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:	979656-003
Policy Effective Date:	January 1, 2026
Policyholder:	WinCo Holdings, Inc.
Employer:	WinCo Holdings, Inc.
Issue State:	Idaho

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

PLEASE READ YOUR CERTIFICATE CAREFULLY.

RIGHT TO RETURN CERTIFICATE WITHIN 10 DAYS
If you are not satisfied, you may return the Certificate to your Employer within 10 days after receipt. Your Employer will refund the amount of premium you have paid provided no claim has been incurred during the 10 day period. Your Certificate will then be void, as though you had never applied for the insurance.

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.

Signed at Wellesley Hills, Massachusetts.

Kevin Strain
President and Chief Executive Officer

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

Group Accident Insurance Certificate

Non-Participating

CONTACT INFORMATION

For questions or concerns regarding your coverage, please contact us at the address or phone number shown on the cover. If your questions or concerns are not resolved, you may contact the Idaho Insurance Department at the following address:

Idaho Department of Insurance
Consumer Affairs
700 W. State Street, 3rd Floor
PO Box 83720
Boise, ID 83720-0043

TABLE OF CONTENTS

	SECTION
BENEFIT HIGHLIGHTS	1
DEFINITIONS	2
ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF EMPLOYEE INSURANCE	3
ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF SPOUSE OR PARTNER INSURANCE	4
ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF DEPENDENT CHILDREN INSURANCE	5
COVERED ACCIDENT BENEFITS	6
ADDITIONAL BENEFITS	7
EXCLUSIONS	8
CLAIM PROVISIONS	9
INSURANCE CONTINUATION	10
CONTINUITY OF COVERAGE	11
GENERAL PROVISIONS	12

1. BENEFIT HIGHLIGHTS

ELIGIBLE CLASSES

Employee Voluntary Accidental Death and Dismemberment Insurance

All United States Employees working in the United States scheduled to work at least 5 hours per week.

Dependent Voluntary Accidental Death and Dismemberment Insurance

All United States Employees working in the United States scheduled to work at least 5 hours per week.

Eligibility Waiting Period: Until the first of the month following date of employment

1. BENEFIT HIGHLIGHTS
EMPLOYEE VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

CLASSIFICATION

All Eligible Employees

AMOUNT OF INSURANCE

You may elect an amount of Voluntary AD&D Insurance in $25,000 increments.

The **Maximum Benefit** is the lesser of:
- $250,000; or
- 10 times your Basic Annual Earnings, rounded to the nearest $25,000.

Your amount of Voluntary AD&D Insurance reduces to 50% when you reach age 70, to 30% when you reach age 75 and to 20% when you reach age 80.

Your Voluntary AD&D Insurance cancels at your retirement.

The following Additional Benefit(s) are included:

Child Care Benefit

Coma Benefit

Common Carrier Benefit

Dependent Child Education Benefit

Dependent Spouse or Partner Education Benefit

Felonious Assault Benefit

Repatriation Benefit

Seat Belt Benefit

CONTRIBUTIONS

The cost of your Voluntary Accidental Death and Dismemberment Insurance is paid for by you.

The following Questions and Answers will help you to better understand your benefits.

Please read them carefully and refer any questions to your Employer or call the Sun Life Group Customer Service Center toll free at 1-800-247-6875.

1. BENEFIT HIGHLIGHTS
DEPENDENT VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

CLASSIFICATION

All Eligible Employees

AMOUNT OF INSURANCE

Spouse or Partner Only	50% of your amount of Voluntary Accidental Death and Dismemberment Insurance in force, subject to a Maximum Benefit of $125,000.
Child Only*	15% of your amount of Voluntary Accidental Death and Dismemberment Insurance in force, subject to a Maximum Benefit of $37,500.
Family Coverage Spouse or Partner	40% of your amount of Voluntary Accidental Death and Dismemberment Insurance in force, subject to a Maximum Benefit of $125,000.
Child*	10% of your amount of Voluntary Accidental Death and Dismemberment Insurance in force, subject to a Maximum Benefit of $37,500.

* child under age 26

Your Dependent Spouse's or Partner'samount of Voluntary AD&D Insurance cancels when you reach age 70.

