SUN LIFE ASSURANCE COMPANY OF CANADA

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

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

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

Policy Number:	939521-001
Policy Effective Date:	August 1, 2020
Policyholder:	Town and Country Super Market, Inc.
Employer:	Town and Country Super Market, Inc.
Issue State:	Missouri

NOTICE TO BUYER. THIS IS A LIMITED BENEFIT CERTIFICATE. THIS CERTIFICATE PROVIDES ACCIDENT ONLY COVERAGE AND DOES NOT PAY BENEFITS FOR LOSS FROM SICKNESS.

PLEASE READ YOUR CERTIFICATE CAREFULLY

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

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

Signed at Wellesley Hills, Massachusetts



Dean A. Connor
President and Chief Executive Officer



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

Group Basic Accidental Death and Dismemberment Insurance Certificate

Non-Participating

Sun Life Financial®

NOTICE TO CERTIFICATEHOLDER

THIS NOTICE IS TO ADVISE YOU THAT SHOULD YOU HAVE ANY QUESTIONS OR COMPLAINTS REGARDING YOUR SUNLIFE GROUP INSURANCE PLAN, YOU MAY CONTACT THE FOLLOWING:

SUN LIFE ASSURANCE COMPANY OF CANADA
ATTN: CUSTOMER RELATIONS
PO BOX 9106
WELLESLEY HILLS, MA 02481
(800) 247-6875

ALSO AVAILABLE TO YOU IS THE CONSUMER SERVICES DIVISION OF THE ARKANSAS INSURANCE DEPARTMENT, 1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS 72201-1904, (501) 371-2640 or (800) 852-5494

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1. BENEFIT HIGHLIGHTS

Eligible Classes:	All Full-Time United States Employees working in the United States enrolled in the Employer's Medical Plan scheduled to work at least 30 hours per week.
Eligibility Waiting Period:	None

1. BENEFIT HIGHLIGHTS

EMPLOYEE BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Amount of Insurance
An amount of insurance equal to your amount of Employee Basic Life Insurance in force under Group Certificate No. 939521-001.

The following Additional Benefit(s) are included:
Bereavement Counseling Benefit
- for you
Coma Benefit
- for you
Common Carrier Benefit
- for you
Portability Benefit
- for you
Repatriation Benefit
- for you
Seat Belt / Air Bag Benefit
- for you

Contributions
The cost of your Employee Basic Accidental Death and Dismemberment Insurance is paid entirely by your Employer. This is your non-contributory insurance.

2. DEFINITIONS

Accident or Accidental means an external event that an average person would consider sudden and unforeseeable and:

- that results, directly and independently of all other causes;
- is independent of any illness, disease or other bodily malfunction; and
- occurs while coverage is in force under the Policy for the Insured.

Accident or Accidental does not mean an unintentional accident caused by or during medical treatment or surgery for Sickness or Injury.

Accident includes accidental drowning and accidental exposure to the elements.

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

You are considered Actively at Work if you usually perform the regular duties of your job at your home as long as you can perform all the regular duties of your job for a full work day and could do so at your Employer's normal place of business.

You are considered Actively at Work on any day that is not your regular scheduled work day (e.g., you are on vacation or holiday) as long as you were Actively at Work on your immediately preceding scheduled work day, and you are neither Confined nor disabled due to an Injury or Sickness.

Coma means a confirmed diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 31 days, and for which period the Glasgow coma score must be 4 or less. The diagnosis of coma must be made by a Physician. Coma does not include: (1) a medically induced coma; or (2) a coma that results from any alcohol or drug use.

Common Carrier includes but is not limited to commercial airplanes, trains, buses, taxis, trolleys, subways, ferries and boats that operate on a regularly scheduled basis between predetermined points or cities. Privately chartered vehicles are not Common Carriers.

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

Covered Accident means an Accident that:

- occurs while the Policy and the Insured's coverage is in force;
- occurs on or after the effective date of insurance; and
- is not excluded by the Policy or applicable riders or endorsements attached to it.

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

Employee means a person who is employed by the Employer within the United States, who is a U.S. citizen or a U.S. resident, scheduled to work at least the minimum hours shown in the Benefit Highlights, and paid regular earnings, and has a legitimate federal tax identification number. Employee does not include a seasonal or temporary employee whose annual work schedule is less than 12 months during a calendar year.

