SUN LIFE ASSURANCE COMPANY OF CANADA

Executive Office:
One Sun Life Executive Park
Wellesley Hills, MA 02481

(800) 247-6875
www.sunlife.com/us

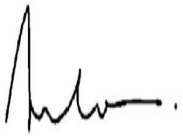
Sun Life Assurance Company of Canada certifies that it has issued and delivered a Group Insurance Policy to the Policyholder shown below.

Policy Number:	941712-003
Policy Effective Date:	January 1, 2021
Policyholder:	McPherson College
Employer:	McPherson College
Issue State:	Kansas

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 otherwise preempted by the federal Employee Retirement Income Security Act ("ERISA").

Signed at Wellesley Hills, Massachusetts.



Dean A. Connor
President and Chief Executive Officer

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

Group Vision Certificate

Non-Participating

DISCLOSURE OF INFORMATION

This Disclosure provides you with information regarding your Group Vision Benefits. It is intended to clarify and to provide additional information about your plan. The Group Certificate provides detailed provisions of coverage including any limitations or restrictions that apply. **Read your certificate carefully.**

What is the Sun Life Vision Plan?
The Sun Life Vision plan is a group vision insurance program provided by us that uses a nationwide network of Participating Providers. Vision Service Plan (VSP) is the vision network administrator and is responsible for the development and management of the vision network. VSP strives to provide the most comprehensive network of Participating Providers possible in all areas of the country. In order to ensure that the quality standards are met, VSP chooses Participating Providers carefully based on their professional licensing, work history, education, malpractice history, professional liability and ethics.

Key features of this plan include:
- Insureds may receive services from Providers of their choice; and
- Insureds may receive higher levels of benefits for vision services when choosing Participating Providers.

How do you find a Participating Provider in the network?
You may obtain provider directories by:
- contacting VSP Customer Service Department at 800-877-7195; or
- viewing the list of Participating Providers on VSP website at www.vsp.com.

It is possible that a Participating Provider may have left or joined the network since the publishing of the directory. You may contact VSP directly to report a directory inaccuracy.

How are Providers in the network compensated?
Reimbursements to vision Participating Providers are based on various factors. When covered services are provided by a Participating Provider the Provider will receive any required Co-payment from you at the time the services are provided. Benefits are provided to you in the form of an Allowance or Discounts for Materials received from a Participating Provider. An Insured must pay any amount over the Allowance and the charges for Discounted Materials directly to the Participating Provider.

The Participating Provider is not given an incentive or bonus that encourages withholding service or that influences referrals to specialists. If you want additional information about how Participating Providers are compensated, please contact us.

Is the Provider allowed to discuss all treatment options with you?
The Vision Participating Provider contracts do not limit the Participating Provider's communications. The contracts do not prohibit the Provider from discussing, with an Insured:
- the available treatment options and services; or
- the compensation methodology.

What is a Benefit Authorization?
Benefit Authorization must be obtained prior to obtaining benefits for covered vision expenses from a Participating Provider. When you or a Dependent seek benefits from a Participating Provider, schedule an appointment and identify yourself as an Insured under the Policy. The Participating Provider will obtain a Benefit Authorization from the Network Plan manager. The Network Plan manager will provide a Benefit Authorization to the Participating Provider to authorize benefits for the Insured. Each Benefit Authorization will contain an expiration date, stating a specific time period for the Insured to obtain covered benefits.

The Network Plan manager will issue Benefit Authorizations based on eligibility information and past service utilization, provided by the Policyholder and the Insured. Any Benefit Authorization issued by the Network Plan manager serves as notice to the Participating Provider that payment will be made provided services or Materials are received prior to the date the Benefit Authorization expires.

DISCLOSURE OF INFORMATION

What are your benefits?
The "Benefit Highlights" and "Covered Vision Benefits" sections of the Certificate contain information regarding benefits including Co-payments, Discounts and Allowances. The "Benefit Highlights" section outlines the benefit levels for treatment both in and out of network. It also includes information about your responsibility for payment related to Co-payments, Discounts and Allowances. If services are not covered by the Policy, you are responsible for full payment.

The "Exclusions" section of the Certificate contains information about charges for which no benefits are paid. Benefits are payable for Visually Necessary Treatment, subject to all of the provisions of the Policy.

The following example illustrates benefit payments using both Participating and Non-Participating Providers. Your plan may differ in Allowances and Co-payment levels. However, this example demonstrates the impact on benefits of using Non-Participating Providers.

This example assumes a $10 Co-payment for a Well Vision Examination, frames and lenses; a retail cost of $75 for a Well Vision Examination, $200 for frames and a prescription for single vision lenses at a retail cost of $150.

Service or Materials	**Network Plan (Participating Provider)**	**Non-Network Plan (Non-Participating Provider)**
Well Vision Examination	No Cost after $10 Co-payment	Reimbursed up to $52 Allowance
Frames	$10 Co-payment for lenses & frames $130 Allowance 20% Discount on any amount exceeding Allowance	Reimbursed up to $57 Allowance
Lenses	No Cost after $10 Co-payment for lenses & frames	Reimbursed up to $55 Allowance
Plan Benefits	$359	$164
You Pay	**$76**	**$261**

Is your information kept confidential?
Vision records and other patient information will be released only upon written authorization from you. Such information may only be used *by us* to determine eligibility for benefits and to administer the Policy. We maintain physical, electronic, and procedural safeguards to protect the confidentiality of information provided to us.

