured's coverage effective date, Unum will pay the Percentage of Face Amount for Permanent Paralysis as the result of a Covered Accident shown in the Benefits at a Glance.

Spina Bifida

Initial Diagnosis Benefit. If an Insured has a Date of Diagnosis for Spina Bifida after the Dependent Child's coverage effective date, Unum will pay the Percentage of Face Amount for Spina Bifida shown in the Benefits at a Glance.

Stroke

Initial Diagnosis Benefit. If an Insured has a Date of Diagnosis for Stroke after the Insured's coverage effective date and Benefit Waiting Period, Unum will pay the Percentage of Face Amount for Stroke shown in the Benefits at a Glance.

Critical Illness Benefit Reduction

Any coverage in force prior to the Insured's 70th birthday will be reduced on the Policy Anniversary Date following the Insured's 70th birthday. The Insured's Face Amount will be reduced to 50% of the Face Amount the Insured had prior to the Policy Anniversary Date. Any coverage in force after the Policy Anniversary Date following the Insured's 70th birthday will not be subject to a benefit reduction on subsequent Policy Anniversary Dates.

MAMMOGRAPHY BENEFIT

Unum will pay the Mammography Benefit Amount shown in the Benefits at a Glance if an Insured has a mammogram while the Insured's coverage is in force.

The Mammography Benefit Amount is payable:

- once while the Insured is age 35 to 39;
- once every two years, or more frequently based on the recommendation of the Insured's Physician, while the Insured is age 40 to 49; and
- once every year while the Insured is age 50 or older.

LIMITATIONS AND EXCLUSIONS

Unum will not pay benefits for a claim that is caused by, contributed to by or occurs as a result of:

- participating or attempting to participate in a felony or being engaged in an illegal occupation;
- committing or trying to commit suicide or injuring oneself intentionally, whether sane or not;
- participating in war or any act of war, whether declared or undeclared;
- being under the influence of or addicted to intoxicants or narcotics. This would not include Physician prescribed medication, taken in the prescribed dosage; or
- having a Date of Diagnosis during the Benefit Waiting Period.

Pre-existing Condition Limitation. Unum will not pay benefits for a claim that is caused by, contributed to by or occurs as a result of a Pre-existing Condition or any medical or surgical treatment for that condition for which the Date of Diagnosis is in the first 12 months after the Insured's coverage effective date.

OTHER FEATURES

Your Right to Continue Coverage (Portability)

If, while You are covered under the policy, Your employment with the Policyholder ends or You are no longer in an eligible group, You may have the right to apply to continue coverage under the policy for Yourself, Your Spouse if covered, and Your Dependent Children.

You must apply for coverage under this portability provision and pay the first premium within 31 days after the date Your employment ends or You are no longer in an eligible group.

You are not eligible to apply for continuing coverage under this provision if the policy is closed to new enrollments or Your coverage under the policy ends for any of the following reasons:

- the policy is cancelled; or
- the policy is changed to exclude the group of employees to which You belong.

Except as provided in this section, Your continuing coverage will be the same coverage provided You under the policy as of the date Your employment ends or You are no longer in an eligible group and any subsequent change to the policy will not apply to Your continuing coverage.

Your continuing coverage is subject to all of the provisions, exclusions and limitations of the policy, except that:

- You may decrease, but not increase, the amount of Your Critical Illness coverage, and the amount of Your Spouse's coverage, if any;
- premiums will be billed directly to You;
- initial premium rates will be based on the portability rates in effect at the time You apply to continue Your coverage; and
- premium rates can be changed by Unum at any time upon 31 days notice to You so long as the change is not due to any change in your age or health or the age or health of Your Spouse or Your Dependent Children.

Your continuing coverage, and any coverage of Your Spouse and Dependent Children, will end on the earliest to occur of:

- Your failure to pay the required premium within the 31 day Grace Period;
- unless Your Spouse applies for continuing coverage under the following provision, the date You die; or
- the coverage under this portability provision is cancelled by Unum for any reason upon 31 days notice.

