



**The ODP Corporation
Flexible Benefits Program**

Summary Plan Description

Effective January 1, 2025

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Introduction

This booklet is part of your Summary Plan Description (“SPD”) and it applies to the health and welfare benefits provided by The ODP Corporation (“ODP”) under the ODP International Welfare Benefits Program (the “Plan”), in effect as of January 1, 2024. The Plan is maintained for eligible associates and their eligible dependents.

Your entire SPD consists of the following documents –

- This document, entitled the Flexible Benefits Program Summary Plan Description (“Flex SPD”), and
- All other booklets, certificates, and summaries for each of the benefit options in which you are enrolled (the “Benefit Summaries”).

For example, the UMR medical Summary Plan Description consists of this Flex SPD, and the UMR Medical Booklet (which contains the Benefit Summaries for Protection HSA, Protection HSA 2, and the Traditional PPO plans). The Benefit Summaries are provided to you at particular times, and can be requested, at no cost, at any time. The Benefit Summaries are available in the Resource Library on [myBenefitsHub](#) or by contacting BenefitsTeam@theodpcorp.com.

This Flex SPD does contain some Benefit Summaries, such as the Flexible Spending Accounts Summary, the Health Savings Account Summary, the Short-Term Disability Summary, the Employee Assistance Program Summary, and the Executive Long-Term Disability Summary.

The Plan is governed by an official written plan document that sets forth the terms and conditions for benefits and is the only source of any rights to benefits. You are entitled to receive upon written request, the official plan document, subject to a reasonable charge for copying.

This Flex SPD contains a summary, in English, of your rights and benefits as a plan participant. If you have difficulty understanding any part of this document or have any questions, you may contact the Plan Administrator, the Benefits Administrator, BenefitsTeam@theodpcorp.com or the Claims Administrator. More information about how to contact the Plan Administrator, the Benefits Administrator and the Claims Administrator is provided under *Administrative Information*. It is important to emphasize that only the Claims Administrator has the authority to interpret and manage the operation of the Plan regarding payment of benefits.

ODP currently intends to continue the Plan. However, ODP reserves the right at any time to amend, modify, reduce, discontinue, or terminate the Plan.

Benefits Basics

Your health and welfare benefits coverage are set forth in various sections within this Flex SPD and the separate Benefit Summaries for each applicable benefit option. This Benefits Basics section contains the eligibility, participation, enrollment, and other general rules affecting all your health and welfare benefits.

Eligibility, Participation and Enrollment

This section explains the Plan rules for eligibility and participation.

You must follow certain rules and procedures, such as enrolling on the [MyBenefitsHub](#) at [ODP.bswift.com](#) within the required timeframe. You should also understand the rules for making and changing benefit elections.

Eligibility – General Information

You are eligible to participate if you are –

- A resident of the United States or on international assignment outside of the United States; and
- Classified as a regular full-time associate scheduled to work at least 30-Hours per week.

If you are a Hawaii resident, you are also eligible to participate if you are classified as a regular part-time associate scheduled to work at least 20 hours per week (per Hawaii state law).

If you are classified as a regular part-time associate scheduled to work less than 30-Hours per week, you may be eligible to enroll in medical coverage if you are determined to be a “30-Hour Associate” as set forth below.

If you are a resident of Puerto Rico, you are not eligible for the benefits described in this Flex SPD. Rather, a separate Summary Plan Description will be available with respect to your eligible benefits. If you are a resident of the Virgin Islands of the United States or the United States Territory of Guam, you may be eligible to participate in some of the benefits in this Flex SPD. You should contact the Benefits Department at [BenefitsTeam@theodpcorp.com](#) for further information.

Ineligible Individuals

You are **not eligible** to participate in the Plan as described in this Flex SPD if you are an:

- associate who is classified as a student intern, seasonal or temporary*
- associate who is a resident of Puerto Rico
- associate who is covered by a collective bargaining agreement, except if such agreement allows for participation
- associate who is leased from another organization, unless the organization is affiliated with ODP, participates in the benefits outlined in this Flex SPD document, and has authorized your eligibility
- individual who is classified by ODP as an independent contractor (without regard to how the individual may be classified by a court or administrative agency), or
- associate of a non-participating subsidiary and/or affiliate.

* A temporary associate is an individual hired for a specific project or for a period that is less than 90 days.

It is expressly intended that individuals not treated as benefits eligible by ODP are to be excluded from participation under all circumstances until ODP changes their classification. Therefore, an independent

contractor or any other ineligible individual who is reclassified by a court, administrative agency, or other party as an eligible associate (or otherwise eligible for benefits coverage) will not be considered an eligible associate (or otherwise eligible) for periods before ODP implements the reclassification decision, even if the decision by the court, administrative agency or other party applies retroactively.

If You Are Rehired – Full Time Associates

If you are classified as a regular full-time associate, terminate employment, and are rehired as a regular full-time associate, your eligibility for health and welfare benefits coverage will depend on how long you were gone from your previous ODP employment –

- If you return to work within 13 weeks and had previously satisfied your waiting period, you will be able to immediately elect health and welfare benefits coverage.
- If you return to work after 13 weeks, you are treated as a new hire and must satisfy the waiting period.