What are our responsibilities regarding your rights?
We are committed to treating all our Insureds in a manner that respects their rights under the Policy. We expect the Providers of care to treat our Insureds as they would any other patient in terms of care provided, accommodations, and timeliness of access to care.

The Sun Life Vision plan does, sometimes, solicit information on Insured satisfaction.

How do you contact us?
You can contact us at:
Sun Life Assurance Company of Canada
One Sun Life Executive Park
Wellesley Hills, MA 02481
Toll-free telephone number: 800-247-6875
Hours: Monday - Friday 8:00 A.M. to 6:00 P.M. ET

TABLE OF CONTENTS

1. BENEFIT HIGHLIGHTS

EMPLOYEE, SPOUSE AND DEPENDENT CHILDREN VISION INSURANCE

Eligible Class: All 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 following 30 days of employment

Covered Benefits

Unless otherwise specified, the following benefits will be payable. Refer to the Covered Vision Benefits section of this Certificate for additional information.

NETWORK PLAN

Well Vision Examination Available one time each Benefit Period.	**Your Cost** No Cost after $10 Co-payment
Contact Lenses Visually Necessary* Available one time each Benefit Period.	**Your Cost** Visually Necessary contact lenses are covered in full when specific benefit criteria are satisfied and when prescribed by a Participating Provider (includes professional fees and Materials). $25 Co-payment applies
Elective (not Visually Necessary)** Available one time each Benefit Period, in place of lenses and frames (glasses).	**Your Cost** $60 Co-payment for elective contact lens services (fitting & evaluation). Covered in full up to the $130 Allowance for contact lenses (Materials).
Frames*** Any frame available at a Participating Provider location. Available one time each Benefit Period.	**Your Cost** $25 Co-payment (for lenses & frame) Covered in full up to the $130 Allowance with a 20% Discount on any amount exceeding Allowance. Some of the Participating Retail Chain Providers provide special Discounts on frames. The frame Allowance for these Providers is $70. Please contact the Network Plan manager by calling toll-free 1.800.877.7195.
Lenses*** Available one time each Benefit Period. Coverage includes prescription glass or plastic, single vision, lined bifocal, lined trifocal or lenticular lenses. Lens options are available at cost controlled pricing as described in the Limitations and Exclusions section.	**Your Cost (Co-payment)** No cost after $25 Co-payment (lenses & frame)
Laser Surgery Available one time per eye per lifetime. Includes Discounts toward laser surgery, photorefractive keratectomy (PRK), laser-assisted in-situ	**Your Cost (Discount off Participating Provider's normal charge)** Discounts averaging 15% off the Participating Provider's normal charge for laser surgery or 5% off any promotional price. ****

keratomileusis (LASIK), Custom PRK, Custom LASIK and Bladeless LASIK.

*Visually Necessary contact lenses are a covered vision expense when specific criteria are satisfied and when prescribed by a Participating Provider or Non-Participating Provider. Prior review and approval by Network Plan manager are not required to be eligible for Visually Necessary contact lenses. Visually Necessary contact lenses or elective contact lenses are not payable in addition to glasses.

**Participating Providers will provide 15% Discount to their normal professional fees for the evaluation and fitting of elective contact lenses.

***Benefits for lenses are per complete set, not per lens.

Benefits for lenses and frames include reimbursement for the following Visually Necessary professional services:
1. Prescribing and ordering proper lenses;
2. Assisting in frame selection;
3. Verifying accuracy of finished lenses;
4. Proper fitting and adjustments of frames;
5. Subsequent adjustments to frames to maintain comfort and efficiency;
6. Progress or follow-up work as necessary.

Frame Allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, Custom PRK, Custom LASIK or Bladeless LASIK patients.

**** If the Participating Provider is offering a price reduction for laser surgery, the Insured will receive an additional 5% off the promotional price. Check with the Participating Provider for specific Discounts available.

NON-NETWORK PLAN

Well Vision Examination Available one time each Benefit Period.	**Allowance** Reimbursed up to the $45 Allowance.
Materials: **Contact Lenses** **(includes fit, follow-up, professional services and Materials)**	**Allowance**
Visually Necessary Available one time each Benefit Period.	Reimbursed up to the $210 Allowance.
Elective (not Visually Necessary) Available one time each Benefit Period.	Reimbursed up to the $105 Allowance.
Frames	**Allowance**
Any frame available at Provider location Available one time each Benefit Period.	Reimbursed up to the $70 Allowance.
Lenses Available one time each Benefit Period. Single Vision	**Allowance** Reimbursed up to the $30 Allowance.

1. BENEFIT HIGHLIGHTS

EMPLOYEE, SPOUSE AND DEPENDENT CHILDREN VISION INSURANCE

Lined Bifocal	Reimbursed up to the $50 Allowance.
Lined Trifocal	Reimbursed up to the $60 Allowance.
Lenticular	Reimbursed up to the $100 Allowance.