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

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

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 or sister; (6) aunt or uncle; (7) first cousin; (8) nephew or niece. This includes adopted, in-law and step-relatives.

2. DEFINITIONS

Hospital means an organized facility licensed in the applicable jurisdiction that provides medical care and Treatment to sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery, with a staff of one or more licensed Physicians and which provides 24 hour nursing service by registered nurses on duty or call.

Injury means accidental body injury that is the direct result of a Covered Accident. Injuries must be independent of Sickness, disease, bodily infirmity and other causes.

Insured means you.

Intoxicated means:
- under the influence of alcohol, illegal drugs or prescription drugs other than as prescribed by your Physician; or
- at or above the minimum blood alcohol level for which you would be considered operating a motorized vehicle under the influence of alcohol in the jurisdiction where the Accident or Injury occurred.

For the purposes of this definition, ”operating” includes allowing the engine to run even if not seated in the vehicle and "motorized vehicle" includes, but is not limited to, automobiles, motorcycles, boats and snowmobiles.

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.

Loss of Limb, Thumb and Index Finger, Hearing, Sight or Speech
- Loss of Limb means that the foot is completely cut off at or above the ankle joint or the hand is completely cut off at or above the wrist.
- Loss of a Thumb and Index Finger means that the thumb and index finger are each completely cut off at the metacarpophalangeal joint.
- Loss of Hearing means the permanent and irrecoverable loss of hearing.
- Loss of Sight of an eye means total and permanent loss of vision of the eye.
- Loss of Speech means the permanent and irrecoverable loss of speech or the ability to speak.

Non-Contributory Insurance means insurance for which the premium is paid entirely by your Employer.

Paralysis means injury to the brain or spinal cord that results in complete and irreversible loss of use of both arms, both legs or one arm and/or one leg.
- Hemiplegia is the complete and irreversible Paralysis of one arm and one leg on the same side.
- Paraplegia is the complete and irreversible Paralysis of both legs.
- Quadriplegia is the complete and irreversible Paralysis of both arms and both legs.

Physician means a person who is operating within the scope of his or her license and is either:
- licensed in the United States or Canada as a medical doctor and authorized to practice medicine and prescribe and administer drugs or to perform surgery; or
- any other duly licensed medical practitioner who is deemed by applicable state or provincial law to have the same authority as a legally qualified medical doctor.

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

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

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 system for 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.

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);
- an Employee Stock Ownership Plan (ESOP).

Sickness means disease or illness, mental illness, drug illness, abuse or addiction, and alcohol illness, abuse or addiction, or pregnancy.

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:
- is a party to a marriage and under state, federal or provincial law is recognized as a spouse or civil union partner; or
- is a domestic partner as defined by the Policyholder.

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 Basic Accidental Death and Dismemberment Insurance?
You are initially eligible for insurance on the latest of:

- August 1, 2020;
- the date you are eligible for Employee Basic Life Insurance under Group Certificate No. 939521-001;
- your first day of employment;
- the date you enroll in your Employer's Medical Plan; or
- the date you first are Actively at Work in an Eligible Class.

When does Employee Basic Accidental Death and Dismemberment Insurance start?
Employee Basic Accidental Death and Dismemberment Insurance starts on the later of the date:

- you are eligible; or
- you are insured for Employee Basic Life Insurance under Group Certificate No. 939521-001; and

you are Actively at Work on that date.

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

What happens if you are rehired by your Employer?
If you are rehired by your Employer within 3 months of the date your employment ends your insurance may be reactivated. Your reactivated insurance will be:

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

If you are rehired by your Employer 3 months or later after the date your employment terminates, your coverage will not be reactivated.

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

When does Employee Basic Accidental Death and Dismemberment Insurance end?
Your Employee Basic Accidental Death and Dismemberment Insurance under the Policy will end upon the earliest of the following:

- the date the Policy terminates;
- the date you are no longer in an Eligible Class;
- the date your class is no longer included for Employee Basic Accidental Death and Dismemberment Insurance;
- the last day for which any required premium has been paid for your Employee Basic Accidental Death and Dismemberment Insurance;
- the date you are no longer insured for Employee Basic Life Insurance under Group Certificate No. 939521-001;
- the last day you are Actively at Work, subject to the Insurance Continuation or Portability provision;
- the date you enter active duty in any armed service, subject to the Insurance Continuation provision;
- the date you retire;
- the date you are approved for the Waiver of Premium Benefit for Employee Basic Life Insurance under Group Certificate No. 939521-001; or
- the date you die.