Your Dependent's amount of Voluntary AD&D Insurance cancels when you retire.

CONTRIBUTIONS

The cost of your Dependent Voluntary Accidental Death and Dismemberment Insurance is paid for by you.

The following Questions and Answers will help you to better understand your benefits.

Please read them carefully and refer any questions to your Employer or call the Sun Life Group Customer Service Center toll free at 1-800-247-6875.

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.

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 or a site where your Employer's business requires you to travel.

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; or
- are not disabled due to an injury or sickness.

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, if required, and you:

- are not Confined; or
- are not 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, trolleys, subways, ferries and boats that operate on a regularly scheduled basis between predetermined points or cities. Privately chartered vehicles are not Common Carriers.

Congenital Anomaly means condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. A significant deviation is one which impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be congenital anomalies.

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 attached to it.

Dependent Child (Dependent Children) means your:

- unmarried or married child from live birth to age26; or
- unmarried or married child of any age who is medically certified as disabled and financially dependent upon you;

unless the child is enrolled in an employer sponsored medical plan other than the parent's.

Dependent Child includes:

- your unmarried or married step-child;
- a foster child placed with you by a licensed agency;

- your adopted child, including any child placed with you for adoption; or
- a child of a Spouse or Partner.

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, Canada, or Mexico. This exclusion does not apply to a Dependent Child who resides with you while you are on a temporary work assignment outside the United States.

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

Eligibility Waiting Period means the length of time you must be a member in an Eligible Class before you can apply for insurance. The Eligibility Waiting Period is shown in the Benefit Highlights. Any period of time you were Actively at Work for the Employer as a full-time Employee will count towards completion of the Eligibility Waiting Period.

Employee means a person who is employed by the Employer within the United States, scheduled to work at least the minimum hours shown in the Benefit Highlights, and paid regular earnings, who has provided the Employer with sufficient and authentic documentation establishing eligibility for employment in the United States as required under the Immigration Reform and Control Act, 8 U.S.C. 1324a(b)(1), and who is not an "unauthorized alien" as defined by 8 U.S.C. 1324a(h)(3). 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 WinCo Holdings, Inc. and includes any Subsidiary or Affiliated company insured under the Group Policy.

Enrollment Period means the period of time each year during which eligible Employees may elect, or change, or cancel insurance under the Policy. The Enrollment Period cannot occur more than once in any 12-month period, unless we agree in writing.

Family Member means: (a) your Spouse or Partner and (b) the following relatives of you or your Spouse or Partner: (1) parent; (2) child; (3) brother; (4) sister. This includes adopted, in-law and step-relatives.

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

2. DEFINITIONS

Felonious Assault means an action that would be characterized as a felony in the jurisdiction where it occurred.

Hospital means a facility licensed in the applicable jurisdiction that is primarily and continuously engaged in providing or operating, either on its premises or facilities available to the hospital on a prearranged basis, under the supervision of a Physician, 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 registered nurse. Hospital does not include: (1) a rest home; (2) a skilled nursing facility; (3) an extended 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 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 any person covered under the Policy.

Intoxicated means:
- under the influence of alcohol, illegal drugs or prescription drugs other than as prescribed by an Insured's Physician; or
- at or above the minimum blood alcohol level for which the Insured 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.

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 Hearing, Limb, Sight, Speech or Thumb and Index Finger
- Loss of Hearing means the permanent and irrecoverable loss of hearing.
- 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 joint.
- 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.
- Loss of a Thumb and Index Finger means that the thumb and index finger are each completely cut off at the metacarpophalangeal joint.

Marriage means an opposite-sex marriage only.

Motorcycle means a motor vehicle licensed for use on public highways which requires a Motorcycle endorsement on a driver’s license to operate the vehicle.

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.

2. DEFINITIONS

Partner means any individual who is a party to a Partnership.

Partner does not include:
- any person who is insured as an Employee; or
- any person residing outside the United States, Canada or Mexico. This exclusion does not apply to your Partner who resides with you while you are on a temporary work assignment outside the United States.

Partnership means any of the following relationships recognized under applicable state law: a same-sex or opposite sex partnership and a civil union partnership.

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 or any Family Member.