Once continuing coverage is cancelled it can not be reinstated.

In the event the Policyholder's coverage under the policy is cancelled or closed to new enrollments, the policy will remain in effect for the benefit of those who have continued their coverage under this provision prior to the policy cancellation date or that date.

The Right of Your Spouse to Continue Coverage if You Die, or are Divorced (Spouse Portability)

If You die or divorce Your Spouse may have the right to apply to continue coverage under the policy.

Your Spouse must apply for coverage under this portability provision and pay the first premium within 31 days after the date of Your death or divorce.

Your Spouse is not eligible to apply to continue coverage under this provision if Your Spouse was not insured under this policy on the date of Your death or divorce.

Except as provided in this section, your Spouse's continuing coverage will be the same coverage provided Your Spouse under the policy as of the date of Your death or divorce and any subsequent change to the policy will not apply to Your Spouse's continuing coverage.

If You die and Your Spouse applies to continue coverage, any eligible Dependent Children will be covered under Your Spouse's continued coverage. Critical Illness Coverage for Dependent Children will be provided at 25% of Your Spouse's Critical Illness Face Amount.

Your Spouse's continuing coverage is subject to all of the provisions, exclusions and limitations of the policy, except that:

- Your Spouse may decrease, but not increase the amount of the Spouse's Critical Illness coverage;
- premiums will be billed directly to Your Spouse;
- initial premium rates will be based on the portability rates in effect at the time Your Spouse applies to continue coverage; and
- premium rates can be changed by Unum at any time upon 31 days notice to Your Spouse.

Your Spouse's and any Dependent Children's continuing coverage will end on the earliest to occur of:

- Your Spouse's failure to pay the required premium within the 31 day Grace Period;
- the date Your Spouse dies; or
- the coverage under this portability provision is cancelled by Unum for any reason upon 31 days notice.

Once continuing coverage is cancelled it cannot be reinstated.

In the event the Policyholder's coverage under the policy is cancelled or closed to new enrollments, the policy will remain in effect for the benefit of those who have continued their coverage under this provision prior to the policy cancellation date or that date.

STATE REQUIREMENTS

CALIFORNIA
CONTACT NOTICE

GENERAL QUESTIONS: If you have any general questions about your insurance, you may contact the Insurance Company by:

CALLING:
1-800-421-0344 (Customer Information Call Center)

-OR-

WRITING TO:
Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

COMPLAINTS: If a complaint arises about your insurance, you may contact the Insurance Company by:

CALLING:
(Compliance Center Complaint Line)
Toll free: 1-800-321-3889, Option 2
Direct: 207-575-7568

-OR-

WRITING TO:
Chief Compliance Officer
Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

WHEN CALLING OR WRITING TO THE INSURANCE COMPANY, PLEASE PROVIDE YOUR INSURANCE POLICY NUMBER.

If the Policy or Certificate of Coverage was issued or delivered by an agent or broker, please contact your agent or broker for assistance.

You also can contact the California Department of Insurance. However, the California Department of Insurance should be contacted only after discussions with the Insurance Company or its agent or other representative, or both, have failed to produce a satisfactory resolution to the problem.

Department of Insurance
Consumer Communications Bureau
300 South Spring Street - South Tower
Los Angeles, California 90013
In-State Toll Free Hotline Telephone Number: 1-800-927-4357
Local Telephone Number: 213-897-8921
Office Hours: 8:00 a.m. - 5:00 p.m.
www.insurance.ca.gov

This form is for contact information only, and it is not to be considered a condition for the Policy.

GENERAL DEFINITIONS

Additional definitions may be contained in other policy provisions, amendments or riders.

Active Employment means You are working for Your Employer for earnings that are paid regularly and that You are performing the material and substantial duties of Your regular occupation. You must be working at least the minimum number of hours as described under Minimum Hours Requirement shown in the Benefits at a Glance.