BENEFIT PERIODS (NETWORK AND NON-NETWORK PLANS)

Well Vision Examination	12 months
Frames	24 months
Lenses or Contact Lenses	12 months

NOTE:
Discounts do not apply for benefits provided by Other Group Vision Expense Coverage.

Each Allowance shown above can be applied only one time during a Benefit Period. There is no remaining balance available for the current Benefit Period or to carry over to the next Benefit Period.

ADDITIONAL DISCOUNTS
Each Insured shall be entitled to receive a Discount of 20% toward the purchase of additional complete pairs of prescription and non-prescription glasses (lenses, lens options and frames) from a Participating Provider on the same day as your covered eye Examination. Each Insured shall be entitled to receive a Discount of 20% toward the purchase of additional complete pairs of prescription and non-prescription glasses (lenses, lens options, and frames) from a Participating Provider within 12 months of the last covered eye Examination. Additional pair means any complete pair of prescription and non-prescription glasses purchased beyond the benefit frequency allowed under the Policy.

Additionally, each Insured shall be entitled to receive a Discount of 15% off Participating Provider professional fees for elective contact lens evaluations and fittings. Discounts are applied to the Participating Provider's normal fees for such services and are available within 12 months of the covered eye Examination from any Participating Provider. Contact lens materials are provided at the Participating Provider's normal charges.

Additional Discounts noted on this Benefit Highlights are subject to change as deemed appropriate by the Participating Provider with prior notification to the Employer.

NOTE: Discounts do not apply to vision care benefits obtained from Non-Participating Providers.

LOW VISION BENEFIT

The Low Vision Benefit is a covered vision expense when specific criteria are satisfied and when prescribed by the Insured's Participating Provider or Non-Participating Provider.

1. BENEFIT HIGHLIGHTS

EMPLOYEE, SPOUSE AND DEPENDENT CHILDREN VISION INSURANCE

	Participating Provider Benefit	Non-Participating Provider Benefit
Supplementary Testing	Covered in Full	Allowance up to $125

Complete low vision analysis/diagnosis, which includes supplemental examinations of visual functions, including the prescription of corrective eyewear or vision aids where indicated.

Supplemental Care Aids	75% of Cost	75% of Cost*

Subsequent low vision aids as Visually Necessary or appropriate.
Co-payment for Supplemental Aids: 25% payable by the Insured.

The maximum benefit available for supplemental examinations and materials or visual aids is $1,000 (excluding Co-payment) in any 24-month period.

Non-Participating Provider Low Vision Benefit
Except for supplementary testing as noted above, low vision benefits secured from a Non-Participating Provider are subject to the same time limits and Co-payment arrangements as described above for a Participating Provider. The Insured should pay the Non-Participating Provider's full fee.

*The Insured will be reimbursed in accordance with an amount not to exceed what the Network Plan would pay a Participating Provider in similar circumstances. There is no assurance that this amount will be within the 25% Co-payment feature.

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

2. DEFINITIONS

Actively at Work means that you perform all the regular duties of your job for a full work day at your Employer's normal place of business, a site approved by your Employer or a site where your Employer's business requires you to travel.

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.

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.

Allowance means the dollar amount provided under the Policy, as shown in the Benefit Highlights.

Benefit Authorization means authorization from the Network Plan manager identifying you as an Insured or your dependent as an Insured under the Policy and identifying the benefits for which each Insured is eligible.

Benefit Period means the number of consecutive months shown in the Benefit Highlights, during which benefits are payable under the Policy. A Benefit Period begins on the later of the date you become insured under the Policy or the last date you incurred covered vision expenses. There may be separate Benefit Periods for an Examination and for each category of Materials.

Confined or Confinement means confined to a hospital or similar facility.

Co-payment means any dollar amount shown in the Benefit Highlights, which is required to be paid by the Insured at the time services are rendered or Materials are provided.

Dependent means your insured Spouse and Dependent Children. Dependent does not include a person who is an Employee of your Employer unless you and your Spouse are each Employees of your Employer and you have or acquire a Dependent Child.

Dependent Child (Dependent Children) means your insured child under age 26.

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

If an unmarried child is age 26 or older and is:
- incapable of self-sustaining employment because of an intellectual disability; developmental disability or physical handicap; and
- chiefly dependent on you for his or her support;
  that child will continue to be considered a Dependent Child under the Policy for as long as these conditions exist.

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

Dependent Child does not include:
- any person who is insured as an Employee;
- your married child whose employer sponsors vision insurance; 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.

Discount means any percentage off professional services or Materials shown in the Benefit Highlights, which are required to be paid by the Insured.

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

Eligibility Waiting Period means the length of time you must be a member in an Eligible Class before you can apply for insurance. The Eligibility Waiting Period is shown in the Benefit Highlights.

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, and paid regular earnings, 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 or elect to become covered under an Alternate Plan. The Enrollment Period cannot exceed 30 days or occur more than once in any 12-month period, unless we agree in Writing.

