

SUN LIFE ASSURANCE COMPANY OF CANADA

Executive Office:
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Wellesley Hills, MA 02481

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

Policy Number:	980742-002
Policy Effective Date:	January 1, 2026
Policyholder:	Pye-Barker Fire & Safety, LLC
Employer:	Pye-Barker Fire & Safety, LLC
Issue State:	Georgia

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

PLEASE READ YOUR CERTIFICATE CAREFULLY.

NOTICE: The laws of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

This Certificate contains the terms of the Group Insurance Policy that affect your insurance. This Certificate is part of the Group Insurance Policy.

This Certificate is governed by the laws of the Issue State shown above unless preempted by the federal Employee Retirement Income Security Act.

Signed at Wellesley Hills, Massachusetts.



Kevin Strain
President and Chief Executive Officer



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

Group Critical Illness Insurance Certificate

Non-Participating



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1. BENEFIT HIGHLIGHTS

Eligible Classes: All Full-Time United States Employees working in the United States scheduled to work at least 30 hours per week.

Eligibility Waiting Period: Until the first of the month following 30 days of employment

Rehired Employee

Eligibility Waiting Period: First of the month following date of rehire, if you are rehired within 1 month

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

1. BENEFIT HIGHLIGHTS

If you are eligible, you may elect to enroll for insurance. We will pay benefits corresponding to the elections you made.

You may also elect insurance for your Spouse. We will pay benefits corresponding to the elections you made.

You may also elect insurance for your Dependent Children. We will pay benefits corresponding to the elections you made.

You must have insurance on yourself in order to elect insurance for your Spouse and your Dependent Children.

Insurance Amounts

Employee Insurance	Minimum: \$10,000 Maximum: \$40,000 Change Increment Amount: \$10,000
Spouse Insurance	Minimum: \$10,000 Maximum: \$40,000 Change Increment Amount: \$10,000
Dependent Children Insurance	Minimum: \$5,000 Maximum: \$20,000 Change Increment Amount: \$5,000

The Spouse Insurance Amount cannot be more than 100% of your Insurance Amount.

The Dependent Children Insurance Amount cannot be more than 50% of your Insurance Amount.

Unless otherwise noted, each Covered Condition listed below is payable once per Insured during the duration of the Policy (except as described in the Recurrence Benefit provision).

In order for a benefit to be payable for any Covered Condition, the Diagnosis must be made while insured under the Policy.

CARDIAC CONDITIONS

Covered Condition	Benefit Percentage	Recurrence Benefit Percentage
Heart Attack (Myocardial Infarction): Non-ST Segment Elevation Myocardial Infarction (NSTEMI)	25%	25%
ST-Segment Elevation Myocardial Infarction (STEMI)	100%	100%
Coronary Artery Obstruction (without Heart Attack)	25%	25%
Sudden Cardiac Arrest	100%	100%
Heart Valve Disease where mitral or aortic valve replacement or repair is recommended via minimally invasive surgery	50%	50%

1. BENEFIT HIGHLIGHTS

CARDIAC CONDITIONS

Covered Condition	Benefit Percentage	Recurrence Benefit Percentage
Heart Valve Disease where mitral or aortic valve replacement or repair is recommended via open heart surgery	100%	100%
Heart Arrhythmia or other cardiac abnormality where pacemaker or implantable cardioverter defibrillator placement is recommended	25%	25%

VASCULAR CONDITIONS

Covered Condition	Benefit Percentage	Recurrence Benefit Percentage
Stroke	100%	100%

ORGAN FAILURE CONDITIONS

Covered Condition	Benefit Percentage	Recurrence Benefit Percentage
End Stage Kidney Failure	100%	100%
Major Organ Failure	100%	100%

PROGRESSIVE NEUROLOGICAL DISEASE CONDITIONS

Covered Condition	Benefit Percentage	Recurrence Benefit Percentage
ALS/Lou Gehrig's disease	100%	N/A
Early Stage Dementia	10%	N/A
Advanced Dementia	100%	N/A
Early Stage Parkinson's Disease	10%	N/A
Advanced Parkinson's Disease	100%	N/A
Early Stage Huntington's Disease	10%	N/A
Advanced Huntington's Disease	100%	N/A
Early Stage Multiple Sclerosis	10%	N/A
Advanced Multiple Sclerosis	100%	N/A

OTHER CONDITIONS

Covered Condition	Benefit Amount/Benefit Percentage	Recurrence Benefit Percentage
Benign Brain or Spinal Cord Tumor	100%	N/A
Coma	100%	N/A
Paralysis	100%	N/A
Severe Burns	100%	N/A
Blindness	100%	N/A
Loss of Speech	100%	N/A
Loss of Hearing	100%	N/A

1. BENEFIT HIGHLIGHTS

OTHER CONDITIONS

Covered Condition	Benefit Amount/Benefit Percentage	Recurrence Benefit Percentage
Occupational Infectious Disease	100%	N/A

CHILDHOOD CONDITIONS (Dependent Children Insurance)

Covered Condition	Benefit Amount/Benefit Percentage	Recurrence Benefit Percentage
Cerebral Palsy	100%	N/A
Congenital Structural Anomaly	100%	N/A
Congenital Heart Defects	100%	N/A
Congenital Metabolic Disorder	100%	N/A
Other Genetic Disorders	100%	N/A
Type 1 Diabetes Mellitus	100%	N/A

Additional Occurrence Benefit Separation Period:
See the Benefit Provisions below for more information.

none

Recurrence Benefit Separation Period:
See the Benefit Provisions section for more information.

6 consecutive months

Preventive Health Benefit:
Limited to 1 exam or screening
per Insured per Benefit Year

Included

Employee
Spouse
Dependent Child

\$50 per exam/screening
\$50 per exam/screening
\$50 per exam/screening

Included Rider(s):

Cancer Rider
Infectious Disease Rider

January 1, 2026
January 1, 2026

Maximum Policy Benefits Payable (for each Insured):

The total benefits paid under this Policy inclusive of any Rider may not exceed \$250,000 for each Insured.

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

Please see the Benefit Provisions, Covered Conditions, and Exclusions and Limitations sections for more information regarding your benefits.

Any limitation applies separately to you, your Spouse and your Dependent Children.

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 will be 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.

You are considered Actively at Work on any day that is not your regular scheduled work day (e.g., you are on vacation or holiday) as long as you were Actively at Work on your immediately preceding scheduled work day, and you are not Confined.

Activities of Daily Living means:

- Bathing – washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- Continence – the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
- Dressing – putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- Eating – feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by feeding tube or intravenously.
- Toileting – getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Transferring – moving into or out of a bed, chair or wheelchair.

Benefit Percentage means the percentage that is applied to the Insurance Amount to determine the amount of benefit payable under the Policy.

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

Clinical Diagnosis means an evaluation by a Physician which includes history, physical exam and potentially additional screening tests.

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

Confined or Confinement, for the purposes of a payable Covered Condition, means admission as an inpatient to a Hospital for a period of at least 20 consecutive hours. Confinement does not include that period of time during which an Insured is in a Hospital emergency room, an observation room, a freestanding surgical facility or an outpatient facility.

Contributory means you pay all or part of the premium.

Critical Illness means only the Covered Conditions described under the Certificate and for which benefits are payable.

Dependent means your insured Spouse and Dependent Children.

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

Dependent Child includes:

- your step-child;
- your grandchild who is a dependent for federal income tax purposes;
- a foster child placed with you by a licensed agency; or

2. DEFINITIONS

- your adopted child, including any child placed with you for adoption.

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 financial support;

that child will 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; or
- any person residing outside the United States or Canada. This exclusion does not apply to a Dependent Child who is a student attending school outside of the United States.

Diagnosis, Diagnoses or Diagnosed means the establishment of a Covered Condition by a Physician through the use of clinical and/or laboratory findings and using generally accepted medical standards.

Employee means a person who is:

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

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

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 31 days during which eligible Employees may elect or change insurance under the Policy. The Enrollment Period cannot exceed 31 days or occur more than once in any 12-month period, unless we agree in Writing.

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

Family Status Change means one of the following events:

- your marriage or divorce;
- the birth of your child;
- the adoption of a child by you;
- the placement of a child with you, pending adoption;
- the placement of a foster child with you;
- the placement of a child for whom you or your Spouse have legal guardianship of the child's person;
- the death of your Spouse or child; or
- the commencement or termination of employment of your Spouse.