If your coverage has ended, can it be reinstated?
If your insurance ends for any reason other than you have voluntarily terminated it, your insurance may be reinstated. Reinstatement will be effective on the date you are insured for Employee Basic Life Insurance under Group Certificate No. 939521-001 and you return to being Actively at Work in an Eligible Class.

Any Accident occurring between your termination date and your reinstatement effective date will not be considered a Covered Accident.

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF EMPLOYEE INSURANCE

Your reinstated insurance will be:

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

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

4. COVERED ACCIDENT BENEFITS

ACCIDENTAL DEATH BENEFIT

What is the Accidental Death Benefit?
We will pay an Accidental Death Benefit when you die within 365 days of the date of the Covered Accident as a result of Injuries received from that Accident. The amount payable is 100% of the amount of insurance in force for your class shown in the Benefit Highlights on your date of death.

What happens if you disappear?
We will presume, subject to no objective evidence to the contrary, that you are dead and death is a result of an Accidental Injury if:

- you disappear as a result of an accidental wrecking, sinking or disappearance of a public conveyance in which you were known to be a fare-paying passenger; and
- your body is not found within 365 days after the date of the conveyance's disappearance.

ACCIDENTAL DISMEMBERMENT BENEFIT

What is the Accidental Dismemberment Benefit?
We will pay an Accidental Dismemberment Benefit if you sustain any of the losses shown below due to Injuries received in a Covered Accident, and the loss occurs within 365 days after the date of the Covered Accident. The amount payable is a percentage of the amount of insurance in force for your class shown in the Benefit Highlights on the date of the Accidental Injury. The following is a list of the losses and applicable percentages:

Loss of one Limb…….....50%

Loss of Sight of one eye…….50%

Loss of thumb and index finger of the same hand…….25%

Loss of Speech or Hearing……..……..50%

Loss of Speech and Hearing…..…….……100%

Paralysis – Quadriplegia……..100%

Paralysis – Paraplegia……...75%

Paralysis – Hemiplegia……...……50%

The maximum amount of Basic Accidental Death and Dismemberment Benefit payable for losses resulting from any one accident is 100%.

5. ADDITIONAL BENEFITS

You are insured for the additional benefits shown below provided you are eligible for those benefits.

These additional benefits are subject to all the terms and conditions of the Policy. In addition to the termination provisions shown in the Eligibility, Effective Dates and Terminations section, termination provisions specific to an additional benefit are shown in this section.

BEREAVEMENT COUNSELING BENEFIT

What is the Bereavement Counseling Benefit?
If you die and a Basic Accidental Death Benefit is payable under the Policy, we will pay a Bereavement Counseling Benefit during an Immediate Family Member's period of bereavement for up to 12 months after you die.

Immediate Family Member means you, your Spouse or your Dependent Child under age 26.

What expenses are reimbursed under the Bereavement Counseling Benefit?
The Bereavement Counseling Benefit equals the Immediate Family Member's incurred expenses for counseling reduced by any reimbursement the Immediate Family Member receives for counseling from other sources.

The Maximum Bereavement Counseling Benefit payable is $250 per Immediate Family Member, to a maximum of $1,000 per Insured's death.

Written Proof of the actual out of pocket counseling expenses incurred must be submitted to us prior to payment.

COMA BENEFIT

What is the Coma Benefit?
If, while insured, you suffer an Accidental Injury that results in you being in a Coma for at least 31 days, a Coma Benefit will be payable. The Coma Benefit is payable for 100 months in equal monthly installments based on your amount of Basic Accidental Death and Dismemberment Insurance shown in the Benefit Highlights at the time of the accident reduced by any amount previously payable as a result of the same accident. We will require monthly proof of the continuance of your Coma, but after one year we will not ask for proof more often than twice a year.

When does the Coma Benefit cease?
The Coma Benefit will cease to be payable when:

- you regain consciousness;
- you die; or
- 100 monthly installments have been paid.

