SUN LIFE ASSURANCE COMPANY OF CANADA

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GROUP SPECIFIED DISEASE INSURANCE
OUTLINE OF COVERAGE

THE CERTIFICATE PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

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

This coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it. Read the Buyer's Guide to Specified Disease Insurance to review the possible limits on benefits in this type of coverage. The Guide is also available from the Company.

Read Your Certificate Carefully - This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual Policy provisions will control. The Certificate and the Policy into which it is incorporated sets forth in detail the rights and obligations of both you and your insurance company and the terms and conditions under which benefits are paid. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY!

FOR PERSONS AGE 65 AND OLDER: NOTICE OF RIGHT TO RETURN CERTIFICATE

Please read your certificate carefully. If you are age 65 or older and you are not satisfied, you may return this Certificate to your Employer within 30 days after you receive it. The amount of premium you have paid will be refunded, provided no claim has been incurred during this period. Your certificate will then be void, as though you had never applied for the insurance

Specified Disease coverage is designed to provide, to persons insured, restricted coverage paying benefits ONLY when a covered Specified Disease is diagnosed. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

You may be able to enroll your spouse and/or dependent children.

This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal health law. Not all specified diseases are covered by this Policy. Benefits for Coronary Artery Bypass Graft, Angioplasty, Non-Invasive Cancer, Skin Cancer, Advanced Alzheimer's Disease and Advanced Parkinson's Disease are provided at a reduced amount.

Note to Employees Covered or Considering Coverage under Health Savings Accounts (HSA) Established in Connection with High Deductible Health Plans (HDHP):

Based on the limited available regulatory guidance, Sun Life believes its Specified Disease Insurance is appropriate for use with an HSA and may be purchased when the employee and/or their family members are covered under an HDHP. However, Sun Life cannot provide legal or tax advice. If there are legal or tax questions, we suggest that you consult your own legal or tax advisor before purchasing this insurance.

BENEFITS

The following conditions, subject to the election of your employer, **MAY** be covered under your Certificate up to 100% of the Insurance Amount. The Insurance Amount is the amount of insurance you have been approved for. To determine the benefit payable, the Company will multiply the Insurance Amount by the benefit percentage for the applicable covered condition.

Core/Circulatory Conditions Category:
Angioplasty**, Coronary Artery Bypass Graft*, End-stage Heart Failure, End-Stage Kidney Disease, Heart Attack, Major Organ Failure, Stroke

Cancer Conditions Category:
Invasive Cancer, Non-Invasive Cancer, Skin Cancer**

Other Conditions Category:
Advanced ALS/Lou Gehrig's Disease, Advanced Alzheimer's Disease*, Advanced Parkinson's Disease*, Benign Brain Tumor, Coma, Complete Blindness, Complete Loss of Hearing, Loss of Speech, Paralysis, Severe Burns

Childhood Conditions Category:
Cerebral Palsy, Cleft Lip/Palate, Complex Congenital Heart Disease, Cystic Fibrosis, Down Syndrome, Muscular Dystrophy, Spina Bifida, Type I Diabetes Mellitus

*These conditions generally provide a payment of no more than 25% of the Insurance Amount.
**These conditions generally provide a payment of no more than 5% of the Insurance Amount.

MAXIMUM BENEFIT

Each Covered Condition is payable once during the lifetime of the Policy (except as described in the Recurrence Benefit and/or Maximum Benefits Payable provisions). All benefits are subject to the terms and conditions of the Certificate.

DEFINITIONS OF CONDITIONS

The definitions applicable to your Certificate may vary by state insurance law and regulation.

Advanced ALS or Lou Gehrig's Disease means, that while insured under the Policy, the Insured has:
- been initially Diagnosed with definite amyotrophic lateral sclerosis (ALS) according to criteria established by the World Federation of Neurology; and
- been determined to require either a feeding tube or non-invasive ventilation.

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

Advanced Alzheimer's Disease means, that while insured under the Policy, an Insured has:
- been initially Diagnosed with Functional Assessment Staging Scale (FAST) Stage 6 or higher for Alzheimer's related dementia; and
- demonstrated memory impairment; decreased ability to plan, organize, sequence; language disturbance; or other cognitive disturbance.

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

Advanced Parkinson's Disease means, that while insured under the Policy, an Insured has:

- been initially Diagnosed with primary idiopathic Parkinson's disease at stage 4 or higher on the Hoehn and Yahr scale; and
- demonstrated resting tremor, rigidity, bradykinesia and dementia despite a generally accepted drug regimen.