Hospital means a facility licensed in the applicable jurisdiction that provides medical care and Treatment to sick and injured persons on an inpatient basis with 24-hour nursing service by or under the supervision of a Physician. Hospital does not include: (1) a rest home; (2) a skilled nursing facility; (3) an extended

2. DEFINITIONS

care facility; (4) a place of convalescence; (5) rehabilitative care; (6) custodial care; or (7) a place primarily for the treatment of drug addiction or alcoholism.

Injury means unintentional physical damage or harm caused directly by an accident occurring while insured under the Policy and not due to sickness, disease or any other causes.

Insurance Amount means the amount of insurance available under the Policy as shown in the Benefit Highlights and for which a person covered under the Policy is insured.

Insured means any person covered under the Policy.

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

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.

Pathological Diagnosis means a Diagnosis based upon a microscopic study of fixed tissue or preparations from the hemic (blood) system.

Physician means a person who is operating within the scope of their license and is either:

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

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

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

Policyholder means the entity to which the Policy is issued.

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

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

Retirement means the first of the following to occur:

- the effective date of your Retirement benefits under:
 - any plan of a federal, state, county, municipal, association retirement system or public retirement, including Public Employees' Retirement System (PERS) or State Teachers' Retirement System (STRS) which you are eligible as a result of your employment with the Employer;
 - any Retirement plan the Employer sponsors; or
 - any Retirement plan to which the Employer:
 - makes contributions; or
 - has made contributions.
- the effective date of your Retirement benefits under the Social Security Act or any similar plan or act.

However, if you meet the definition of Employee and are receiving Retirement benefits under the Social Security Act, Public Employees' Retirement System (PERS), State Teachers' Retirement System (STRS) or similar plan or act, you will not be considered retired.

2. DEFINITIONS

Retirement benefits do not include:

- a 401(k) or 403(b) plan;
- a profit-sharing plan;
- a thrift plan;
- a non-qualified plan of deferred compensation;
- an Individual Retirement Account (IRA);
- a Tax Sheltered Annuity (TSA); or
- an Employee Stock Ownership Plan (ESOP).

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 person who under state, federal or provincial law is recognized as a spouse or a partner in a registered domestic partnership.

Spouse does not include:

- any person who is insured as an Employee; or
- any person residing outside the United States or Canada.

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

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

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 Critical Illness Insurance?

You are initially eligible for Employee Critical Illness Insurance on the latest of:

- January 1, 2026;
- 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.

When must you enroll for Contributory Employee Critical Illness Insurance?

You must enroll within 90 days of the date you are initially eligible for Employee Critical Illness Insurance otherwise you will be considered a Late Entrant.

If you refuse your insurance or do not enroll within the required time frame, you will not be allowed to enroll until the next Enrollment Period or until a Family Status Change.

When does Employee Critical Illness Insurance start?

For Contributory Employee Critical Illness Insurance:

Employee Critical Illness Insurance starts on the later of the date:

- you are eligible; or
- you enroll and agree to make any required contribution toward the cost of insurance, if you are Actively at Work on that date.

If you are not Actively at Work on that date, your insurance will not start until you resume being Actively at Work.

When can you make changes in Employee Critical Illness Insurance?

You may request a change in your Insurance Amount or benefit elections during any Enrollment Period after you are covered under the Policy.

You may also request a change in your Insurance Amount or benefit elections at any time due to a Family Status Change. Such requests must be made within 31 days of the date the Family Status Change occurred.

You may only increase or decrease your Insurance Amount or benefit elections within the limits shown in the Benefit Highlights.

When does a change in Employee Critical Illness Insurance start?

If you are Actively at Work, any increase in your Insurance Amount or benefits, for reasons other than a Family Status Change, will start on the January 1st following the date of change, when you apply for a different incremental amount and you agree to make any required contribution toward the cost of insurance.

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

Whether or not you are Actively at Work, any reduction in your Insurance Amount or benefits, for reasons other than a Family Status Change, will start on the January 1st following the date of change, when you reduce coverage.

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

- the date you apply for such change, if you apply within 31 days of the Family Status Change and you agree to make any required contribution toward the cost of insurance; or
- the date of your Family Status Change.

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF EMPLOYEE INSURANCE

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

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

Any change in your Insurance Amount or benefits will only affect benefits for a Covered Condition that is Diagnosed after the effective date of the change.

Any change is subject to all the terms of the Policy.

When does Employee Critical Illness Insurance end?

Your Employee Critical Illness Insurance under the Policy will end on the earliest of the following to occur:

- the date the Policy terminates;
- the last day of the period for which any required premium has been paid for your Critical Illness Insurance or any part of your insurance;
- the date you request in Writing to cancel your Employee Critical Illness Insurance; or
- the date you die.

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

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

What happens if you re-enroll for Critical Illness Insurance after insurance has ended?

If you voluntarily terminate your insurance while eligible under the Policy:

You may not re-enroll for insurance until the next Enrollment Period. Insurance for yourself and any Dependents you elect to insure will be effective on the January 1st following the date you re-enroll as long as you are Actively at Work on that date and your Dependents are not Confined on that date.

If you are not Actively at Work on that date, your insurance will not start until you resume being Actively at Work.

If your Dependent is Confined on that date, insurance for that Dependent will not start until that Dependent is no longer Confined. Confinement does not apply to a newborn child, newly placed foster child or a newly adopted child.

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

If your employment has terminated and you are rehired by your Employer:

You must re-enroll for insurance within 90 days of your return to work in an Eligible Class. If your Employer requires you to satisfy a new Eligibility Waiting Period, then you must enroll within 90 days of completion of the new Eligibility Waiting Period. Insurance for yourself and any Dependents you elect to insure will be effective on the date you enroll and agree to make any required contribution toward the cost of insurance, as long as you are Actively at Work on that date and your Dependents are not Confined on that date.

If you are not Actively at Work on that date, your insurance will not start until you resume being Actively at Work.

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF EMPLOYEE INSURANCE

If your Dependent is Confined on that date, insurance for that Dependent will not start until that Dependent is no longer Confined. Confinement does not apply to a newborn child, newly placed foster child or a newly adopted child.

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

You may not re-enroll for insurance if you continued your insurance under the Portability provision, unless you cancel such coverage.

If you do not re-enroll for insurance within 90 days after the date you are rehired, you may not re-enroll for insurance until the next Enrollment Period.

4. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE

When are you eligible for Spouse Critical Illness Insurance?

If you are in an Eligible Class, you are initially eligible for Spouse Critical Illness Insurance on the latest of:

- January 1, 2026;
- the date you are eligible for Employee Critical Illness Insurance; or
- the date you acquire a Spouse.

When must you enroll for Contributory Spouse Critical Illness Insurance?

You must enroll within 90 days of the date you are initially eligible for Spouse Critical Illness Insurance otherwise you will be considered a Late Entrant.

If you refuse your Spouse insurance, or do not enroll within the required time frame, you will not be allowed to enroll your Spouse until the next Enrollment Period or until a Family Status Change.

When does Spouse Critical Illness Insurance start?

For Contributory Spouse Critical Illness Insurance:

Spouse Critical Illness Insurance starts on the latest of the date:

- you are eligible for Spouse insurance;
- you are insured under the Policy for Employee Critical Illness Insurance; or
- you enroll for Spouse insurance and you agree to make any required contribution toward the cost of insurance,

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

If you are not Actively at Work on that date, your Spouse insurance will not start until you resume being Actively at Work.

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

When can you make changes in Spouse Critical Illness Insurance?

You may request a change in your Spouse Insurance Amount or benefit elections during any Enrollment Period after you are covered under the Policy.

You may also request a change in your Spouse Insurance Amount or benefit elections at any time due to a Family Status Change. Such requests must be made within 31 days of the date the Family Status Change occurred.

You may only increase or decrease your Spouse Insurance Amount or benefit elections within the limits shown in the Benefit Highlights.

When does a change in Spouse Critical Illness Insurance start?

If you are Actively at Work, any increase in your Spouse Insurance Amount or benefits, for reasons other than a Family Status Change, will start on the January 1st following the date of change, when you apply for a different incremental amount and you agree to make any required contribution toward the cost of insurance.

Your Spouse must not be Confined on the date of the increase.

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

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

4. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE

Whether or not you are Actively at Work, any reduction in your Spouse Insurance Amount or benefits, for reasons other than a Family Status Change, will start on the January 1st following the date of change, when you reduce coverage.