What happens if I die while in a Coma?
If you die without regaining consciousness, your remaining Basic Accidental Death and Dismemberment Benefit will be payable.

COMMON CARRIER BENEFIT

What is the Common Carrier Benefit?
If your loss of life occurs while traveling as a fare paying passenger on a public conveyance operated by a common carrier, an additional Common Carrier benefit will be payable.

The Common Carrier Benefit is 100% of the amount of Basic Accidental Death Benefit payable.

REPATRIATION BENEFIT

What is the Repatriation Benefit?
If a Basic Accidental Death Benefit is payable and your death occurs at least 100 miles from your permanent place of residence, we will reimburse the Executor or Administrator of your estate for the reasonable and customary expenses incurred for the preparation of the body and its transportation to the place of burial or cremation up to a maximum benefit of $2,000. Written Proof of the expenses incurred must be submitted to us prior to payment.

SEAT BELT/AIR BAG BENEFIT

What is the Seat Belt Benefit?
We will pay a Seat Belt Benefit if your loss of life occurs as a result of an automobile accident and you were wearing a seat belt at the time of the accident.

The Seat Belt Benefit is 25% of the amount of Basic Accidental Death Benefit payable or $25,000, whichever is less.

We must receive satisfactory Written proof that your death resulted from an automobile accident and that you were wearing a seat belt at the time of the accident. A copy of the police report is required.

What is the Air Bag Benefit?
We will pay an Air Bag Benefit if the Seat Belt Benefit is payable and you were positioned in a seat protected by a Supplemental Restraint System which inflated on impact.

The Air Bag Benefit is 10% of the amount of Basic Accidental Death Benefit payable or $5,000, whichever is less.

We must receive satisfactory Written proof that your death resulted from an automobile accident and that the Supplemental Restraint System properly inflated. A copy of the police report is required.

Seat Belt means a properly installed seat belt, lap and shoulder restraint, or other restraint approved by the National Highway Traffic Safety Administration.

Supplemental Restraint System means a factory installed air bag which inflates for added protection to the head and chest areas.

Automobile means a motor vehicle licensed for use on public highways.

6. EXCLUSIONS

What exclusions apply to the benefits payable?

No benefits will be payable for any loss that is the result of a Covered Accident that is due to or results from:

- committing or attempting to commit suicide, while sane; or
- injuring oneself intentionally; or
- bodily or mental infirmity or disease of any kind, or an infection unless due to an accidental cut or wound; or
- war or an act of war, or any type of armed conflict (this does not include acts of terrorism); or
- active Participation in a Riot, Rebellion or Insurrection; or
- riding in or driving any motor-driven vehicle in a race, stunt show, speed test or driving while Intoxicated; or
- Injuries sustained from any aviation activities, other than riding as a fare paying passenger; or
- committing of or attempting to commit an assault, felony or other criminal act; or
- voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless administered on the advice of a Physician and used as directed.

7. 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 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?
For the Accidental Death Benefit, Written notice of claim must be given to us no later than 30 days after date of death.

For the Accidental Dismemberment Benefit and all other claims, Written notice of claim must be given to us no later than 12 months after your date of loss or within 12 months after the date the expense is incurred.

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

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, you are considered to have complied with the requirements of this Certificate for filing Proof of claim if you, within the time fixed in this Certificate for filing Proof of Claim, submit written proof of the occurrence, character and extent of the loss for which claim is made.

PROOF OF CLAIM

When does Written Proof of claim have to be submitted?
For the Accidental Death Benefit, Written Proof of claim must be given to us no later than 90 days after date of death.

For the Accidental Dismemberment Benefit and all other claims, Written Proof of claim must be given to us no later than 15 months after your date of loss or within 15 months after the date the expense is incurred.

Failure to furnish Proof within the time limit will not invalidate nor reduce any claim if it was not reasonably possible to provide Proof within the time required, so long as given as soon as reasonably possible. Proof of claim may not be given later than one year after the time Proof is otherwise required unless you are legally incompetent.

What is considered Proof of claim?
Proof of claim must consist of at least the following information:

- a description of the loss or expense;
- the date the loss or expense occurred;
- the cause of the loss or expense;
- hospital records, physician records, x-rays, narrative reports, or lab, toxicology or other diagnostic testing materials as appropriate for the Treatment of the Injury;
- police accident reports;
- the death certificate; 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.