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

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

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

Exclusions:

No benefit will be payable for the following:

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

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

No benefit will be payable for a recurrence or metastasis of an original tumor which was Diagnosed prior to the effective date of insurance.

Invasive Cancer means, that while insured under the Policy, the Insured has been initially Diagnosed with a malignant neoplasm, which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of neighboring tissue. Invasive Cancer includes leukemia and lymphoma. Non-invasive conditions or pre-cancerous conditions are not Invasive Cancer.

The Diagnosis must be:

- made by a Physician; and
- supported by pathological confirmation or its equivalent.

A Clinical Diagnosis will be accepted only if consistent with professional medical standards.

Exclusions:

No benefit will be payable for the following:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumors classified as Ta;
- malignant melanoma of the skin that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- squamous cell or basal cell cancer of the skin or any other non-melanoma of the skin, without lymph node or distant metastasis;
- early prostate cancer classified as T1a or T1b (or equivalent staging) without lymph node or distant metastasis; or
- thyroid cancer less than or equal to 1.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis.

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

Cancerous tumors that have not spread, such as a tumor in breast that has not lead to cancerous tumors elsewhere, or prostate cancer that has not spread from the prostate gland are not considered Invasive Cancer. Such tumors may meet the definition of Non-Invasive Cancer.

No benefit will be payable for a recurrence or metastasis of an original cancer which was Diagnosed prior to the effective date of insurance.

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

***Exclusions*:**
No benefit will be payable for the following:
- Autism-as primary Diagnosis; and
- motor deficits due to an underlying medical condition (syndrome, genetic or hereditary condition).

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

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

Coma means a Diagnosis, while insured under the Policy, of a state of unconsciousness with no reaction to external stimuli and which requires an external life support system, both of which have persisted continuously for at least 168 hours.

The Diagnosis of Coma must be made by a Physician.

Exclusions:
Coma does not include medically induced coma.

Complete Blindness means, that while insured under the Policy, the Insured has been initially Diagnosed with an irreversible reduction in sight, lasting at least 180 days, that results in a corrected visual acuity of 20/400 or less or a visual field less than 20 degrees when testing both eyes together. Benefits for Complete Blindness are not payable if the condition is a consequence of another condition for which another Specified Disease benefit has been paid.

The Diagnosis of Complete Blindness must be made by a Physician.

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

Complete Loss of Hearing does not include loss of hearing that can be corrected to above 70 decibels by the use of any hearing aid or device. Benefits for Complete Loss of Hearing are not payable if the condition is a consequence of another condition for which another Specified Disease benefit has been paid.

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

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

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

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

Coronary Artery Bypass Graft means, that while insured under the Policy, an Insured has been initially Diagnosed with Coronary Artery Disease requiring a procedure to bypass one or more diseased, narrowed or blocked coronary arteries with arterial or venous grafts and is performed by a Physician.

Exclusions:
No benefit will be payable for diseases requiring other procedures such as percutaneous transluminal coronary angioplasty (PTCA) or laser procedures.

Cystic Fibrosis means evidence of a lung disease that your covered Dependent Child under the age of 18 has been initially Diagnosed with by a Physician while insured under the Policy. The Diagnosis must be confirmed with sweat chloride tests and genetic testing.

Exclusions:
Cystic Fibrosis does not include the following:

- asymptomatic;
- clinical features limited to CABVD (congenital absence of vasdeferens); or
- gastrointestinal issues.

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

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

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

End-stage Heart Failure means, that while insured under the Policy, the Insured has been Diagnosed with severe and irreversible failure of the heart which is not remediable by medical or device therapy or by surgical therapy other than heart transplant. To qualify under End-stage Heart Failure, the Insured must be listed with the United Network of Organ Sharing (UNOS) on a heart transplant waiting list. Severe and irreversible failure of the heart shall be conclusively proven if an Insured has undergone a heart transplant as the recipient while insured under the Policy.

The Diagnosis of End-stage Heart Failure must be made by a Physician.

End-Stage Kidney Disease means, that while insured under the Policy, the Insured has been Diagnosed with a renal disease that has resulted in either:

- the chronic and irreversible failure of both kidneys to function and which requires regular dialysis for a minimum of 90 days; or
- the need for a kidney transplant.

The Diagnosis of End-Stage Kidney Disease must be made by a Physician. In the event a kidney is transplanted at the same time as other organs, only one benefit is payable.

Heart Attack means, that while insured under the Policy, the Insured has been Diagnosed with Coronary Artery Disease that results in the death of heart muscle due to acute obstruction of a coronary artery that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction and includes at least one of the following:
- heart attack symptoms; or
- new electrocardiogram (ECG) changes consistent with a Heart Attack.