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

- the date you apply for such change, if you apply within 31 days of the Family Status Change and you agree to make any required contribution toward the cost of insurance; or
- the date of your Family Status Change.

Your Spouse must not be Confined on the date of the increase.

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

If your Spouse is Confined on that date, any increase in your Spouse Insurance Amount or benefits due to a Family Status Change will not start until your Spouse is no longer Confined.

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

Any change in your Spouse Critical Illness Insurance Amount or benefits will only affect benefits for a Covered Condition that is Diagnosed after the effective date of the change.

Any change is subject to all the terms of the Policy.

When does Spouse Critical Illness Insurance end?

Your Spouse Critical Illness Insurance under the Policy will end on the earliest of the following to occur:

- the date the Policy terminates;
- the last day of the period for which any required premium has been paid for your Critical Illness Insurance or your Spouse Critical Illness Insurance or any part of the insurance;
- the date you request in Writing to cancel your Spouse Critical Illness Insurance;
- the date you die; or
- the date your Spouse dies.

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

- the date you are no longer in an Eligible Class;
- the date your Eligible Class is no longer included for Spouse insurance;
- the date you are no longer insured under the Policy;
- the date your Spouse no longer meets the definition of Spouse as described in this Certificate;
- the date your Spouse enters active duty in any armed service;
- the date you retire;
- the date your class is no longer included for Spouse insurance; or
- the last day you are Actively at Work, subject to any applicable Portability provision(s) provided.

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

When are you eligible for Dependent Children Critical Illness Insurance?

If you are in an Eligible Class, you are initially eligible for Dependent Children Critical Illness Insurance on the latest of:

- January 1, 2026;
- the date you are eligible for Employee Critical Illness Insurance; or
- the date you acquire your Dependent Children.

When must you enroll for Contributory Dependent Children Critical Illness Insurance?

You must enroll within 90 days of the date you are initially eligible for Dependent Children Critical Illness Insurance otherwise you will be considered a Late Entrant.

If you refuse your Dependent Children insurance or do not enroll within the required time frame, you will not be allowed to enroll your Dependent Children until the next Enrollment Period or until a Family Status Change.

When does Dependent Children Critical Illness Insurance start?

For Contributory Dependent Children Critical Illness Insurance:

Dependent Children Critical Illness Insurance starts on the latest of the date:

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

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

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

If your Dependent Child is Confined on the date your Dependent Children insurance would normally start, your Dependent Children insurance for that child will not start until your child is no longer Confined. Confinement does not apply to a newborn child, newly placed foster child or a newly adopted child.

When can you make changes in Dependent Children Critical Illness Insurance?

You may request a change in your Dependent Children Insurance Amount or benefit elections during any Enrollment Period after you are covered under the Policy.

You may also request a change in your Dependent Children Insurance Amount or benefit elections at any time due to a Family Status Change. Such requests must be made within 31 days of the date the Family Status Change occurred.

You may only increase or decrease your Dependent Children Insurance Amount or benefit elections within the limits shown in the Benefit Highlights.

When does a change in Dependent Children Critical Illness Insurance start?

If you are Actively at Work, any increase in your Dependent Children Insurance Amount or benefits, for reasons other than a Family Status Change, will start on the January 1st following the date of change, when you apply for a different incremental amount and you agree to make any required contribution toward the cost of insurance.

Your Dependent Child must not be Confined on the date of the increase.

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

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

If your Dependent Child is Confined on that date, any increase in your Dependent Children Insurance Amount or benefits will not start for that Dependent Child until your Dependent Child is no longer Confined.

Whether or not you are Actively at Work, any reduction in your Dependent Children Insurance Amount or benefits, for reasons other than a Family Status Change, will start on the January 1st following the date of change, when you reduce coverage.

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

- the date you apply for such change, if you apply within 31 days of the Family Status Change and you agree to make any required contribution toward the cost of insurance; or
- the date of your Family Status Change.

Your Dependent Child must not be Confined on the date of the increase.

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

If your Dependent Child is Confined on that date, any increase in your Dependent Children Insurance Amount or benefits due to a Family Status Change will not start for that Dependent Child until your Dependent Child is no longer Confined.

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

Any change in your Dependent Children Insurance Amount or benefits will only affect benefits for a Covered Condition that is Diagnosed after the effective date of the change.

Any change is subject to all the terms of the Policy.

How can you add a child or children to your Dependent Children Critical Illness Insurance?

After you and a Dependent Child are covered under the Policy, and you are Actively at Work, any child who becomes one of your Dependent Children will automatically be covered.

How does Dependent Children Critical Illness 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 Critical Illness Insurance when a newborn child, newly placed foster child or newly adopted child becomes one of your Dependent Children, then such child will automatically be covered for 31 days from the date they become your Dependent Child. To continue coverage beyond 31 days, you must:

- enroll for Dependent Children Critical Illness 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, if applicable to continue your Dependent Children Critical Illness Insurance.

If your newborn child, newly placed foster child or newly adopted child is Diagnosed with a Covered Condition within this 31-day time period and prior to your election of coverage, a benefit may be payable, subject to all other conditions of the Policy. Any benefit will be based on a \$5,000 maximum Insurance Amount.

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

When does Dependent Children Critical Illness Insurance end?

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

Dependent Children Critical Illness Insurance under the Policy will end on the earliest of the following to occur:

- the date the Policy terminates;
- the last day of the period for which any required premium has been paid for your Critical Illness Insurance or your Dependent Children Critical Illness Insurance or any part of the insurance;
- the date you request in Writing to cancel your Dependent Children Critical Illness Insurance;
- the date you die; or
- the date your Dependent Child dies, but only with respect to that person.

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

- the date you are no longer in an Eligible Class;
- the date your Eligible Class is no longer included for Dependent Children insurance;
- the date you are no longer insured under the Policy;
- the date your Dependent Child no longer meets the definition of Dependent Child as described in this Certificate, but only with respect to that person;
- the date your Dependent Child enters active duty in any armed service;
- the date you retire;
- the date your class is no longer included for Dependent Children insurance; or
- the last day you are Actively at Work, subject to any applicable Portability provision(s) provided.

6. BENEFIT PROVISIONS

What benefits are payable?

A lump-sum benefit, as shown in the Benefit Highlights, is payable when an Insured is Diagnosed with a Covered Condition. A benefit is only payable if an Insured is Diagnosed with a Covered Condition while insured under the Policy. The Diagnosis of a Covered Condition must be made by a Physician qualified to make such a Diagnosis.

If an Insured is Diagnosed with more than one Covered Condition on the same date:

- the Covered Condition with the higher benefit amount will be payable; or
- if the benefit amounts are the same, the Covered Condition with the earliest Diagnosis will be payable.

Any benefits payable are subject to the limitations, exclusions and other conditions stated in the Policy.

How is the amount of the benefit determined?

To determine an amount based on Benefit Percentage, we will multiply the Insured's Insurance Amount by the Benefit Percentage for the applicable Covered Condition as shown in the Benefit Highlights to determine the benefit to be paid.

How is the date of Diagnosis determined?

When a diagnostic test or procedure is standardly used to confirm a Covered Condition, the date of the Diagnosis is the date the diagnostic test or procedure is performed by a Physician. If multiple tests are required, the date of Diagnosis is the date the first test or procedure was performed confirming the Diagnosis. Diagnostic test or procedure means lab tests including pathology, imaging or formal testing of cognition.

When a Clinical Diagnosis is standardly used to confirm a Covered Condition, the date of Diagnosis is the date the Physician first documents the Diagnosis.

If a condition routinely requires both diagnostic testing and Clinical Diagnosis, the later of the two will apply.

Additional Occurrence Benefit

When is an additional Covered Condition payable?

Unless otherwise noted, if we pay a benefit for a particular Covered Condition, we will pay a benefit for a different Covered Condition listed in the Benefit Highlights or in any attached Rider.

Recurrence Benefit

When is a Recurrence Benefit payable?

Unless otherwise noted, a Recurrence Benefit is payable if:

- benefits have been paid under the Policy because an Insured was Diagnosed with a particular Covered Condition; and
- the Insured is Diagnosed with the same Covered Condition more than 6 consecutive months later.

How is the amount of the Recurrence Benefit determined?

We will multiply the Insured's Insurance Amount by the Recurrence Benefit Percentage for the applicable Covered Condition as shown in the Benefit Highlights to determine the benefit to be paid.