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

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

Spouse means any individual who under applicable state or provincial law is recognized as a spouse.

Spouse does not include:
- any person who is insured as an Employee; or
- any person residing outside the United States, Canada or Mexico. This exclusion does not apply to your Spouse who resides with you while you are on a temporary work assignment outside the United States.

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.

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

- January 1, 2026;
- the first day of the month following your date of employment; or
- the date you first are Actively at Work in an Eligible Class.

You are also eligible for Employee Insurance during any Enrollment Period or as a result of a Family Status Change, provided you are Actively at Work and in an Eligible Class.

When must you enroll for Employee Insurance?
You must enroll within 31 days of the date you are initially eligible for Employee Insurance or within 31 days of the date of a Family Status Change or during any Enrollment Period.

When does Employee Insurance start?
Employee Voluntary Insurance starts on the later of the date:

- you are eligible;
- you enroll; and
- you 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 Insurance?
During any Enrollment Period after you are covered under the Policy and Actively at Work, you may request a change in your Employee Insurance benefit option.

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

When does a change in Employee Insurance start?
If you are Actively at Work, any increase in insurance or benefits will start on the January 1stfollowing the date you apply for a change in your coverage.

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

Any reduction in insurance due to your age will start on the January 1st following the date of change, whether or not you are Actively at Work.

Whether or not you are Actively at Work, any other reduction in insurance will start on the January 1st following the date you apply for a change in your coverage.

Any change in insurance will only affect benefits for a Covered Accident that occurs after the effective date of the change.

What happens if you are rehired by your Employer?
If you are rehired by your Employer within 30 days of the date your employment ends, your insurance may be reactivated. Your reactivated insurance will:

- be the same insurance for which you were insured prior to termination of employment;
- be subject to all the terms and provisions of the Policy.

If you had partially satisfied your Eligibility Waiting Period prior to your termination of employment, your previous time employed with your Employer will count towards completion of your Eligibility Waiting

Period. Your Eligibility Date will be the later of the date you are rehired or the day after you complete the Eligibility Waiting Period.

If you are rehired by your Employer 30 days or later after the date your employment terminates, your coverage will not be reinstated. You will be eligible for insurance on the day after you complete a new Eligibility Waiting Period.

You must re-enroll within 31 days of your rehire date.

When does Employee Insurance end?
Your 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 insurance;
- the last day for which any required premium has been paid for your insurance;
- the last day you are Actively at Work, subject to any applicable Insurance Continuation provisions provided;
- the date you enter active duty in any armed service during time of war, declared or undeclared;
- the date you retire; or
- the date you die.

If your coverage has ended, can it be reinstated?
If your insurance ends for any reason other than you have voluntarily terminated your insurance, then you may apply to reinstate your insurance within 12 months from when your insurance ended. To reinstate your insurance, you must apply within 31 days after you return to being Actively at Work in an Eligible Class. Reinstatement will be effective on the latest date when all of the following have occurred:

- you agree to make any required contribution toward the cost of your insurance; and
- you return to being Actively at Work.

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

A new Eligibility Waiting Period will not apply.

4. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF SPOUSE OR PARTNER INSURANCE

When are you eligible for Spouse or Partner Insurance?
If you are in an Eligible Class shown in the Benefit Highlights, you are initially eligible for Spouse or Partner Insurance on the latest of:

- January 1, 2026;
- the date you are insured for Employee Voluntary Insurance; or
- the date you acquire a Spouse or Partner.

You are also eligible for Spouse or Partner Insurance during any Enrollment Period or as a result of a Family Status Change, provided you are in an Eligible Class and have a Spouse or Partner.

When must you enroll for Spouse or Partner Insurance?
You must enroll within 31 days of the date you are initially eligible for Spouse or Partner Insurance or within 31 days of the date of a Family Status Change or during any Enrollment Period.

When does Spouse or Partner Insurance start?
Spouse or Partner Voluntary Insurance starts on the latest of the date:

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

if your Spouse or Partner is not Confined on that date.

What if my Spouse or Partner is Confined?
If your Spouse or Partner is Confined on the date your Spouse or Partner Insurance would normally start, your Spouse or Partner Insurance will not start until your Spouse or Partner is no longer Confined.