Your work site must be:

- Your Employer's usual place of business;
- an alternative work site at the direction of Your Employer; or
- a location to which Your job requires You to travel.

Normal vacation is considered Active Employment.

Temporary and seasonal workers are excluded from coverage.

Benefit Waiting Period means the first 30 days following the effective date of the Insured's coverage.

Certificate of Coverage means a written statement prepared by Unum and may include attachments. It tells You:

- the coverage to which the Insured may be entitled;
- to whom benefits are payable; and
- limitations, exclusions and/or requirements that apply within this policy.

Covered Loss means a condition covered by this policy as shown in the Benefits at a Glance and as applied for by You and approved by Unum.

Dependent Child(ren) means Your unmarried children from live birth but less than age 25. Dependent Children include Your own natural offspring, lawfully adopted children and stepchildren, including children of Your domestic partner. They also include foster children and other children who are dependent on You for main support and living with You in a regular parent-child relationship. A child will be considered adopted on the date of placement in Your home.

After attainment of age 25 Dependent Child(ren) also includes dependent children who became incapable of self-sustaining employment, prior to age 25, due to mental or physical handicap. Such child will continue to be an Insured subject to the following: (1) the Employee must furnish proof of such incapacity and dependency to Unum within 31 days of the child's 25th birthday; and (2) proof of continued incapacity and dependency must be furnished at Our request, but not more than annually, after the two year period following the child's 25th birthday.

No Dependent Child can be covered as both an Employee and a Dependent Child.

Eligibility Waiting Period means the continuous period of time that You must be in Active Employment in an eligible group before You are eligible for coverage.

Employee means a person who is in Active Employment in the United States with the Employer.

Employer means the Policyholder and includes any division, subsidiary or affiliated company.

Evidence of Insurability means a statement of Your or Your Spouse's medical history which Unum will use to determine if You or Your Spouse are approved for coverage. Evidence of Insurability will be at Unum's expense.

Grace Period means the period of time following the premium due date during which premium payment may be made.

Injury means a bodily injury which is the result of an accident.

Insured means any person covered under the policy.

Layoff or **Leave of Absence** means that You are temporarily absent from Active Employment for a period of time that has been agreed to in advance in writing by Your Employer.

Your normal vacation time is not considered a temporary Layoff or Leave of Absence.

Payable Claim means a claim for which Unum is liable under the terms of the policy.

Physician means a person performing tasks that are within the limits of his or her medical license and is:

- licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize You, Your Spouse, Dependent Children, parents or siblings, a business or professional partner, or any person who has a financial affiliation or business interest with You, as a Physician for a claim that You send to Us.

Policyholder means the Employer to whom the policy is issued.

Pre-existing Condition means a Sickness or Injury or symptoms of a Sickness or Injury, whether diagnosed or not, for which the Insured received medical treatment, consultation, care or services, including diagnostic measures, took prescribed drugs or medicine or had been prescribed drugs or medicine to be taken during the 12 months just prior to the Insured's coverage effective date; or the Insured had a Sickness or Injury or symptoms of a Sickness or Injury, whether diagnosed or not, for which an ordinarily prudent person would have consulted a health care provider during the 12 months just prior to the Insured's coverage effective date.

Scheduled Enrollment Period means a period of time determined by Unum and Your Employer.

Sickness means an illness or disease.

Spouse means Your lawful Spouse, including a legally separated Spouse, residing in the United States. You may not cover Your Spouse if Your Spouse is enrolled for coverage as an Employee. Spouse, wherever used, includes:

- Your domestic partner named in Your declaration of domestic partnership on file with the Secretary of State of California;
- Your partner in a civil union, registered domestic partnership or substantially similar legal relationship created in another jurisdiction; or
- Your unregistered domestic partner. Your unregistered domestic partner is the person named in Your signed declaration of domestic partnership approved and recorded by Your Employer.