How many times can you receive a Recurrence Benefit?

Unless otherwise noted, there is no limit to the number of Recurrence Benefits for a given Covered Condition per Insured, subject to all other requirements of the Policy.

7. COVERED CONDITIONS

What Critical Illness conditions are covered?

The Covered Conditions defined below.

CARDIAC CONDITIONS

Coronary Artery Obstruction (without Heart Attack) means an Insured is Diagnosed with 75% or more blockage of one or more coronary arteries, recommending surgical intervention (excluding catheterization).

Heart Arrhythmia or other cardiac abnormality means an Insured is Diagnosed with an irregular electrical conduction through the heart muscle or other cardiac conditions requiring an implantable device to assist with regulating electrical conduction.

Heart Attack means an Insured is Diagnosed with evidence of damage to the heart muscle due to inadequate blood supply to the heart or blockage of one or more coronary arteries. A ST-segment elevation myocardial infarction (STEMI) and non-ST-segment elevation myocardial infarction (NSTEMI) are considered a Heart Attack.

ST-segment elevation myocardial infarction (STEMI) means a type of myocardial infarction where:

- there is complete and prolonged blockage of a coronary blood vessel;
- results in new electrocardiographic (EKG) changes inclusive of ST-segment elevation; and
- includes elevation of cardiac enzymes or biochemical markers showing a pattern and to a level consistent with a Diagnosis of Heart Attack.

Non-ST-segment elevation myocardial infarction (NSTEMI) means a type of myocardial infarction where:

- there is partial or temporary blockage of a coronary blood vessel;
- may result in new electrocardiographic (EKG) changes not inclusive of ST-segment elevation; and
- includes elevation of cardiac enzymes or biochemical markers showing a pattern and to a level consistent with a Diagnosis of Heart Attack.

Heart Attack does not include:

- any established (old) heart attack;
- any heart attack that occurs during a surgical procedure or any other medical procedure;
- other acute coronary syndromes (including but not limited to unstable angina or coronary artery spasm);
- any other disease or Injury involving the cardiovascular system; or
- cardiac arrest not caused by a heart attack, such as Sudden Cardiac Arrest.

Heart Valve Disease means an Insured is Diagnosed with a condition which results in one or more heart valves not opening or closing properly resulting in stenosis (narrowing of the valve) or regurgitation (leakage) requiring repair or replacement of the valve.

Sudden Cardiac Arrest means an Insured is Diagnosed with an unexpected and sudden functional loss where the heart abruptly stops beating due to an internal electrical disturbance which stops the flow of blood to the body.

If the Sudden Cardiac Arrest is caused by a Heart Attack, then payment may be made under Heart Attack first, unless a Heart Attack benefit is not payable at that time.

VASCULAR CONDITIONS

Stroke means an Insured is Diagnosed with cerebrovascular disease resulting in a brain tissue infarction or hemorrhage documented by brain imaging and/or medical intervention to remove blockage in association with acute onset of new neurologic deficits consistent with central nervous system damage.

7. COVERED CONDITIONS

Stroke does not include:

- Transient Ischemic Attacks (TIAs);
- Transient Global Amnesia (TGA); or
- external trauma causing Injury to the brain.

ORGAN FAILURE CONDITIONS

End Stage Kidney Failure means an Insured is Diagnosed with chronic and irreversible failure of both kidneys requiring dialysis for 90 days or more, or the need for a kidney transplant.

In the event a kidney is transplanted at the same time as other organs, only one benefit is payable.

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

In order for a benefit to be payable, either an Insured:

- is unable to undergo a transplant due to advanced disease; or
- is recommended for transplant as soon as an appropriate donor is located, and is registered with the:
 - United Network of Organ Sharing (UNOS) or other nationally recognized transplant program; or
 - National Marrow Donor Program (NMDP).

Major Organ Failure does not include any of the following:

- bone marrow failure that results from the Treatment process for cancer;
- overwhelming multiple system organ failure due to an acute illness;
- failure of any other organ not listed above; or
- a transplant in which an 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.

PROGRESSIVE NEUROLOGICAL DISEASE CONDITIONS

ALS or Lou Gehrig's Disease means an Insured is Diagnosed with definite amyotrophic lateral sclerosis (ALS) according to criteria established by the World Federation of Neurology.

Dementia means an Insured is Diagnosed with a neurological disorder which is chronic or persistent and results in impaired memory, cognitive decline, personality changes and impaired reasoning.

An **Early Stage** benefit is payable upon a Diagnosis of Dementia with one or more of the following:

- a Global Deterioration Scale (GDS) or Functional Assessment Staging (FAST) Stage 5 or lower;
- the sum of the Clinical Dementia Rating (CDR) score is less than 15;
- a Mini Mental Status Exam (MMSE) score of 10 - 24; or
- a Montreal Cognitive Assessment (MoCA) score of 10 - 25.

An **Advanced** benefit is payable upon a Diagnosis of Dementia with one or more of the following:

- the inability to perform 2 or more Activities of Daily Living without the assistance of another person;
- a Global Deterioration Scale (GDS) or Functional Assessment Staging (FAST) Stage 6 or higher;
- the sum of the Clinical Dementia Rating (CDR) score is 15 or greater;
- a Mini Mental Status Exam (MMSE) score of 9 or less; or
- a Montreal Cognitive Assessment (MoCA) score of 9 or less.

7. COVERED CONDITIONS

The Diagnosis must include clinically based assessments or testing supporting the Diagnosis.

The Diagnosis of Early Stage and Advanced Dementia excludes mild cognitive impairment.

Benefits are only payable for a Covered Condition that is Diagnosed while insured under the Policy. Therefore, only the Advanced benefit may be payable if an Insured was Diagnosed with Dementia prior to the date their insurance starts under the Policy.

Huntington's Disease means an Insured is Diagnosed with the neurodegenerative genetic disorder which causes progressive degeneration of nerve cells in the brain related to movement, cognition and/or psychiatric issues.

An **Early Stage** benefit is payable upon the initial Diagnosis of Huntington's Disease based on a genetic test.

An **Advanced** benefit is payable upon the loss of 2 or more Activities of Daily Living and documentation of cognitive decline requiring assistance for safety.

The Diagnosis of Early Stage and Advanced Huntington's Disease must be based on symptoms, and include medical records documenting genetic testing, neurological exams, neuropsychological testing and/or psychiatric evaluation.

Benefits are only payable for a Covered Condition that is Diagnosed while insured under the Policy. Therefore, only the Advanced benefit may be payable if an Insured was Diagnosed with Huntington's Disease prior to the date their insurance starts under the Policy.

Multiple Sclerosis means an Insured is Diagnosed with at least one of the following:

- two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
- well defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
- a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

An **Early Stage** benefit is payable upon initial Diagnosis of Multiple Sclerosis.

An **Advanced** benefit is payable upon an Insured being unable to perform 2 or more Activities of Daily Living without the assistance of another person.

Benefits are only payable for a Covered Condition that is Diagnosed while insured under the Policy. Therefore, only the Advanced benefit may be payable if an Insured was Diagnosed with Multiple Sclerosis prior to the date their insurance starts under the Policy.

Parkinson's Disease means an Insured is Diagnosed with a progressive neurological condition that results in a resting tremor, rigidity, bradykinesia (slow movement) and/or alteration of posture and balance.

An **Early Stage** benefit is payable upon initial Diagnosis of Parkinson's Disease.

An **Advanced** benefit is payable upon an Insured either:

- receiving an initial Diagnosis of primary idiopathic Parkinson's Disease at stage 4 or higher on the Hoehn and Yahr scale; or
- being unable to perform 2 or more of the Activities of Daily Living without the assistance of another person.

7. COVERED CONDITIONS

The Diagnosis must include documentation of consistent symptoms, exam findings and history.

Benefits are only payable for a Covered Condition that is Diagnosed while insured under the Policy. Therefore, only the Advanced Parkinson's Disease benefit may be payable if an Insured was Diagnosed with Parkinson's prior to the date an Insured's insurance starts under the Policy.

OTHER CONDITIONS

Benign Brain or Spinal Cord Tumor means an Insured is Diagnosed with a non-malignant tumor located in the cranial vault and limited to the brain, meninges, cranial nerves, pituitary gland or spinal cord. Surgery or radiation Treatment must be recommended or the tumor causes irreversible objective neurological deficit(s).

No benefit will be payable for the following:

- hematomas, cysts or granulomas; or
- intracranial malformations of the arteries or veins; or
- pituitary adenomas less than 10 mm. in diameter.