The Diagnosis of Heart Attack must be made by a Physician.

Exclusions:
Heart Attack does not include:
- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty; or
- silent myocardial infarction, including ECG or imaging changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

Loss of Speech means, that while insured under the Policy, the Insured is initially Diagnosed with total, permanent and irreversible loss of the ability to speak. The loss must:
- be as a result of Injury or sickness affecting the speech organs; and
- have continued without interruption for a period of at least six (6) consecutive months.

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

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

Major Organ Failure means, that while insured under the Policy, the Insured is Diagnosed with any end-stage disease as specified by the most current edition of the International Classification of Diseases (ICD) of the liver, lung, small intestine, pancreas or bone marrow that has resulted in the chronic and irreversible failure of the organ to function.

For all organs listed above, a transplant is recommended as soon as an appropriate donor is located, and the Insured is either registered with the:
- United Network of Organ Sharing (UNOS); or
- National Marrow Donor Program (NMDP).

The Diagnosis of Major Organ Failure must be made by a Physician.

Exclusions:
Major Organ Failure does not include any of the following:
- bone marrow failure that results from the Treatment process for cancer;
- failure of any other organ not listed above; or
- a transplant in which the Insured's own bone marrow is used.

If multiple organs are to be replaced at the same time, only one benefit for Major Organ Failure is payable.

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

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

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

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

A Clinical Diagnosis will be accepted if consistent with professional medical standards.

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

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

No benefit will be payable for a recurrence or metastasis of an original Non-Invasive Cancer which was Diagnosed prior to the effective date of insurance.

Paralysis means, that while insured under the Policy, the Insured has been Diagnosed with total and irreversible loss of use of two or more limbs due to Injury or disease of the spinal cord and that is continuously present for a period of at least 180 days. Limb is defined as the complete arm or the complete leg.

The Diagnosis of Paralysis must be made by a Physician and shall not include any impairment caused by a Stroke or other sickness.

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

Skin Cancer means that while insured under the Policy, the Insured has been Diagnosed with basal cell cancer or squamous cell cancer of the skin. A malignant melanoma of the skin, is not deemed Skin Cancer, but may be covered under the Invasive Cancer or Non-Invasive Cancer benefit, depending on its

size. A non-melanoma cancer of the skin that is accompanied by lymph node or distant metastasis (cancer that has spread the lymph nodes or to other areas in addition to the skin) may meet the definition of Invasive Cancer.

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

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

Stroke means, that while insured under the Policy, the Insured has been Diagnosed with cerebrovascular disease resulting in a brain tissue infarction or hemorrhage documented by brain imaging in association with acute onset of new neurologic deficits consistent with central nervous system damage.

The Diagnosis of Stroke must be made by a Physician.

Exclusions:
For the purposes of this Policy, Stroke does not include:
- Transient Ischemic Attacks (TIAs) or "mini-stroke", which means a neurological event due to a temporary lack of adequate blood and oxygen to the brain that results in the signs and symptoms of a stroke that subside within a short period of time;
- Transient Global Amnesia (TGA); or
- External trauma causing Injury to the brain.

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

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

OTHER EXCLUSIONS AND LIMITATIONS

The limitations and exclusions applicable to your Certificate may vary by state insurance law and regulation.

The Company will not pay any benefit for any Specified Disease diagnosed outside the United States or Canada without confirmation of the Diagnosis by the type of Physician specified for each of the Covered Conditions in Section 7 of the certificate who practices in the United States or Canada.

The Company will not pay a benefit for any Specified Disease that is not listed in the Benefit Highlights in the Certificate or due to or results from, treatment or complications of treatment not related to a Specified Disease, intentionally self-inflicted injuries, active military duty, participation in war or in a riot, rebellion or insurrection, committing or attempting to commit a felony or being engaged in an illegal occupation, your incarceration in a penal institution, your engagement in scuba diving, parachuting, hang gliding, motorized racing, ballooning, kick-boxing, cliff diving, mountain climbing, powerboat racing, heli-skiing, big game hunting, cave exploration, underwater diving, rodeo events or white water rafting, or being legally intoxicated or under the influence of any narcotic unless taken on the advice of a Physician and taken as prescribed.

The Company may not pay a benefit for any Specified Disease that results from a pre-existing condition. Pre-existing condition means any condition for which any insured:
- received medical treatment, care or services for the condition; or
- took prescribed drugs or medicines for the condition.

GENERAL

Premium rates for the coverage may change.

Specified Disease insurance coverage is subject to termination as stated in the Policy.