Examination means a vision test, including a determination as to the need and method for correction of Visual Acuity, that is performed by a Provider. An Examination may include but not be limited to the following procedures:

- case history, including
  - chief complaint or reason for visit,
  - patient medical/eye health history, and
  - record of current medications;
- record of Visual Acuity with and without present correction, if applicable;
- dilation, if necessary;
- pupil responses;
- external exam findings;
- internal exam findings;
- screening of visual fields perception;
- appraise present prescription;
- retinoscopy (when applicable);
- subjective refraction at far and near point;
- binocular and ocular mobility testing;
- test of accommodation or near point refraction;
- tonometry;
- diagnosis/prognosis; and
- specific recommendations.

2. DEFINITIONS

Experimental Nature means a procedure or lens that is not used universally or accepted by the vision care profession.

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

Family Status Change means one of the following events:
- your Marriage or Divorce;
- the birth of your child;
- the adoption of a child by you;
- the placement of a child with you, pending adoption;
- the death of your Spouse or child;
- the commencement or termination of employment of your Spouse or Dependent Child;
- the change from part-time to full-time employment by you or your Spouse;
- the change from full-time to part-time employment by you or your Spouse; or
- the taking of an unpaid leave of absence by you or your Spouse.

Insured means any person covered under the Policy.

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

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

Marriage means any of the following relationships as recognized under local, state, federal or provincial law: a same-sex or opposite-sex marriage; a civil union partnership under which the partners have the same legal rights and responsibilities as a married couple; and a same-sex or opposite-sex registered domestic partnership under which the partners have the same legal rights and responsibilities as a married couple.

Materials means:
- low vision aids;
- corrective, prescription or contact lenses; or
- frames.

Multifocal Lenses means lenses with more than one optical center (i.e., a bifocal, a trifocal, or Progressive Lenses).

Network Plan means the vision-care delivery system established by the Network Plan manager in which Participating Providers participate and under which we provide certain vision benefits.

Non-Network Plan means the plan under which we provide certain vision benefits for services and Materials received from a Non-Participating Provider.

Non-Participating Provider means an Ophthalmologist, Optician, Optometrist, vision center or any vision-care provider who is not a participant in our Network Plan.

Ophthalmologist means a Physician specializing in the eye who is trained to examine, diagnose, treat and manage diseases of the visual system, including all types of surgical procedures.

Optician means a professional trained to fit and adjust eyewear based on the specifications provided by an Optometrist or Ophthalmologist.

2. DEFINITIONS

Optometrist means a primary health care professional who can diagnose, manage and treat conditions and diseases of the human eye and visual system, as required by state law.

Orthoptics means the teaching and training process for the improvement of visual perception and coordination of the two eyes for efficient and comfortable binocular vision.

Other Group Vision Expense Coverage means:
- any other group policy providing benefits for vision expenses; or
- any plan providing vision expense benefits (whether through a vision services organization or other party providing prepaid health or related services) which is arranged through any employer or through direct contact with persons eligible for that plan.

Participating Provider means an Ophthalmologist, Optician, Optometrist, vision center or any vision-care provider who is a participant in our Network Plan.

Participating Retail Chain Providers mean Providers who have not contracted as Participating Providers but who have agreed to bill the Network Plan manager directly in the form of an Allowance as shown in the Benefit Highlights for certain covered vision expenses. Participating Retail Chain Providers do not provide an Allowance for all covered vision expenses shown in the Benefit Highlights.

Physician means a person who is operating within the scope of his or her license and is either:
- licensed in the United States 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 law to have the same authority as a legally qualified medical doctor.

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

Plano Lenses means lenses which have less than a +/- .50 diopter power.

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

Prior Plan means the Employer's group plan of vision insurance that was in force on the day before the effective date of the Policy.

Progressive Lenses means Multifocal Lenses with no visible lines.

Proof means any information that is:
- required by us under the terms of the Policy; and
- satisfactory to us.

Provider means a qualified Ophthalmologist or Optometrist who is operating within the scope of his or her license or a dispensing Optician.

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.

Spouse means any individual who is a party to a Marriage and:
- under local, state, federal or provincial law is recognized as a spouse, a partner in a civil union, a partner in a registered domestic partnership under which the partners have the same legal rights and responsibilities as a married couple, or are otherwise accorded the same rights as a spouse; or
- is a domestic partner as defined by the Policyholder.

Spouse does not include:
- any person who is insured as an Employee; or

- any person residing outside the United States. This exclusion does not apply to your Spouse who resides with you while you are on a temporary work assignment outside the United States.

Visual Acuity means the sharpness of vision, the ability of the eye to distinguish detail.

Visually Necessary means an Examination and Materials necessary to restore or maintain Visual Acuity and health.

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

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 vision insurance?
You are initially eligible for Employee vision insurance on the latest of:

- January 1, 2021;
- the first day of the month following the date your Eligibility Waiting Period ends; or
- the date you first are Actively at Work in an Eligible Class.

You are also eligible for Employee vision 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 vision insurance?
For Contributory Employee vision insurance, you must enroll within 31 days of the date you are initially eligible for Employee vision insurance.

If you do not enroll for insurance during your initial Enrollment Period, you will not be insured for any Contributory Employee vision insurance.