How can you make changes in Spouse or Partner Insurance?
During any Enrollment Period after your Spouse or Partner is covered under the Policy and not Confined, and you are Actively at Work, you may request a change in your Spouse or Partner Insurance.

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

When does a change in Spouse or Partner Insurance start?
If you are Actively at Work, any increase in insurance or benefits will start on the January 1st following the date you apply for a change in your coverage.

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

Whether or not you are Actively at Work, any other reduction in insurance will start on the January 1st following the date you apply for a change in your coverage.

Any change in Spouse or Partner Insurance will only affect benefits for a Covered Accident that occurs after the effective date of the change.

When does Spouse or Partner Insurance end?
Spouse or Partner Insurance will end on the earliest of the following to occur:

- the date the Policy terminates;
- the date you are no longer in an Eligible Class;
- the date your class is no longer included for insurance;
- the last day for which any required premium has been paid for your insurance or your Spouse or Partner Insurance;

- the date you are no longer insured under the Policy;
- the last day you are Actively at Work, subject to any applicable Insurance Continuation provisions provided;
- the date your Spouse or Partner enters active duty in any armed service during time of war, declared or undeclared;
- the date your Spouse or Partner no longer meets the definition of Spouse or Partner as described in this Certificate;
- the date you retire;
- the date you attain age 70; or
- the date your Spouse or Partner dies.

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

When are you eligible for Dependent Children Insurance?
If you are in an Eligible Class shown in the Benefits Highlights, then you are initially eligible for Dependent Children Insurance on the latest of:

- January 1, 2026;
  - the date you are insured for Employee Voluntary Insurance; or
  - the date you acquire your Dependent Children.

You are also eligible for Dependent Children Insurance during any Enrollment Period or as a result of a Family Status Change, provided you are in an Eligible Class and have one or more Dependent Children.

When must you enroll for Dependent Children Insurance?
You must enroll within 31 days of the date you are initially eligible for Dependent Children Insurance or within 31 days of the date of a Family Status Change or during any Enrollment Period.

When does Dependent Children Insurance start?
Dependent Children Voluntary Insurance starts on the latest of the date:

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

if your Dependent Child is not Confined on that date.

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

How can you make changes in Dependent Children Insurance?
During any Enrollment Period after your Dependent Children are covered under the Policy and not Confined, and you are Actively at Work, you may request a change in your Dependent Children Insurance.

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

When does a change in Dependent Children Insurance start?
If you are Actively at Work, any increase in insurance or benefits will start on the January 1st following the date you apply for a change in your coverage.

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

Whether or not you are Actively at Work, any reduction in insurance will start on the January 1st following the date you apply for a change in your coverage.

Any change in insurance for your Dependent Child will only affect benefits for a Covered Accident that occurs after the effective date of the change.

How can you add a child or children to your Dependent Children 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.

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

How does Dependent Children 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 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 60 days from the date they become your Dependent Child. To continue coverage beyond 60 days, then you must:

- enroll for Dependent Children Insurance within 60 days from the date the newborn child, newly placed foster child or newly adopted child becomes your Dependent Child; and
- pay the appropriate premium (if any) and the premium is received by us within 31 days of the date the monthly premium notice is received by the Policyholder and a notice of premium (if any) is provided to you by the Policyholder.

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

Coverage provided for such child will be the same as that provided for other Dependent Children, if you are covered for Dependent Children Insurance when such Child is born, placed or adopted; otherwise coverage will be provided at the minimum benefit level available to Dependent Children generally.

For the purpose of this section, your adopted child or child pending adoption or placement will be insured as shown above from the date such child is placed with you. In the case of a newborn child, coverage will begin from the moment of birth provided that a written agreement to adopt such child has been entered into by the insured prior to the birth of the child. Placed means physical placement in the care of the adopting insured, or if physical placement is prevented due to the medical needs of the child, the date the adopting insured sign an agreement for adoption and assumes financial responsibility.