We, **Us** and **Our** means Unum Life Insurance Company of America.

You, **Your** and **Yourself** means an Employee who is eligible for Unum coverage.

THE FOLLOWING NOTICES AND CHANGES TO YOUR COVERAGE ARE REQUIRED BY THE STATE OF ALASKA. PLEASE READ CAREFULLY.

If you have a complaint about your insurance you may contact Unum at 1-800-321-3889, or the department of insurance in your state of residence. Links to the websites of each state department of insurance can be found at www.naic.org.

Si usted tiene alguna queja acerca de su seguro puede comunicarse con Unum al 1-800-321-3889, o al departamento de seguros de su estado de residencia. Puede encontrar enlaces a los sitios web de los departamentos de seguros de cada estado en www.naic.org.

The states of **Florida** and **Maryland** require us to advise residents of these states that if your Certificate was issued in a jurisdiction other than the state in which you reside, it may not provide all of the benefits required by the laws of your residence state.

If you are a resident of Alaska and the provisions referenced below appear in your Certificate in a form less favorable to you as an insured, they are amended as follows:

The certificate cover page is amended to remove Unum's discretionary authority to determine eligibility for benefits and interpret the terms and provisions of the policy when making a benefit determination under the policy.

The **Time of Payment of Claims** provision in the **CLAIM INFORMATION** section of the policy is amended to include the following: “Claim payments must be made within 30 days of receipt of a clean claim, or within 15 days of receipt of additional information for other than a clean claim. If claims are not paid within the time limit, interest accrues at an interest rate of 15% per year.”

The **Overpayments** provision in the **CLAIM INFORMATION** section of the policy is amended by limiting the right to request reimbursement of overpayments to 12 months from the date of the overpayment.

The **LIMITATIONS AND EXCLUSIONS** provision in the **BENEFIT INFORMATION** section is amended to remove any exclusion for a claim that is caused by, contributed to by or occurs as a result of committing acts of terrorism.

ERISA

Additional Summary Plan Description Information

If this policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. If ERISA applies, the following provisions are part of the Plan. Benefit determinations are controlled exclusively by the policy, your certificate of coverage and the information contained in this document.

Name of Plan:
Canon Medical Systems, Inc.

Name and Address of Employer:
Canon Medical Systems USA, Inc.
2441 Michelle Dr
Tustin, California
92781

Plan Identification Number:
a. Employer IRS Identification #: 68-0178440
b. Plan #: 501

Type of Welfare Plan:
Specified Disease

The Plan may include other welfare benefits insured through Unum which are offered through your Employer.

Type of Administration:
The Plan is administered by the Plan Administrator. Benefits are administered by Unum as the insurer.

ERISA Plan Year Ends:
December 31

Plan Administrator, Name, Address, and Telephone Number:
Toshiba America Medical Systems, Inc.
2441 Michelle Drive
Tustin, California
92780
(714) 730-5000

Toshiba America Medical Systems, Inc. is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of Legal Process on the Plan:
Toshiba America Medical Systems, Inc.
2441 Michelle Drive

Tustin, California
92780

Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

Funding and Contributions:

The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under policy number R0146035 CI-0%-01.

This coverage may be provided under a Plan that provides other benefits as well. Contributions to the Plan are made as stated under your certificate of coverage. The contributions made by you and your Employer, if any, for this coverage may be used by the Plan to provide any of the benefits under the Plan. The Employer is ultimately responsible for paying any difference between the total cost of benefits under the Plan and the amounts you and other employees contribute.

EMPLOYER'S RIGHT TO AMEND THE PLAN

The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of this Plan (including any related documents and underlying policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan.

EMPLOYER'S RIGHT TO REQUEST POLICY CHANGE

The Employer can request a policy change. Only an officer or registrar of Unum can approve a change. The change must be in writing and endorsed on or attached to the policy.