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 vision insurance start?
Employee vision insurance starts on the later of the date:

- you are eligible;
- you enroll; or
- you agree to make any required contribution toward the cost of insurance;

if you are Actively at Work on that date.

When does Employee vision insurance end?
Your Employee vision insurance under the Policy will end on the earliest of the following:

- the date the Policy terminates;
- the date you are no longer in an Eligible Class;
- the date your class is no longer included for insurance;
- the last day for which any required premium has been paid for your Employee vision insurance;
- the date you request in Writing to end your Employee vision insurance;
- the last day of the month in which you are Actively at Work, subject to the Insurance Continuation provision provided;
- the date you enter active duty in any armed service during time of war, declared or undeclared;
- the last day of the month in which you retire; or
- the date you die.

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

A new Eligibility Waiting Period will not apply.

Your reinstated insurance will be:

- the same insurance you had prior to the termination of your employment; and
- subject to all the terms and provisions of the Policy.

4. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE

When are you eligible for Spouse vision insurance?
If you are in an Eligible Class, you are initially eligible for Spouse vision insurance on the latest of:

- January 1, 2021;
- the date you are insured for Employee vision insurance; or
- the date you acquire a Spouse.

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

When does Spouse vision insurance start?
For Contributory Spouse vision insurance, Spouse vision insurance starts on the latest of the date:

- you are eligible for Spouse vision insurance;
- you are insured under the Policy for Employee vision insurance;
- you enroll for Spouse vision insurance; or
- 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 vision insurance will not start until you resume being Actively at Work.

What if your Spouse is Confined?
If your Spouse is Confined on the date your Spouse vision insurance would normally start, your Spouse vision insurance will not start until your Spouse is no longer Confined.

When does Spouse vision insurance end?
Spouse vision insurance will end on the earliest of the following to occur:

- the date the Policy terminates;
- the date you are no longer in an Eligible Class;
- the date your class is no longer included for insurance;
- the last day for which any required premium has been paid for your insurance or your Spouse Insurance;
- the date you are no longer insured under the Policy; except that if you die, your Spouse vision insurance will continue;
- the date you request in Writing to end your Spouse vision insurance;
- the last day of the month in which you are Actively at Work, subject to any Insurance Continuation provisions provided;
- the date your Spouse enters active duty in any armed service during time of war, declared or undeclared;
- the date your Spouse no longer meets the definition of Spouse as described in this Certificate;
- the last day of the month in which you retire;
- the date you die; or
- the date your Spouse dies.

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

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

- January 1, 2021;
- the date you are insured for Employee vision insurance; or
- the date you acquire your Dependent Children.

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

When does Dependent Children vision insurance start?
For Contributory Dependent Children vision insurance
Dependent Children vision insurance starts on the latest of the date:

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

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

If you are not Actively at Work, your Dependent Children vision insurance will not start until you resume being Actively at Work.

What if your Dependent Child is Confined?
If your Dependent Child is Confined on the date your Dependent Children vision insurance would normally start, your Dependent Children vision insurance will not start until your Dependent Child is no longer Confined. Confinement does not apply to a newborn child or a newly adopted child.

How does Dependent Children vision 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 vision 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 vision 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 vision insurance.

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

When does Dependent Children vision insurance end?
Dependent Children vision insurance will end on the earliest of the following to occur:

- the date the Policy terminates;
- the date you are no longer in an Eligible Class;
- the date your class is no longer included for insurance;
- the last day for which any required premium has been paid for your insurance or your Dependent Children vision insurance;
- the date you are no longer insured under the Policy;
- the date you request in Writing to end your Dependent Children vision insurance;

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

- the last day of the month in which you are Actively at Work, subject to any Insurance Continuation provisions provided;
- the date your Dependent Child enters active duty in any armed service during time of war, declared or undeclared;
- 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; or
- the last day of the month in which you retire; or
- the date you die; or
- the date your Dependent Child dies.

6. COVERED VISION BENEFITS

What is the Vision Benefit?
We will provide benefits for covered vision expenses when incurred by the Insured while covered under the Policy, subject to all the terms and conditions of the Policy. Benefits will be payable after the Insured has paid any Co-payment required during the Benefit Period. Benefits for certain covered vision expenses may be provided in the form of an Allowance or Discount.

The amount of any Co-payment, Allowance or Discount shown in the Benefit Highlights will apply to each Insured separately and can be applied only one time during a Benefit Period.

We will provide the benefits of the Network Plan shown in the Benefit Highlights for covered vision expenses incurred by the Insured if the Examination is provided by or Materials are purchased from a Participating Provider. The Insured must pay any amount over the Allowance.

We will provide the benefits of the Network Plan shown in the Benefit Highlights for frames purchased from a Participating Retail Chain Provider. The Insured should discuss requested vision services with the Participating Retail Chain Provider or the Network Plan manager for details.

We will provide the benefits of the Non-Network Plan shown in the Benefit Highlights for covered vision expenses incurred by the Insured if the Examination is provided by or Materials are purchased from a Non-Participating Provider. The Insured must pay the entire amount, after which the Allowance will be reimbursed as described in the Claim Provisions section.