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

- the date the Policy terminates;
- the date you are no longer in an Eligible Class;
- the date your class is no longer included for insurance;
- the last day for which any required premium has been paid for your insurance or your Dependent Children Insurance;
- the date you are no longer insured under the Policy;
- the last day you are Actively at Work, subject to any applicable Insurance Continuation provisions provided;
- the date your Dependent Child enters active duty in any armed service during time of war, declared or undeclared;
- the date your Dependent Child no longer meets the definition of Dependent Child as described in this Certificate, but only with respect to that person;
- the date you retire; or
- the date your Dependent Child dies.

6. COVERED ACCIDENT BENEFITS

VOLUNTARY ACCIDENTAL DEATH BENEFIT

What is the Voluntary Accidental Death Benefit?
We will pay a Voluntary Accidental Death Benefit when an Insured dies 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 the Insured's date of death.

What happens if you disappear or your Spouse or Partner disappears or your Dependent Child disappears?
We will presume, subject to no objective evidence to the contrary, that the Insured is dead and death is a result of an Accidental Injury if:

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

VOLUNTARY ACCIDENTAL DISMEMBERMENT BENEFIT

What is the Voluntary Accidental Dismemberment Benefit?
We will pay a Voluntary Accidental Dismemberment Benefit if an Insured sustains 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:

Life	100%
Sight of one eye	50%
One limb	50%
Speech and hearing	100%
Speech or hearing	50%
Thumb and index finger of the same hand	25%
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%

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

7. 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.

CHILD CARE BENEFIT

What is the Child Care Benefit?
If you or your Dependent Spouse or Partner dies and a Voluntary Accidental Death Benefit is payable under the Policy, a Child Care Benefit is payable if:

- your Dependent Child is enrolled in a legally licensed Child Care Center on the date of the accident; or
- your Dependent Child enrolls in a legally licensed Child Care Center within 365 days after your or your Dependent Spouse's or Partner's death; and
- your Dependent Child is under age 13.

What is the amount of the Child Care Benefit?
The Child Care Benefit is the lesser of:

- the actual cost charged by the Child Care Center per year; or
- 10% of your or your Dependent Spouse's or Partner's Voluntary Accidental Death Benefit payable; or
- $4,000.

The Child Care Benefit is payable each year for a maximum of 4 years per Dependent Child or until the child attains age 13, whichever is less. The Child Care Benefit is payable upon receipt of satisfactory proof of paid expenses and that your Dependent Child is enrolled in a legally licensed Child Care Center

Child Care expenses do not include:

- expenses incurred prior to your or your Dependent Spouse's or Partner's death; or
- charges for room and board; or
- charges for ordinary living, traveling or clothing expenses.

Child Care Center means a provider which is duly licensed, certified or accredited by the jurisdiction in which it is located, is run according to the laws and regulations applicable to child care facilities and which provides child care and supervision for children in a group setting on a regular basis. Child Care Center does not include a hospital, the child's home or care provided during the child's normal school hours.

COMA BENEFIT

What is the Coma Benefit?
If, while insured, you or your Spouse or Partner suffers an Accidental Injury that results in you or your Spouse or Partner 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 or your Spouse's or Partner's amount of Voluntary 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.

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

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

7. ADDITIONAL BENEFITS

What happens if I or my Spouse or Partner dies while in a Coma?
If you or your Spouse or Partner die without regaining consciousness, you or your Spouse's or Partner's remaining Voluntary Accidental Death and Dismemberment Benefit (if any) will be payable. We will require monthly proof of the continuance of your Spouse's or Partner's Coma, but after one year we will not ask for proof more often than twice a year.

COMMON CARRIER BENEFIT

What is the Common Carrier Benefit?
If an Insured's 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 the lesser of:
- 100% of of the amount of Voluntary Accidental Death Benefit payable; or
- $1,000,000.

DEPENDENT CHILD EDUCATION BENEFIT

What is the Dependent Child Education Benefit?
If you die and a Voluntary Accidental Death Benefit is payable under the Policy, your Dependent Child may be eligible for a Dependent Education Benefit.

What is the Education Benefit for your Dependent Child?
A Dependent Child is eligible for an Education Benefit if the Dependent Child enrolls as a full-time student at a post-secondary school before reaching age 26 and within 1 year after your date of death.

The annual Dependent Child's Education Benefit is the lesser of:
- 10% of your Voluntary Accidental Death Benefit payable; or
- Incurred Expenses; or
- $5,000.