Coma means an Insured is Diagnosed with 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.

Coma does not include a medically induced coma.

Paralysis means an Insured is Diagnosed with total and irreversible loss of use of two or more limbs due to Injury 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.

Paralysis does not include any impairment caused by a Stroke or other sickness.

Severe Burns means an Insured is Diagnosed with third-degree burns over at least 18% of the body surface.

Blindness means an Insured is 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 Blindness are not payable if the condition is a consequence of another condition for which another Covered Condition benefit has been paid.

Loss of Speech means an Insured is 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 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 Covered Condition benefit has been paid.

Loss of Hearing means an Insured is 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.

7. COVERED CONDITIONS

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 Loss of Hearing are not payable if the condition is a consequence of another condition for which another Covered Condition benefit has been paid.

Occupational Infectious Disease means an Insured is Diagnosed with Human Immunodeficiency Virus (HIV) infection or Hepatitis B, C and/or D resulting from accidental exposure to HIV or Hepatitis B, C and/or D by contaminated body fluids during the course of performing the Insured's regular occupation for which remuneration is earned. To prove occupational exposure, all of the following must be submitted:

- documentation showing that within five days of the accidental exposure, the exposure was reported and recorded by the appropriate person according to legislation, regulations or standard guidelines that apply to the occupation;
- a negative antibody for HIV or Hepatitis B, C and/or D test, performed by a state certified and licensed laboratory within five days of exposure; and
- a positive antibody for HIV or Hepatitis B, C and/or D test, taken in the 90 to 180 days following the exposure.

Occupational Infectious Disease does not include HIV or Hepatitis B, C and/or D that occurs as a result of IV drug use, sexual transmission or is determined not to be accidental.

CHILDHOOD CONDITIONS

The following conditions apply only to your insured Dependent Children.

Cerebral Palsy means your Dependent Child is Diagnosed with a nonprogressive, neurological defect affecting muscle control resulting from an injury to or congenital abnormality of the brain.

The Diagnosis of Cerebral Palsy must be supported by abnormal brain imaging (MRI or equivalent).

A benefit is not payable for the following:

- Autism as primary Diagnosis; and
- motor deficits due to an underlying medical condition (syndrome, genetic or hereditary condition).

Congenital Heart Defects means your Dependent Child is Diagnosed with structural abnormalities of the heart requiring surgical intervention to sustain life including, but not limited to, coarctation of the aorta, tetralogy of Fallot, transposition of the great arteries, total anomalous pulmonary venous connection, patent ductus arteriosus, hypoplastic left heart syndrome, truncus arteriosus, Ebstein anomaly or atresia of any heart valve, single ventricle and ventricular septal defect.

Congenital Metabolic Disorder means your Dependent Child is Diagnosed with a genetic or inherited disorder that results in defects of production (synthesis) or breakdown (catabolism) of proteins, carbohydrates and/or fatty acids. These disorders include: Niemann-Pick disease, Tay Sachs disease, Gaucher's Disease, Sandhoff disease, phenylketonuria, glycogen storage disease (also known as Pompe disease and Anderson disease), Lesch Nyhan syndrome, Zellweger syndrome (excluding other Zellweger spectrum disorders), sickle cell anemia and cystic fibrosis.

Congenital Structural Anomaly means your Dependent Child is Diagnosed with a structural malformation of the body that arises in utero and impairs the function of the body. These include, but are not limited to, cleft lip, cleft palate, anal atresia, biliary atresia, diaphragmatic hernia, omphalocele, gastroschisis, spina bifida (excluding spina bifida occulta), pyloric stenosis, Hirschsprung's disease, club foot, webbed fingers or toes, sixth toes or fingers.

Other Genetic Disorders means your Dependent Child is Diagnosed with a disorder involving chromosomal abnormalities requiring medical Treatment and includes: Down syndrome, infantile onset ascending spastic paralysis, juvenile primary lateral sclerosis, Fragile X syndrome, DiGeorge syndrome, Turner syndrome, Prader Willi, Canavan disease, vascular Ehlers-Danlos syndrome, osteogenesis

7. COVERED CONDITIONS

imperfecta (excluding type 1), achondroplasia, spinal muscular atrophy types 0, 1, 2, and 3, hemophilia, neurofibromatosis, and muscular dystrophy.

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

8. EXCLUSIONS AND LIMITATIONS

What exclusions apply to the benefits payable?

In addition to any exclusions stated in the Covered Conditions section, we will not pay any benefit that is caused by, contributed to in any way, or resulting from any Covered Condition Diagnosed outside the United States or Canada without confirmation of the Diagnosis by a Physician who practices in the United States or Canada. This exclusion does not apply to an Insured while traveling overseas or while residing outside the United States while you are on a temporary work assignment.

We will not pay a benefit for any condition that is not included in the Benefit Highlights of this Certificate or any attached Rider or that is due to or results from:

- substance abuse, including abuse of alcohol, alcoholism, abuse of a legally obtained prescription medication, and illegal use of a non-prescribed drug or narcotic; or
- voluntarily taking or using any drug, medication, narcotic, or controlled substance (unless it is administered and taken as prescribed by a Physician or taken according to the “over the counter” package directions).

9. PREVENTIVE HEALTH BENEFIT

What is the Preventive Health Benefit?

A Preventive Health Benefit is payable for each Insured who has any of the following preventive exams and screenings performed or reviewed by a licensed medical professional:

- annual physical exam
- abdominal and aortic aneurysm ultrasonography
- biopsies for cancer
- bone density screening
- bone marrow testing
- BRCA (cancer genetic mutation test)
- breast cancer screening (for example, clinical breast exam, mammography, MRI, thermography, ultrasound)
- CA15-3 (blood test for breast cancer)
- CA125 (blood test for ovarian cancer)
- cardiac exercise stress test
- carotid doppler
- CEA (blood test for colon cancer)
- chest x-ray
- colorectal cancer screening (for example, fecal occult blood test, colonoscopy, sigmoidoscopy)
- CT angiography
- dental exam
- diabetes tests (for example, fasting blood glucose test, hemoglobin A1c, and gestational diabetes test)
- double contrast barium enema
- echocardiogram
- electrocardiogram (ECG) - resting or stress
- flexible Sigmoidoscopy
- hemoccult stool analysis
- immunizations
- interscholastic sports physical exam
- lipid panel (total cholesterol including serum cholesterol test, triglycerides, HDL, LDL)
- Lymphocyte Genome Sensitivity (LGS) test (universal blood test for cancer)
- pap smear (including ThinPrep)
- prostate cancer screening (for example, digital rectal exam, PSA blood test)
- serum protein electrophoresis (blood test for myeloma)
- skin cancer screening
- smoking cessation program
- testicular ultrasound
- vision exam
- weight reduction program

To receive this benefit, you must notify us of which preventive exam or screening was performed.

10. CLAIM PROVISIONS

How is a claim submitted?

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

NOTICE OF CLAIM

When does Written notice of claim have to be submitted?

Written notice of claim must be given to us no later than 90 days after the date of Diagnosis.

If notice cannot be given within the applicable time period, we must be notified as soon as it is reasonably possible.

When we receive Written notice of claim, we will send the forms for Proof of claim. If the forms are not received within 15 days after Written notice of claim is sent, Proof of claim may be sent to us without waiting to receive the Proof of claim forms.

If you have questions on how to submit a claim, please visit our website at <https://www.sunlife.com/us>.

PROOF OF CLAIM

When does Written Proof of claim have to be submitted?

Written Proof of claim must be given to us no later than 180 days after the date of Diagnosis of the Covered Condition.

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 the individual is legally incompetent.

What is considered Proof of claim?

Proof of claim must consist of at least the following information:

- a description of the Covered Condition;
- the date the Diagnosis occurred;
- the cause of the Covered Condition;
- hospital records, Physician records, x-rays, narrative reports, or lab, toxicology or other diagnostic testing materials as appropriate for the Covered Condition;
- police accident reports; and
- any other information we may require to make a claim determination.

We may require as part of the Proof, authorizations to obtain medical and non-medical information. Proof must be satisfactory to us.

10. CLAIM PROVISIONS

PAYMENT OF BENEFITS

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.

When will a decision on your claim be made?