Are you required to get a Benefit Authorization?
Benefit Authorization must be obtained prior to the Insured obtaining benefits for covered vision expenses from a Participating Provider. When the Insured seeks benefits from a Participating Provider, the Insured must schedule an appointment and identify himself or herself as an Insured under the Policy, so the Participating Provider can obtain a Benefit Authorization from the Network Plan manager. The Network Plan manager will provide a Benefit Authorization to the Participating Provider to authorize benefits for the Insured. Each Benefit Authorization will contain an expiration date, stating a specific time period for the Insured to obtain covered benefits.

The Network Plan manager will issue Benefit Authorizations in accordance with the latest eligibility information furnished by the Policyholder and the Insured regarding past service utilization, if any. Any Benefit Authorization issued by the Network Plan manager serves as notice to the Participating Provider that payment will be made provided services or Materials are received prior to the date the Benefit Authorization expires.

What are covered vision expenses?
Covered vision expenses include expenses for Examinations and Materials shown in the Benefit Highlights. The Insured is eligible for one Examination in each Benefit Period.

If the Examination covered by the Policy indicates that corrective Materials are necessary for the Insured's visual health and welfare, benefits will be available for:

- Lenses - Up to two lenses provided one time in each Benefit Period, as shown in the Benefit Highlights.
- Frames - One frame(s) provided one time in each Benefit Period, as shown in the Benefit Highlights.
- Contact Lenses - Up to two contact lenses provided instead of regular lenses and frame, one time in each Benefit Period, as shown in the Benefit Highlights.

Services related to Examinations and Materials include but are not limited to:

- Prescribing and ordering proper lenses;
- Assisting in the selection of a frame;
- Verifying the accuracy of the finished lenses;
- Proper fitting and adjustment of the frame or lenses;
- Subsequent adjustments to frames to maintain comfort and efficiency; and

- Progress or follow-up work as necessary.

Maximum Benefit Periods, Co-payments, Discounts, Allowances, and other limits for certain services are shown in the Benefit Highlights and under the Limitations and Exclusions provisions. Services performed outside these limits are not covered vision expenses and are the Insured's responsibility. Benefits, Co-payments, Discounts and Allowances may differ based on whether the Insured uses a Participating Provider or a Non-Participating Provider.

7. LIMITATIONS AND EXCLUSIONS

What limitations apply to the benefits payable?
In no event will coverage exceed the lesser of:

- the actual cost of the Examination and Materials, or
- the limits of coverage shown in the Benefit Highlights.

The Allowance for lenses shown in the Benefit Highlights is for two lenses. If only one lens is needed, coverage will be 50% of the Allowance shown for two lenses.

Benefits will not be payable for replacement of lost or broken Materials until the next eligible Benefit Period.

The Policy is designed to cover Visually Necessary Materials rather than cosmetic Materials. When the Insured selects any of the following extras, the Policy will pay the basic cost of the allowed lenses, and the Insured will pay the additional costs for the options.

- Optional cosmetic processes
- Anti-reflective coating
- Color coating
- Mirror coating
- Scratch coating
- Blended lenses
- Cosmetic lenses
- Laminated lenses
- Oversize lenses
- Progressive Lenses
- Photochromic lenses; tinted lenses except Pink #1 and Pink #2
- UV (ultraviolet) protected lenses
- A frame that costs more than the Allowance
- Contact lenses (except as noted in the Benefit Highlights).

What exclusions apply to the benefits payable?
Covered Vision Benefits do not include and no benefits are provided for:

- Services and/or materials not shown as covered vision expenses in the Benefit Highlights or Covered Vision Benefits;
- Plano lenses (lenses with refractive correction of less than ± .50 diopter);
- Two pair of glasses instead of bifocals;
- Replacement of lenses and frames furnished under the Policy which are lost or broken, except at the normal intervals when services are otherwise available;
- Orthoptics or vision training and any associated supplemental testing;
- Medical or surgical treatment of the eyes;
- Replacement of lost or damaged contact lenses, except at the normal intervals when services are otherwise available;
- Contact lens insurance policies or service agreements;
- Refitting of contact lenses after the initial (90-day) fitting period;
- Additional office visits associated with contact lens pathology;
- Contact lens modification, polishing or cleaning; or
- Services associated with CRT or Orthokeratology.

8. CLAIM PROVISIONS

How is a claim submitted?
If you select a Participating Provider, at the time the Participating Provider performs the Examination or provides Materials, pay your Co-payment and any other charges not covered at the time of service. No paperwork is required.

If you select a Non-Participating Provider, you do not receive the preferred pricing available through a Participating Provider. You must provide full payment to the Non-Participating Provider at the time of service. You must submit the original invoice, including an itemized statement of charges and your prescription to the address obtained by calling toll-free 1.800.877.7195.

NOTICE OF CLAIM

When does Written notice of claim have to be submitted?
If you are seeking payment from a Non-Participating Provider, Written notice of claim must be given to us no later than 90 days after the date the expense is incurred, but is not required prior to 20 days after the date the expense is incurred. Participating Providers must submit Written Notice of Claim within 180 days, but not before 20 days after the date the expense is incurred. You can send the notice to the address obtained by calling toll-free 1.800.877.7195. We need enough information to identify you or your Spouse or Dependent Child as an Insured.