PAYMENT OF BENEFITS

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

7. CLAIM PROVISIONS

When will a decision on your claim be made?
We will send you a Written notice of our decision on your claim within a reasonable time after we receive the claim but not later than 30 days after receipt of the claim. If we cannot make a decision within 30 days after receiving your claim, we will request a 30 day extension as permitted by U.S. Department of Labor regulations. If we cannot render a decision within the extension period, we will request an additional 30 day extension. Any request for extension will specifically explain:

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

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

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

- the specific 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) following an adverse determination on review, if ERISA applies;
- the identity of an internal rule, guideline, protocol or other similar criterion, if any, that was relied upon to deny the claim and a copy of the rule, guideline, protocol or criterion or a statement that a copy is available free of charge upon request; and
- the 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 180 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 45 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 45 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.

7. 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 setting forth:

- the specific reasons for the denial;
- the specific Policy provisions on which the denial is based;
- your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
- your right to bring a civil action under ERISA, §502(a), if ERISA applies;
- the identity of an internal rule, guideline, protocol or other similar criterion, if any, that was relied upon to deny the claim and a copy of the rule, guideline, protocol or criterion or a statement that a copy is available free of charge upon request;
- 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."; and
- the identity of any medical or vocational experts whose advice was obtained in connection with the appeal, regardless of whether the advice was relied upon to deny the appeal.

To whom are benefits payable?
Benefits payable for your loss of life will be payable in accordance with the beneficiary designation. Unless you otherwise specify, if more than one beneficiary survives you, all surviving beneficiaries will share equally. The beneficiary designation must be in Writing, Signed by you and in a form acceptable to us. If no beneficiary is alive on the date of your death or you do not elect a beneficiary the benefit will be payable to your estate.

For other benefits, we will pay you, except in the following situations:

1. You are a minor. In such case, claim may be made by any relative by blood or marriage we deem to be equitably entitled and we will pay to such person or persons;
2. 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 in item 1; or
3. 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 your beneficiary is a minor or is not competent, we have the right to pay up to $1,000 to the person or institution that appears to have assumed custody and main support for the minor, until the appointed legal representative makes a formal claim. If we pay benefits in good faith to a person or institution, we will not have to pay those benefits again.

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 in items 1, 2, or 3 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 $2,000 to any individual or entity we determine has incurred or paid expenses as a result of funeral services provided to or on your behalf. If we pay such a benefit, we will not have to pay that benefit amount again and the total benefit due under the Policy shall be reduced by the amount paid under this provision.

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

- to your Spouse, up to a cumulative amount of $2,000; or
- if you have no Spouse, up to a cumulative amount of $2,000 to any one or more of the following relatives in the following order of priority:
    1. your child or children; or
    2. your mother or father.

8. INSURANCE CONTINUATION

Are there any conditions under which your Employer can continue your insurance?
While the Policy is in force and subject to the conditions stated in the Policy, your Employer may continue your insurance that was in force on the date immediately before the date you ceased to be Actively at Work by paying the required premium to us for any of the following reasons and durations:

- Absence due to Injury or Sickness – up to 12 months
- Layoff – up to 1 month
- Leave of Absence – up to 1 month
- Vacation – based on your Employer's policy, not to exceed 3 months.

You should contact your Employer for more details.

While the Policy is in force, you may be eligible to continue your insurance pursuant to the Family and Medical Leave Act of 1993, as amended or continue coverage pursuant to a state required continuation period (if any). You should contact your Employer for more details.

While the Policy is in force, you may be eligible to continue your insurance coverage pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA). You should contact your Employer for more details.

9. PORTABILITY

What is portable insurance and when are you eligible for it?
Portable insurance is an optional benefit that you may elect to continue your insurance if your insurance ends because you terminate employment; and you port your Basic Life Insurance under Group Certificate No. 939521-001 and you meet the following requirements:

- the Policy is still in force; and
- you are under age 70 at the time employment terminates; and
- you have not retired; and
- the hours you work for your Employer have not been reduced; and
- your insurance is not being continued under any Insurance Continuation provision; and
- you have not suffered an Injury or Sickness that results in a life expectancy of less than 12 months; and
- you have not exercised your portable insurance right under a similar certificate issued by us; and
- you reside in the United States or Canada on the date your insurance ends.