We will send you a Written notice of our decision on your claim within a reasonable time after we receive the claim but not later than 90 days after receipt of the claim. If we cannot make a decision within 90 days after receiving your claim, we will request a 90 day extension as permitted by U.S. Department of Labor regulations. Any request for extension will specifically explain:

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

If a period of time is extended because you failed to provide necessary information, the period for making the benefit determination is tolled from the date we send notice of the extension to you until the date on which you respond and provide the requested information. You will have 45 days to provide the specified information.

What if your claim is denied?

If we deny all or any part of your claim, you will receive a Written notice of denial stating:

- the specific reason(s) for the denial;
- the specific Policy provision(s) on which the denial is based;
- your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
- a description of any additional material or information needed to prove entitlement to benefits and an explanation of why such material or information is necessary;
- a description of the appeal procedures and time limits;
- your right to bring a civil action under ERISA, §502(a), if applicable, following an adverse determination on review; and
- the identity of any medical or vocational experts whose advice was obtained in connection with the claim, regardless of whether the advice was relied upon to deny the claim.

Can you request a review of a claim denial?

If all or part of your claim is denied, you may request in Writing a review of the denial within 60 days after receiving notice of denial.

You may submit Written comments, documents, records or other information relating to your claim for benefits, and may request free of charge copies of all documents, records, and other information relevant to your claim for benefits.

We will review the claim on receipt of the Written request for review and will notify you of our decision within a reasonable time but not later than 60 days after the request has been received. If an extension of time is required to process the claim, we will notify you in Writing of the special circumstances requiring the extension and the date by which we expect to make a determination on review. The extension cannot exceed a period of 60 days from the end of the initial period.

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

10. CLAIM PROVISIONS

What if your claim is denied on review?

If we deny all or any part of your claim on review, you will receive a Written notice of denial stating:

- the specific reasons for the denial;
- the specific Policy provisions on which the denial is based;
- your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
- your right to bring a civil action under ERISA, §502(a), if applicable; and
- the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Insurance regulatory agency."

To whom are benefits payable?

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

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

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

Method A: We may pay up to the sum of \$5,000 to any individual or entity we determine has incurred or paid expenses as a result of funeral services provided to or on your behalf. If we pay such a benefit, we will not have to pay that benefit amount again and the total benefit due under the Policy shall be reduced by the amount paid under this provision.

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

- to your Spouse if living; or
- if there is no surviving Spouse, to your surviving children in equal shares.

If we pay benefits in good faith to a relative, we will not have to pay those benefits again.

11. 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. Your insurance may be continued for any of the following reasons and durations:

- Absence due to Injury or sickness – up to 3 months
- Layoff – up to 60 days
- Leave of Absence – up to 60 days
- Vacation – based on your Employer's policy, not to exceed 3 months

You should contact your Employer for more details.

While the Policy is in force, you may be eligible to continue your insurance pursuant to the Family and Medical Leave Act of 1993, as amended or continue insurance 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 pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA), as amended. You should contact your Employer for more details.

If you return to an Actively at Work status in an Eligible Class immediately following an allowed continuation period shown above, re-enrollment is not required. Your insurance will remain in force and be subject to all other terms of the Policy.

If you do not return to an Actively at Work status in an Eligible Class immediately following an allowed continuation period shown above your insurance will terminate. You may be eligible for coverage under the Portability provision.

If you or your Employer do not elect to continue your insurance as allowed above or cancel insurance during an allowed continuation period, your insurance will terminate. You may be eligible for coverage under the Portability provision.

If you return to an Actively at Work status in an Eligible Class, you may re-enroll for insurance on yourself, your Spouse and your Dependent Children at the next Enrollment Period after your return to an Actively at Work status.

Your insurance will be effective on the January 1st following the date you re-enroll as long as you are Actively at Work on that date.

Insurance for your Spouse and your Dependent Children will be effective on the January 1st following the date you re-enroll as long as you are Actively at Work on that date and your Spouse or Dependent Child are not Confined on that date.

If you are not Actively at Work on that date, your insurance will not start until you resume being Actively at Work.

If your Spouse or Dependent Child are Confined on that date, insurance for that person will not start until they are no longer Confined. Confinement does not apply to a newborn child, newly placed foster child or a newly adopted child.

You may not re-enroll for insurance if you continued your insurance under the Portability provision, unless you cancel such coverage.

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

12. PORTABILITY

What is portable insurance and when are you eligible?

Portable insurance is an optional benefit that you may elect to continue your insurance for each Insured up to the later of the day before you reach age 70 or 12 months from the date your portable insurance started if:

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

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

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

When must you apply for portable insurance?

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

What is the amount of portable insurance?

You may apply for portable insurance in an amount up to 100% of each Insured's Insurance Amount in force under the Policy on the date your insurance terminates. You may port to a lower Insurance Amount or benefit election, if available. You cannot port to a higher Insurance Amount or benefit election.

When does your portable insurance start?

Upon approval of your application and receipt of first premium, your portable insurance will become effective the day following termination of insurance.

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

When is portable insurance available to your Spouse and when is your Spouse eligible?

Portable insurance is available for your Spouse up to the later of the day before your Spouse reaches age 70 or 12 months from the date your Spouse's portable insurance started if all of the following requirements are met:

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

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

12. PORTABILITY

When must your Spouse apply for portable insurance?

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

What is the amount of your Spouse's portable insurance?

Your Spouse may apply for portable insurance in an amount up to 100% of their Insurance Amount and Dependent Children Insurance Amount in force under the Policy on the date of your death or divorce.

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

When does your Spouse's portable insurance start?

Upon approval of your Spouse's application and receipt of first premium, your Spouse and Dependent Children's portable insurance will become effective the day following their termination of insurance.

13. CONTINUITY OF COVERAGE

What happens if your Employer replaces other insurance with this Certificate and the Policy?

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

What if you are not Actively at Work when your Employer replaces the Prior Policy with the Policy?

You and your Spouse and Dependent Children will be covered under the Policy if you are not Actively at Work on January 1, 2026 if:

- you were insured under the Prior Policy on the day before January 1, 2026;
- you are a member of an Eligible Class;
- your Employer continues to remit premiums for your coverage; and
- you are not receiving or eligible to receive benefits under the Employer's Prior Policy.

If you, your Spouse or Dependent Child are Diagnosed with a Covered Condition, and were never Actively at Work while covered under the Policy, any benefit payable will be based on the Policy and the insurance amount payable under the Prior Policy, not to exceed the Maximum Insurance Amount payable under the Policy.

What if your Spouse or Dependent Child is Confined when your Employer's Prior Policy is replaced with the Policy and you are Actively at Work?

Your Spouse and Dependent Children will be covered under the Policy if they are Confined on January 1, 2026 if:

- your Spouse or Dependent Child was insured under your Employer's Prior Policy on the day before January 1, 2026;
- you are a member of an Eligible Class for Spouse or Dependent Children coverage;
- your Employer continues to remit premiums for your Spouse or Dependent Children coverage; and
- your Spouse or Dependent Child are not receiving or eligible to receive Spouse or Dependent Child benefits under your Employer's Prior Policy.

If your Spouse or Dependent Child are Diagnosed with a Covered Condition, and you are Actively at Work, any benefit payable will be based on the Policy and the insurance amount payable under the Prior Policy, not to exceed the Maximum Insurance Amount payable under the Policy.

Does the Eligibility Waiting Period apply when your Employer's Prior Policy is replaced with the Policy?

We will apply any period of time satisfied under the Prior Policy to meet the requirements of the Eligibility Waiting Period toward the satisfaction of the period of time required by the Policy's Eligibility Waiting Period.

14. GENERAL PROVISIONS

AGENCY

Can the Policyholder, Employer, or third party administrator act as our agent?

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

ALTERATION

Who can alter the Policy?

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

ASSIGNMENT

Can benefit payments be assigned?

You can assign benefits to a provider. You cannot assign any interest in the Policy unless we agree in Writing to such an assignment. We have the right to determine the extent to which any assignment will be honored and the priority of such assignment. We do not assume any responsibility for the validity or sufficiency of any assignment. Any payments made under such assignment after consented to by us will discharge our liabilities under the Policy, to the extent of such payments.

CLERICAL ERROR

What happens when there is a clerical error in the administration of the Policy?

Clerical errors in the administration of the Policy or delays in keeping records for the Policy whether by us, the Policyholder, the Employer or third party administrator:

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

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

This provision does not apply to benefit administration errors by the Policyholder, the Employer or third party administrator which result in an Employee:

- not enrolling for insurance within required time limits;
- failing to request increased amounts of insurance within required time limits; or
- failing to exercise any available Insurance Continuation or Portability options.