We will ask you to authorize the sources of vision services to release your medical information. If you do not furnish any required information or authorize its release, we will not reimburse you for benefits.

We will not invalidate or reduce the claim if notice cannot be given within the applicable time period. However, we must be notified as soon as it is reasonably possible.

CLAIM FORMS

When we receive Written notice of claim, we will send the forms for Proof of claim. If you do not receive the forms within 15 days after Written notice of claim is sent, you are considered to have complied with the requirements of this Certificate for filing Proof of claim if you, within the time fixed in this Certificate for filing Proof of Claim, submit written proof of the occurrence, character and extent of the loss for which claim is made.

PROOF OF CLAIM

When does Written Proof of claim have to be submitted?
Proof of claim must be given to us no later than 90 days after the expense is incurred.

We will not invalidate or reduce the claim, 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.

Written notice of claim must be given to us within 20 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. You can send the notice to the address obtained by calling toll-free 1-800-877-7195. We need enough information to identify you or your Spouse or Dependent Child as an Insured.

We will ask you to authorize the sources of vision services to release your medical information. If you do not furnish any required information or authorize its release, we will not reimburse you for benefits.

8. CLAIM PROVISIONS

COMPLAINTS AND GRIEVANCES

What is considered a complaint or grievance and how is it reported?
You shall report any complaints and/or grievances to us or the Network Plan manager at the address obtained by calling toll-free 1.800.877.7195. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Complaints and grievances may be submitted to us verbally or in Writing. You may submit written comments or supporting documentation concerning your complaint or grievance to assist in our review. We will resolve the complaint or grievance within 30 working days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than 120 working days after our receipt of the complaint or grievance. If we determine that resolution cannot be achieved within 30 working days, we will notify you of the expected resolution date. Upon final resolution, we will notify you of the outcome in Writing.

PAYMENT OF BENEFITS

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 30 days after receipt of your Proof of claim. If we cannot make a decision within 30 days after receiving your claim, we will request a 15 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 to the request for additional information. You will have 45 days to provide the specified information.

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

To whom are benefits payable?
We will pay benefits for covered vision expenses directly to the Participating Provider. We will reimburse you for covered vision expenses for services you receive from a Non-Participating Provider.

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

- the specific 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;
- a description of any additional material or information needed to prove entitlement to benefits and an explanation of why such material or information is necessary;
- a description of the appeal procedures and time limits;
- your right to bring a civil action under ERISA, §502(a) following an adverse determination on review; 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.

8. CLAIM PROVISIONS

CLAIM DENIAL APPEALS

Can you request an appeal of a claim denial?
If, under the terms of the Policy, a claim is denied in whole or in part, a request may be submitted to us by you, or your authorized representative, for a full review of the denial. You may designate any person, including your Provider, as your authorized representative. References in this section to "you" include your authorized representative, where applicable.

Initial Appeal

The request must be made within 180 days following denial of a claim and should contain sufficient information to identify the person for whom the claim was denied, including:

- your name or your Spouse's or Dependent Child's name;
- your or your Spouse's or Dependent Child's identification number and date of birth;
- the Provider of services; and
- the claim number.

You or your Spouse or Dependent Child may review, during normal working hours, any documents held by us pertinent to the denial. You or your Spouse or Dependent Child may also submit Written comments or supporting documentation concerning the claim to assist in our review. Our response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to you or your Spouse or Dependent Child as follows:

Denied Claims for Services Rendered: within 30 calendar days after receipt of a request for an appeal from you or your Spouse or Dependent Child.

Second Level Appeal

If you disagree with the response to the initial appeal of the claim, you have a right to a second level appeal. Within 60 calendar days after receipt of our response to the initial appeal, you may submit a second appeal to us along with any pertinent documentation. We shall communicate our final determination to you in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

Other Remedies

When you have completed the appeals process described above, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. The Policyholder should advise you to contact the U.S. Department of Labor or the state insurance regulatory agency for details. Additionally, under the provisions of ERISA (Section 502(a)) 29 U.S.C. 1132(a), you have the right to bring a civil action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole, and you disagree with the outcome.

COORDINATION OF BENEFITS

What is Coordination of Benefits?
If an Insured is covered under more than one vision plan, the benefits from other plans may be taken into account. This may require a reduction in benefits under the Policy, so that the combined benefits will not be more than the actual expenses.

How are benefits computed under COB?
We will consider ourselves primary and benefits under the Policy will be determined first when you or your Spouse or Dependent Child are:

- insured under the Policy and
- covered under another vision plan.

However, if you or your Spouse or Dependent Child are covered under two group vision policies with us, the Policy under which the person is the employee will be considered primary.

When a Dependent Child is covered under a vision plan by each parent, the benefits of the plan of the parent whose birthday falls earlier in the year is primary. If both parents have the same birthday, the benefits of the plan that covered the parent for a longer period is primary.

If the Policy is not considered primary, benefits under the Policy may be reduced so that all benefits received are not more than the actual expenses.