MODIFYING OR CANCELLING THE POLICY

The policy can be cancelled:

- by Unum; or
- by the Policyholder.

Unum may cancel or modify the policy if:

- the Policyholder does not promptly provide Unum with information that is reasonably required;
- the Policyholder fails to perform any of its obligations that relate to the policy;
- fewer than 10 employees or less than 5% of those eligible are insured under the policy;
- the premium is not paid in accordance with the provisions of the policy that specify whether the Policyholder, the employee, or both, pay(s) the premiums;
- the Policyholder does not promptly report to Unum the names of any employees who are added or deleted from the eligible group;
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger,

divestiture, acquisition, sale or reorganization of the Policyholder and/or its employees;
- Unum provides 31 days notice at any time after the Initial Rate Guarantee for any reason; or
- Unum is notified of a change in Federal or State Law materially affecting the policy.

If Unum cancels or modifies the policy, for any of the reasons listed above, a written notice will be delivered to the Policyholder at least 31 days prior to the cancellation date or modification date. The Policyholder may cancel the policy if the modifications are unacceptable.

If any premium is not paid during the 31 day grace period, the policy will cancel automatically at the end of the grace period. The Policyholder is liable for premium for coverage during the grace period. The Policyholder must pay Unum all premiums due for the full period the policy is in force. In the event of termination, the policy may be reinstated only as agreed upon by Unum and the Policyholder. If Unum agrees to reinstate the policy, such reinstatement will not constitute waiver of the termination provision in the future.

The Policyholder may cancel the policy by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Policyholder and Unum agree, the policy can be cancelled on an earlier date. If Unum or the Policyholder cancels the policy, coverage will end at 12:00 midnight on the last day of coverage.

If the policy is cancelled, the cancellation will not affect a payable claim.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;

- reference specific Plan provision(s) on which the determination is based;

- describe additional material or information necessary to complete the claim and why such information is necessary;

- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the

Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;

- a reference to the specific Plan provision(s) on which the determination is based;

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;

- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- the statement that "You or 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".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

YOUR RIGHTS UNDER ERISA

As a participant in this 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, all documents governing the Plan, including insurance contracts, 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 copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit 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 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 that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from 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, if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any 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, D.C. 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.

DISCRETIONARY ACTS

The Plan, acting through the Plan Administrator, delegates to Unum and its affiliate Unum Group discretionary authority to make benefit determinations under the Plan.

Unum and Unum Group may act directly or through their employees and agents or further delegate their authority through contracts, letters or other documentation or procedures to other affiliates, persons or entities. Benefit determinations include determining eligibility for benefits and the amount of any benefits, resolving factual disputes, and interpreting and enforcing the provisions of the Plan. All benefit determinations must be reasonable and based on the terms of the Plan and the facts and circumstances of each claim.

Once you are deemed to have exhausted your appeal rights under the Plan, you have the right to seek court review under Section 502(a) of ERISA of any benefit determinations with which you disagree. The court will determine the standard of review it will apply in evaluating those decisions.

NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that the member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

Persons Covered

Generally, an individual is covered by the Association if the insurer was a member of the Association and the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

Amounts of Coverage

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

  For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

  - Life Insurance
    - 80% of death benefits but not to exceed $300,000
    - 80% of cash surrender or withdrawal values but not to exceed $100,000

  - Annuities and Structured Settlement Annuities
    - 80% of present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for all life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

  The maximum amount of protection provided by the Association to an individual, as of July 1, 2016 is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the

date on which the insurer became an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract.
- A policy issued by a health care service plan (HMO), a hospital or medical organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society.
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts, that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual.
- Employer and association plans to the extent they are self funded or uninsured.
- A policy or contract providing any health care benefits under Medicare Part C or Part D.
- An annuity issued by an organization that is only licensed to issue charitable gift annuities.
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract.
- Any policy of reinsurance unless an assumption certificate was issued.
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1067.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance Guarantee Association
P.O. Box 16860
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.