CONFORMITY WITH STATUTES

What is the effect of Conformity with Statutes?

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

DISCHARGE OF OUR RESPONSIBILITY

What is the effect of payments under the Policy?

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

14. GENERAL PROVISIONS

EXAMINATION

What are our examination rights?

We, at our expense, have the right to have any person with respect to whom a claim has been filed:

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

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

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 re-enrolled 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 an Insured's eligibility for insurance.

INSURER'S AUTHORITY

What is our authority?

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

This does not prohibit the Insured from seeking legal redress.

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 3 years after the time Proof of claim is required.

The claimant must exhaust all internal appeal/administrative remedies prior to filing any legal proceeding. If the claimant fails to exhaust all administrative remedies prior to initiating any legal action, we shall be entitled to legal fees in defense of the action. For claims subject to ERISA, if a claimant files state law causes of action that are later determined by a court to be preempted by ERISA, we shall be entitled to legal fees in defense of those causes of action.

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

14. GENERAL PROVISIONS

LIMIT OF EXCESS PREMIUM REFUNDS

Is there a limit on excess 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 Excess 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, your Spouse or your Dependent Child are not eligible for coverage, you should contact your Employer regarding the refund of premiums due, if any.

REIMBURSEMENT

What if a benefit is underpaid or overpaid?

Reimbursement will be made to us for any overpayments that we may make due to any reason. You must repay us within 60 days unless we agree to a longer time period. Deductions may be made from future benefit payments to recover any such overpayments.

If we have underpaid a benefit for any reason, we will make a lump sum payment for that amount.

Interest does not accrue on any underpaid or overpaid benefit unless required under the applicable law.

14. 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 a copy of your Written application for insurance is or has been given to you, your beneficiary, if any, or your estate representative.

TIME PERIODS

What time periods apply to this Certificate?

For the purpose of effective dates and termination dates under this Certificate, all days begin at 12:00 midnight and end at 11:59:59 PM at the Policyholder's location.

SUN LIFE ASSURANCE COMPANY OF CANADA

CRITICAL ILLNESS CERTIFICATE CANCER RIDER

This Rider is part of the Certificate issued under Policy Number 980742-002 and is effective on January 1, 2026. It is part of, and subject to, the other terms and conditions of the Certificate. If the terms of this Rider and the Certificate conflict, this Rider's provisions will control.

This Rider, while in force, will provide a lump-sum benefit, as shown in the Benefit Highlights below, when an Insured, on or after the latest of January 1, 2026, the Covered Condition effective date (if applicable) or the date an Insured's insurance starts, is Diagnosed with a Covered Condition as defined below. Any benefits payable are subject to the limitations, exclusions and other provisions stated in the Certificate.

BENEFIT HIGHLIGHTS

Covered Condition	Benefit Percentage per Occurrence
Skin Cancer	5%
Non-Invasive Cancer	25%
Invasive Cancer	100%
Metastasis of a Non-Invasive Cancer or Skin Cancer	75%

DEFINITIONS

Complete Remission/No Evidence of Cancer means that there is a disappearance of cancer in response to Treatment.

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

For the purposes of this Rider, we will not consider Physician follow-up visits, regular screenings (lab studies or imaging) or receipt of maintenance drug therapy including hormonal therapy, immunotherapy or chemo-prevention to be Treatment, as long as the therapy is meant to prevent recurrence of a cancer currently in remission rather than suppress or treat an existing cancer.

BENEFIT PROVISIONS

What benefits are payable?

A benefit is only payable if an Insured is Diagnosed with a Covered Condition while insured under the Rider. The Diagnosis must be made by a Physician qualified to make such Diagnosis.

If an Insured is Diagnosed with more than one Covered Condition on the same date:

- the Covered Condition with the higher benefit amount will be payable; or
- if the benefit amounts are the same, the Covered Condition of the earliest Diagnosis will be payable.

You may receive benefits for multiple occurrences of cancer. See Covered Conditions below.

How is the amount of the benefit determined?

We will multiply the Insured's Insurance Amount by the Benefit Percentage for the applicable Covered Condition as shown in the Benefit Highlights above to determine the benefit to be paid.

How is the date of Diagnosis determined?

When a diagnostic test or procedure is standardly used to confirm a Covered Condition, the date of the Diagnosis is the date the diagnostic test or procedure is performed by a Physician. If multiple tests are required, the date of Diagnosis is the date the first test or procedure was performed that confirmed the Diagnosis. Diagnostic test or procedure means lab tests including pathology, imaging or formal testing of cognition.

When a Clinical Diagnosis is standardly used to confirm a Covered Condition, the date of Diagnosis is the date the Physician first documents the Diagnosis.

If a condition routinely requires both diagnostic testing and Clinical Diagnosis, the later of the two will apply.

For a Clinical Diagnosis that is subsequently confirmed as a higher grade upon a Pathological Diagnosis, the difference between the two benefits will be payable.

Additional Occurrence Benefit

The Additional Occurrence Benefit as described in the Certificate does not apply to multiple Diagnoses of different cancers. See Covered Conditions below for a description of how a benefit for an additional occurrence of cancer is payable.

When is an additional Covered Condition payable?

Unless otherwise noted, if we pay a benefit for a particular Covered Condition, we will pay a benefit for a different Covered Condition listed in the Benefit Highlights above, in the Certificate or in any attached Rider.

Recurrence Benefit

The Recurrence Benefit as described in the Certificate does not apply to these benefits. See Covered Conditions below for a description of how a benefit for the same occurrence of cancer is payable.

COVERED CONDITIONS

What Critical Illness conditions are covered under this Rider?

The Covered Conditions defined below.

Skin Cancer means an Insured is Diagnosed with basal cell cancer or squamous cell cancer of the skin.

Non-Invasive Cancer means an Insured is Diagnosed with a malignant neoplasm wherein the tumor cells still lie within the tissue of origin without having invaded neighboring lymph nodes or tissue. Non-Invasive Cancer includes cancers described as NX, N0, MX or M0.

Non-Invasive Cancer includes:

- Stage 0 or Stage 1 Melanoma;
- Prostate Cancer within the capsule; and
- early-stage Myelodysplastic Syndrome.

Non-Invasive Cancer does not include any cancers listed under Invasive Cancer.

Invasive Cancer means an Insured is Diagnosed with a malignant neoplasm, which is characterized by the uncontrolled growth and spread of malignant cells to neighboring tissues or lymph nodes, or to other organs or areas of the body. Invasive Cancer includes cancers described as N1, N2, N3 or M1.

Invasive Cancer also includes certain life-threatening cancers Diagnosed at earlier stages. These include:

- Breast Cancer stage 1 and above (including in-situ/DCIS);
- Prostate Cancer invasive beyond capsule;
- Stage 1 or higher brain, pancreatic, esophageal, lung, liver, biliary tract or head and neck cancers;
- Stage 2 or higher Melanoma; or
- all blood cancers (Leukemia, Multiple Myeloma or Lymphoma).

Invasive Cancer does not include lesions described as benign, pre-malignant, uncertain, borderline, non-invasive or carcinoma in-situ (Tis) unless otherwise specified.

What is considered a new occurrence of cancer?

A new occurrence of cancer is defined as follows:

- the first Diagnosis of cancer for which we pay a Cancer Covered Condition benefit under the Policy; or
- a Diagnosis of a new and unrelated cancer that occurs more than 6 months after the previous Diagnosis of cancer for which we paid a Cancer Covered Condition benefit; or
- a Diagnosis of the same cancer for which we previously paid a Cancer Covered Condition benefit, if the Insured:
 - is Diagnosed with the same cancer more than 6 consecutive months later; and
 - has not received Treatment for the same cancer for 6 consecutive months after the initial Diagnosis of the cancer.

How many times can you receive a benefit for a new occurrence of cancer?

There is no limit to the number of new occurrence benefits per Insured, subject to all other requirements of the Policy.

What is considered the same occurrence of cancer?

A same occurrence of cancer means an Insured:

- is Diagnosed with the same cancer less than 6 consecutive months later; and
- has continued to receive Treatment for the same cancer for 6 consecutive months after the initial Diagnosis for the cancer.

When can another benefit be payable for the same occurrence of cancer?

A benefit may be payable under Metastasis of a Non-Invasive Cancer or Skin Cancer if the cancer spreads and the Insured cannot meet the criteria for a new occurrence.