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:

- Absence due to injury or sickness - for up to 12 months;
- Layoff – for up to 1 month;
- Leave of Absence - for up to 1 month;
- School Recess – up to 3 months;
- Vacation – based on your Employer's policy, not to exceed 3 months.

While the Policy is in force, you may be eligible to continue your insurance as long as your Employer keeps paying premiums on your behalf. 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.

Are there any conditions under which you can continue your insurance?
Federal law requires certain employers to offer continuation coverage to Employees for a specified period of time upon termination of employment or reduction of work hours for any reason other than gross misconduct. You should contact your Employer to find out whether or not this requirement applies. Your Employer will advise you of your rights to continuation coverage, if any, and the cost.

If this requirement does apply, you must elect to continue coverage within 60 days from your Family Status Change or notification of rights by your Employer, whichever is later.

You may elect to extend coverage for your eligible Dependents, or your eligible Dependents may elect to continue coverage under certain circumstances or due to a Family Status Change. Dependents must elect to continue coverage within 60 days from the event or notification of rights by your Employer, whichever is later.

You must pay the required premium for continuation coverage directly to your Employer. We are not responsible for determining who is eligible for continuation coverage. If the Policy contains a continuance provision that is mandated by a state law, Insureds eligible under that provision will have the choice of electing:

- the state continuance coverage and then the federal continuance coverage, if allowed by state law; or
- the federal continuance alone.

10. CONTINUITY OF COVERAGE

What happens if your Employer replaces other vision coverage with this Certificate and the Policy?
If an Insured was covered under the Prior Plan, the Continuity of Coverage benefits set forth in this Section may be available.

What if you are not Actively at Work when your Employer replaces the Prior Plan with the Policy?
You and your Spouse and your Dependent will be insured under the Policy if you are not Actively at Work on January 1, 2021 if:

- you were insured under the Prior Plan on the day before the Policy Effective Date;
- you are a member of an Eligible Class; and
- your Employer continues to remit premiums for your coverage.

What if your Spouse or Dependent Child is Confined when your Employer's Prior Plan is replaced with the Policy and you are Actively at Work?
Your Spouse or Dependent Child will be insured under the Policy on January 1, 2021 if:

- your Spouse or Dependent Child was insured under your Employer's Prior Plan on the day before the Policy Effective date;
- you are a member of an Eligible Class for Spouse or Dependent Children coverage; and
- you or your Employer continues to remit premiums for your Spouse or Dependent Children coverage.

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

11. GENERAL PROVISIONS

AGENCY

Can the Policyholder or Employer act as our agent?
For all purposes of the Policy, the Policyholder or Employer acts on its own behalf or as your agent. Under no circumstances will the Policyholder or Employer be deemed an agent of Sun Life Assurance Company of Canada.

ALTERATION

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

CLERICAL ERROR

What happens when there is a clerical error in the administration of the Policy?
Clerical errors in connection with the Policy or delays in keeping records for the Policy whether by us, the Policyholder, or the Employer:

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

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

This provision does not apply to benefit administration errors by the Policyholder or the Employer which results in an Employee:

- not enrolling for insurance within required time limits; or
- failing to exercise any available continuation options.

CONFORMITY WITH STATUTES

What is the effect of Conformity with Statutes?
If any provision of the Policy conflicts with any applicable law, the provisions of the Policy 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.

INCONTESTABILITY

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

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

11. GENERAL PROVISIONS

INSURER'S AUTHORITY

What is our authority?
We have 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, based upon enrollment information provided by the Policyholder, 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 our determinations shall uphold such determination unless the claimant proves that our determinations are arbitrary and capricious.

LEGAL PROCEEDINGS

What are the time limits for legal proceedings?
No legal action may start:

- until 60 days after Proof has been given; nor
- more than 5 years after the time Proof of claim is required.

LIMIT OF PREMIUM REFUNDS

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

MISSTATEMENT OF FACTS

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

- a fair adjustment of premium will be made, subject to the "Limit of Premium Refunds" section; and
- the actual facts will decide whether, and in what amount, and for what duration insurance is valid under the Policy.

NON-PARTICIPATING

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

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 Dependent Child or Spouse 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. 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.

11. GENERAL PROVISIONS

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 it is contained in your Written application, Signed by you, and a copy of your Written application for insurance is or has been given to you, your beneficiary, if any, or to 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

Group Vision Certificate

Non-Participating

McPherson College Employee Benefit Plan (The Plan) has been established to provide welfare benefits for its employees.

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

SUMMARY PLAN DESCRIPTION

Plan Sponsor: McPherson College
1600 E Euclid Street
Mc Pherson, KS 67460

Plan Administrator: McPherson College
1600 E Euclid Street
Mc Pherson, KS 67460

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

Agent for Service of Legal Process: McPherson College
1600 E Euclid Street
Mc Pherson, KS 67460

Employer Identification Number (EIN): 48-0543736

Plan Number: 501

End of Plan Year: December 31st

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

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

Funding: Sun Life provides the Plan Administrator with certain insurance benefits in connection with the Plan. Those insurance benefits are described in your 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. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

Assistance with Your Questions

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