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 employment terminates. The application for portable insurance is available from your Employer.

What is the amount of portable insurance?
You may apply for portable insurance in an amount up to 100% of your amount of insurance in force under the Policy on the date your employment terminates to a maximum of $500,000.

If you are insured for Basic Life Insurance, Voluntary Life Insurance, Basic Accidental Death and Dismemberment Insurance and/or Voluntary Accidental Death and Dismemberment Insurance under a Policy issued by us, the total combined amount of portable insurance you may apply for cannot exceed $1,000,000 per Insured.

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

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

10. CONTINUITY OF COVERAGE

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

What if you are not Actively at Work when your Employer's Prior Policy is replaced with This Policy?
You will be insured under This Policy if you are not Actively at Work on August 1, 2020 and:

- you were insured under your Employer's Prior Policy on the day before August 1, 2020;
- 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 your Employer's Prior Policy.

Any benefit payable will be the lesser of:

- the benefit payable under This Policy; or
- the benefit payable under your Employer's Prior Policy.

11. 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 an agent of Sun Life Assurance Company of Canada.

ALTERATION

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

BENEFICIARY

How can you change your Beneficiary?
You can change your beneficiary at any time by giving Written notice. The beneficiary's consent is not required for this or any other change in this Certificate, unless the designation of the beneficiary is irrevocable.

CLERICAL ERROR

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

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

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

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

- not enrolling for insurance within required time limits;
- failing to request increased amounts of insurance within required time limits; 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 provisions will be automatically amended to meet the minimum requirements of the law except as otherwise pre-empted by federal law.

EXAMINATION AND AUTOPSY

What are our examination and autopsy rights?
We, at our expense, have the right to have any insured 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.

We, at our expense, may have an autopsy conducted unless prohibited by law.

This right may be used as often as reasonably necessary during the pendency of a claim.

INCONTESTABILITY

What is the Incontestability Provision?
Except for non-payment of premium, no statement made by you 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 your lifetime. The statement must be contained in an application Signed by you.

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

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.

LIMIT OF PREMIUM REFUNDS

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

MISSTATEMENT OF AGE

What happens if there is a misstatement of age in the administration of the Policy?
If the age of any insured is determined not to be accurate:

- a fair adjustment of premium based on the true facts will be made, subject to the "Limit of Premium Refunds" section; and
- the true age will decide what amount, and for what duration insurance is valid under the Policy; and
- if the age of any insured has been misstated, all amounts payable under the Policy shall be such as the premium paid would have purchased at the correct age.

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 are not eligible for coverage, you should contact your Employer regarding the refund of premiums due, if any.

REIMBURSEMENT

11. GENERAL PROVISIONS

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

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

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

STATEMENTS

Are statements warranties?
In the absence of fraud, all statements made in any application are considered representations and not warranties. No representation by you in enrolling for insurance under the Policy will be used to reduce or deny a claim unless it is contained in your Written application, Signed by you, and a copy of your Written application for insurance is or has been given to you, your beneficiary, if any, or to your estate representative.

TIME PERIODS

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

SUN LIFE ASSURANCE COMPANY OF CANADA

Group Basic Accidental Death and Dismemberment Insurance Certificate

Non-Participating



Town and Country Super Market, Inc. Employee Benefit Plan (The Plan) has been established to provide welfare benefits for its eligible employees.

The Employee Retirement Income Security Act of 1974 (ERISA) requires that the Plan Administrator provide you with a Summary Plan Description which discloses required information about the employee benefit plan. The following section entitled "Summary Plan Description" is not part of the Group Insurance Policy. The information in the Summary Plan Description is provided by the 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: Town and Country Super Market, Inc.
1104 Highway 32 East
Salem, MO 65560

Plan Administrator and Named Fiduciary:
Drusilla Howard
Town and Country Super Market, Inc.
1104 Highway 32 East
Salem, MO 65560

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:

Town and Country Super Market, Inc.
1104 Highway 32 East
Salem, MO 65560

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

Employer Identification Number (EIN): 43-0783891

Plan Number: 501

End of Plan Year: July 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 your employer and (if applicable) includes the cost of any insurance premiums contributed 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.