Metastasis of a Non-Invasive Cancer or Skin Cancer means an Insured, while covered under the Policy:

- is Diagnosed with and paid a benefit for a Non-Invasive Cancer or Skin Cancer; and
- is later Diagnosed with a metastasis of the same cancer to either the lymph nodes or other organ or part of the body; and
- cannot meet the criteria for a new occurrence.

A benefit is payable once for the same occurrence of cancer per Insured.

What if you have a Diagnosis of cancer prior to the date your insurance starts under the Policy?

For a Diagnosis of a cancer that existed prior to the date an Insured's coverage starts under the Policy, a benefit may be payable for a subsequent Diagnosis of cancer if:

- it is a new and different cancer unrelated to any other Diagnosis of cancer and not a confirmation of a prior Diagnosis of an existing cancer for which the Insured is currently receiving Treatment; or
- it is the same cancer, and the Insured is either in Complete Remission or there is No Evidence of Cancer on the date the Insured's coverage starts under the Policy.

EXCLUSIONS AND LIMITATIONS

What exclusions apply to the benefits payable?

In addition to any limitations and exclusions stated in this Rider, the exclusions and limitations of the Certificate will apply.

TERMINATION

This Rider will end on the earliest of the following to occur:

- the date your Employer elects to terminate this Rider;
- the date your insurance under the Certificate terminates;
- the date the Policyholder ceases to remit any required premium; or
- the date the Policy terminates.



Kevin Strain
President and Chief Executive Officer

SUN LIFE ASSURANCE COMPANY OF CANADA

CRITICAL ILLNESS CERTIFICATE INFECTIOUS DISEASE RIDER

This Rider is part of the Certificate issued under Policy Number 980742-002 and is effective on January 1, 2026. It is part of, and subject to, the other terms and conditions of the Certificate. If the terms of this Rider and the Certificate conflict, this Rider's provisions will control.

This Rider, while in force, will provide a lump-sum benefit, as shown in the Benefit Highlights below, when an Insured, on or after the latest of January 1, 2026, the Covered Condition effective date (if applicable) or the date an Insured's insurance starts, is Diagnosed with a Covered Condition as defined below. Any benefits payable are subject to the limitations, exclusions and other provisions stated in the Certificate.

BENEFIT HIGHLIGHTS

Covered Condition	Benefit Percentage
Infectious Disease Severe Infectious Disease Recurrence Limitation: Limited to 1 Diagnosis per 6-month period per Insured Maximum Benefit: Unlimited	25%

Additional Occurrence Benefit Separation Period: none
See the Benefit Provisions below for more information.

BENEFIT PROVISIONS

What benefits are payable?

A benefit is only payable if an Insured is Diagnosed with a Covered Condition while insured under the Rider. The Diagnosis must be made by a Physician qualified to make such Diagnosis.

If an Insured is Diagnosed with more than one Covered Condition on the same date:

- the Covered Condition with the higher benefit amount will be payable; or
- if the benefit amounts are the same, the Covered Condition of the earliest Diagnosis will be payable.

How is the amount of the benefit determined?

To determine an amount based on Benefit Percentage, we will multiply the Insured's Insurance Amount by the Benefit Percentage for the applicable Covered Condition as shown in the Benefit Highlights above to determine the benefit to be paid.

How is the date of Diagnosis determined?

When a diagnostic test or procedure is standardly used to confirm a Covered Condition, the date of the Diagnosis is the date the diagnostic test or procedure is performed by a Physician. If multiple tests are required, the date of Diagnosis is the date the first test or procedure was performed confirming the Diagnosis. Diagnostic test or procedure means lab tests including pathology, imaging or formal testing of cognition.

When a Clinical Diagnosis is standardly used to confirm a Covered Condition, the date of Diagnosis is the date the Physician first documents the Diagnosis.

If a condition routinely requires both diagnostic testing and Clinical Diagnosis, the later of the two will apply.

Additional Occurrence Benefit

When is an additional Covered Condition payable?

Unless otherwise noted, if we pay a benefit for a particular Covered Condition, we will pay a benefit for a different Covered Condition listed in the Benefit Highlights above, in the Certificate or in any attached Rider.

The Additional Occurrence Benefit as described here does not apply to multiple Diagnoses of Infectious Disease. Please see the limitations and maximums in the Benefit Highlights above.

Recurrence Benefit

The Recurrence Benefit as described in the Certificate does not apply to these benefits. Please see the limitations and maximums in the Benefit Highlights above.

COVERED CONDITIONS

What Critical Illness conditions are covered under this Rider?

The Covered Condition(s) defined below.

Infectious Disease

Infectious Disease means an Insured is Diagnosed with a disease caused by pathogenic microorganisms, such as bacteria, viruses, parasites or fungi that can be spread directly or indirectly from one person to another.

A **Severe Infectious Disease** benefit is payable if, due to a Diagnosis of an Infectious Disease, an Insured is Hospital Confined for 5 consecutive days. The initial Diagnosis of the Infectious Disease does not have to occur while insured under the Rider in order for this benefit to be payable.

The Infectious Diseases covered under the Severe Infectious Disease benefit include, but are not limited to:

- anthrax;
- bacterial pneumonia;
- C.diff;
- cholera;
- Coronavirus;
- Ebola virus disease;
- diphtheria;
- encephalitis;
- Hepatitis A;
- Legionnaire's disease;
- Lyme disease;
- malaria;
- Measles;
- Meningitis;
- methicillin-resistant staphylococcus aureus (MRSA);

- Monkeypox
- mosquito borne diseases;
- necrotizing fasciitis;
- novel virus, as identified by the Centers for Disease Control and Prevention (CDC) or the World Health Organization (WHO);
- osteomyelitis;
- pertussis (whooping cough);
- Polio;
- rabies;
- Rocky Mountain spotted fever;
- sepsis;
- tetanus;
- tick borne disease;
- tuberculosis;
- typhoid fever;
- Typhus;
- Vancomycin Resistant Enterococci (VRE)

We must receive documentation of positive test results for a particular disease.

We will not pay a benefit for an Infectious Disease that was acquired and treated during a Hospital Confinement for another Covered Condition. However, this does not apply if an Insured requires a separate Hospital Confinement specifically to treat this Infectious Disease.

EXCLUSIONS AND LIMITATIONS

What exclusions apply to the benefits payable?

In addition to any limitations and exclusions stated in this Rider, the exclusions and limitations of the Certificate will apply.

TERMINATION

This Rider will end on the earliest of the following to occur:

- the date your Employer elects to terminate this Rider;
- the date your insurance under the Certificate terminates;
- the date the Policyholder ceases to remit any required premium; or
- the date the Policy terminates.



Kevin Strain
President and Chief Executive Officer

SUN LIFE ASSURANCE COMPANY OF CANADA

Group Critical Illness Insurance Certificate

Non-Participating



Pye-Barker Fire & Safety, LLC Employee Benefit Plan (The Plan) has been established to provide welfare benefits for its eligible employees and their eligible dependents.

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

SUMMARY PLAN DESCRIPTION

Plan Sponsor: Pye-Barker Fire & Safety, LLC
2500 Northwinds Pkwy
Suite 200
Alpharetta, GA 30009

Plan Administrator and Named Fiduciary:
Pye-Barker Fire & Safety, LLC
2500 Northwinds Pkwy
Suite 200
Alpharetta, GA 30009

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

Agent for Service of Legal Process for the Plan:

Alliant Insurance Services
1125 Sanctuary Pkwy
Ste 300
Alpharetta, GA 30009

Service of Legal Process for Sun Life:

General Counsel
96 Worcester Street
Wellesley Hills, MA 02481

Employer Identification Number (EIN): 20-0378887

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.

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

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

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

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

Funding: The benefits under the Plan are funded, at least in part, by the Group Insurance Policy issued by Sun Life Assurance Company of Canada. Those insurance benefits are described in your Certificate.

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

If your claim for benefits is denied in whole or in part, you will receive a written notice within the time required by ERISA from the date you filed your claim, stating the reasons why your claim was denied. You will then have the right, upon written notice from you or your authorized representative, to review that claim denial. The claim denial notice will include the name and address of the person you may ask for such a review. Additional information about claims submitted and review procedures may be obtained by contacting your Plan Administrator.

Your Rights under ERISA:

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

Receive Information About Your Plan and Benefits

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

Assistance with Your Questions

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