The Dependent Child Education Benefit is payable at the end of each semester per Dependent Child, for a maximum of four consecutive years per child. Proof of the child's enrollment and Incurred Expenses are required each semester prior to payment of the benefit.

Incurred Expenses include tuition, fees, cost of books, room and board, transportation and any other costs paid directly to the school.

What is the Education Benefit for your Spouse or Partner?
A Spouse or Partner is eligible for an Education Benefit if the Spouse or Partner enrolls in any school for the purpose of retraining or developing skills needed for employment within 1 year after your date of death.

The Spouse or Partner Education Benefit is equal to the expenses paid directly to such school or $5,000, whichever is less.

Proof of enrollment and expenses are required prior to payment of the benefit.

FELONIOUS ASSAULT BENEFIT

What is the Felonious Assault Benefit?
We will pay a Felonious Assault Benefit if the Voluntary Accidental Death Benefit or Voluntary Accidental Dismemberment Benefit is payable as a result of you sustaining a Felonious Assault while you were at work or while traveling on business for the Employer.

The Felonious Assault Benefit is the lesser of:

- 25% of the Voluntary Accidental Death and Dismemberment Benefit payable; or
- $5,000.

The Felonious Assault cannot be inflicted by an employee of the Employer, a Family Member or a member of your household. Your household includes any person residing with you whether or not related by blood or marriage.

REPATRIATION BENEFIT

What is the Repatriation Benefit?
If a Voluntary Accidental Death Benefit is payable and an Insured's death occurs at least 100 miles from your permanent place of residence, we will reimburse the Executor or Administrator of an Insured's 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 $5,000. Written Proof of the expenses incurred must be submitted to us prior to payment.

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

The Seat Belt Benefit is 10% of the amount of Voluntary Accidental Death Benefit payable or $25,000, whichever is less.

We must receive satisfactory written proof that an Insured's death resulted from an automobile accident and that the Insured was 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 pay an Air Bag Benefit if the Seat Belt Benefit is payable and the Insured was positioned in a seat protected by a Supplemental Restraint System which inflated on impact.

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

We must receive satisfactory written proof that an Insured's 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.

8. 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, whether sane or insane;
- injuring oneself intentionally;
- a Sickness or infection including physical or mental condition which is not caused solely by or as a direct result of a Covered Accident;
- war or an act of war (this does not include acts of terrorism);
- active Participation in a Riot or Insurrection;
- riding in or driving any motor-driven vehicle in a race, stunt show, speed test as a professional or while Intoxicated;
- aviation, other than riding as a fare paying passenger;
- participation in a felony;
- alcoholism or drug addiction; or
- Congenital Anomalies of Dependent Children are not excluded if they are due to Accident.

9. 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 written notice of claim must be given to us no later than 12 months after the Insured's date of loss.

For all other claims, written notice of claim must be given to us no later than 12 months after the Insured's date of loss, or within 12 months after the date the expense is incurred.

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.

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 written proof of claim must be given to us no later than 15 months after the Insured's date of loss.

For all other claims, proof of claim must be given to us no later than 15 months after the Insured's date of loss or within 15 months after the date the expense was incurred.

If Proof cannot be given within the time limit, Proof must be given as soon as reasonably possible. Proof of claim may not be given later than one year after the time Proof is otherwise required unless you are legally incompetent.

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; and
- the cause of the loss.
- 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.

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

9. CLAIM PROVISIONS

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.

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 45 days after receipt of the claim. If we cannot make a decision within 45 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.
- 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.

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);
- 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 loss of life will be payable in accordance with the beneficiary designation (other than your Employer). 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, we, at our option, may make payments as follows:

- to your Spouse or Partner if living; or
- if there is no surviving Spouse or Partner, to your surviving children in equal shares; or
- if there is no surviving Spouse or Partner or children, to your surviving parents in equal shares; or
- if none of the above, to your estate.

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

1. 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;
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 a benefit is payable to your estate, if you are a minor, or you are not competent, we have the right to pay an amount of the benefit up to $5,000 to any of your relatives that we consider entitled. If we pay benefits in good faith to a relative, we will not have to pay those benefits again.

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.

10. 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 by paying the required premium to us for any of the following reasons and durations:

- Leave of Absence - up to 6 months
- Absence due to injury or sickness – for up to 12 months
- 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.

11. 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 ("Previous Plan") with the insurance provided by this Certificate and the Policy ("This Plan") within 60 days prior to January 1, 2026, Continuity of Coverage benefits as stated in this Section may be available to you. These benefits will be available as long as the insurance and level of benefits under the Previous Plan were substantially similar to the insurance provided by this Plan.

What if you are not Actively at Work when your Employer replaces your Previous Plan with This Plan?
You will be covered under This Plan if you are not Actively at Work on January 1, 2026 if:

- you were insured under the Previous Plan on the day before January 1, 2026;
- you are a member of an Eligible Class;
- premiums for you are paid up to date; and
- you are not receiving or eligible to receive benefits under the Previous Plan.

If you sustain Injuries that result from a Covered Accident Benefit as defined in the Covered Accident Benefit section of This Plan, and were never Actively at Work while covered under This Plan, any benefit payable will be the lesser of:

- the benefit payable under This Plan; or
- the benefit payable under the Previous Plan.

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

12. GENERAL PROVISIONS

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 us 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 connection with the Policy or delays in keeping records for the Policy whether by us, the Policyholder or the Employer:

- will not terminate insurance that would otherwise have been effective.
- 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 continuation options.

CONFORMITY WITH STATUTES

What is the effect of Conformity with Statutes?
If any provision of the Policy conflicts with any applicable law, the provisions of Policy will be automatically amended to meet the minimum requirements of the law and to reflect updated statutory references.

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.

EXAMINATION AND AUTOPSY

What are our examination and autopsy rights?
We, at our own expense, have the right to have any person whose claim is pending or ongoing be:

- 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 reasonably required.

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

12. GENERAL PROVISIONS

INCONTESTABILITY

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

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

INSURER'S AUTHORITY

What is our authority?
We have discretionary authority to make all final determinations regarding claims for benefits. This discretionary authority includes, but is not limited to, the determination of eligibility for benefits, based upon enrollment information provided by the Policyholder, and the amount of any benefits due, and to construe the terms of the Policy.

Any decision made by us in the exercise of this authority, including review of denials of benefit, is conclusive and binding on all parties. Any court reviewing our determinations shall uphold such determination unless the claimant proves that our determinations are arbitrary and capricious.

LEGAL PROCEEDINGS

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

- until 60 days after Proof has been given; nor
- more than 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 FACTS

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

- a fair adjustment of premium will be made, subject to the "Limit of Premium Refunds" section; and
- the true 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.

12. GENERAL PROVISIONS

NOTICE

How are required notices provided?
Any obligation we may have to give written notice will be satisfied by sending such notice to the last known address of the person or institution entitled to such notice.

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 all Policy requirements must be satisfied.

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.

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.

SUN LIFE ASSURANCE COMPANY OF CANADA

This is a Limited Certificate - Read it Carefully

Group Accident Insurance Certificate

Non-Participating

WinCo Holdings, Inc. Employee Benefit Plan (The Plan) has been established to provide welfare benefits for its employees.

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

SUMMARY PLAN DESCRIPTION

Plan Sponsor: WinCo Holdings, Inc.
650 North Armstrong Place
Boise, ID 83704

Plan Administrator: WinCo Holdings, Inc.
650 North Armstrong Place
Boise, ID 83704

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

Subsidiaries/Affiliates: WinCo Foods, LLC

Agent for Service of Legal Process: WinCo Holdings, Inc.
650 North Armstrong Place
Boise, ID 83704

Employer Identification Number (EIN): 82-0290448

Plan Number: 501

End of Plan Year: December 31st

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

Participants: The insured employees described in 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 your benefits under the Plan includes the cost of any insurance premiums contributed by you.

Funding: Sun Life provides the Plan Administrator with certain insurance benefits in connection with the Plan. Those insurance benefits are described in your Certificate.

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

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

such a review. Additional information about claims submitted and review procedures may be obtained by contacting your Plan Administrator.

Your Rights under ERISA:

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

Receive Information About Your Plan and Benefits

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

Assistance with Your Questions

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

about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.