If you are classified as a 30-Hour Associate, see the rehire provisions in the *30-Hour Associate* section.

Participation – Waiting Period Rules

If you meet the eligibility requirements, you must satisfy a benefit waiting period before benefits become effective. You will satisfy your benefits waiting period on:

- the 1st of the month following 30 days of service.
- Hawaii: the 1st of the month following or coinciding with 28 days of service.

If you are a 30-Hour Associate, the above rules do not apply to you. In that case, see the section below for your special eligibility and participation rules.

Enrollment Notifications

The Benefits Administrator will initially send enrollment notifications to the home email address indicated in mycloud, which is the system of record. If no home email address is available, notices will be sent via U.S. mail to the home address in mycloud. Upon registering and accessing *myBenefitsHub* at ODP.bswift.com, you may indicate your ongoing preferred method of benefits notifications (e.g., home email, personal email, work email, U.S. mail). You also have an option of adding your mobile phone and selecting the ability to receive text messaging for important benefits reminders.

Enrollment Timelines - New Hires & Newly Eligibles

Your enrollment window will open on *myBenefitsHub* at ODP.bswift.com approximately 2-3 days after your date of hire and will remain open through your benefits effective date (1st of the month following 30 days of service). Your enrollment deadline will be provided when you log into *myBenefitsHub*. Benefit elections must be made prior to your benefits effective date. If enrollments are made later in the benefits waiting period which results in missed payroll deductions, the system will automatically recoup associated arrears from future paychecks until paid in full.

If You Are Not Actively at Work

Regardless of the benefits effective dates outlined above, if you are not actively at work (e.g., on a leave of absence) on the day that participation in any life insurance and/or disability is scheduled to begin, your participation will not take effect until you actively return to employment (except as may be provided in the separate life insurance or long-term disability Benefit Summary).

Long Term Disability and If You Initially Waived Coverage

If you did not enroll during your initial eligibility period and you enroll during any future Annual Enrollment period, you will be required to provide Evidence of Insurability (“EOI”). Your participation will take effect as follows:

- On the date that the LTD Claims Administrator has stated in writing that your EOI has been approved, providing that you are actively at work on that date.

The Enrollment Process

You may enroll anytime once your enrollment window opens and up through the benefits effective date.

- Go to *myBenefitsHub* at ODP.bswift.com. Review the logon options. If you are on the ODP network (including VPN), you can access the site via Single-Sign-On (SSO).
- Once logged in, you will be prompted that you have an enrollment event. Click the “Visit the Enrollment Center” link to begin the enrollment process.

Review and Save Your Elections!

During the enrollment process, you will be required to review and acknowledge certain sections to proceed. These sections include your demographic information (e.g., address, SSN, date of birth) and that your listed dependents meet the eligibility requirements. The “Review & Confirm” page includes your enrollment selections and rates, and you must acknowledge that “I agree, and I’m finished with my enrollment” to save and submit your enrollment. If you notice an error or wish to change your elections, you can go through the enrollment process again. You can make as many corrections or changes as necessary through your enrollment deadline date. **Note:** if any of your demographic information is incorrect in *myBenefitsHub*, it must be corrected within mycloud first (either through mycloud Employee Self-Service, or via HR Employee Services).

Leave of Absence – Full Time Associates

If you are classified as a regular, full-time associate, and go on an approved leave of absence, your eligibility for health and welfare benefits coverage will continue for a maximum of six (6) months and will thereafter terminate unless you return to work prior to that six-month date.

If you are classified as a 30-Hour Associate, refer to the leave of absence provisions in the 30-Hour Associate section.

Associates of Acquired Companies and/or New Participating Subsidiaries

The benefits described in this Flex SPD apply to eligible associates of ODP. For associates of newly acquired companies and/or new participating subsidiaries, the eligibility rules, and the effective date of the coverage (if any) may be different than described in this document and will be provided for each affected location.

Annual Enrollment Period

Every fall during the Annual Enrollment period, information will be available regarding any new benefits or changes applicable for the upcoming Plan Year. You can enroll, make changes to your current elections, add/remove dependents, or choose to waive coverage during Annual Enrollment.

The choices you make during the Annual Enrollment period take effect the following January 1 and stay in effect throughout the entire Plan Year unless you experience a Qualified Change in Status event (refer to *Changing your Elections during the Year* for further information).

“Safe Harbor 30-Hour” Associates

An associate is designated as “safe harbor” if they work an average of at least 30-Hours a week for a twelve-month look-back measurement period. Every associate (both full-time and part-time) is measured for safe-harbor eligibility.

- An associate’s initial measurement period (“IMP”) is the first 12 months of employment, measured from date of hire.

- After going through the IMP, the associate will fall into the standard measurement period (“SMP”), which is the twelve months prior to the Annual Enrollment period (generally October to October) but based on pay period cycles.

Eligibility and Participation

In response to the Affordable Care Act, ODP provides access to coverage under the medical options to all eligible part-time associates that meet the “safe harbor” measurement of at least 30 Hours per week using a 12-month measurement period described above. This eligibility section does not apply to you if you are classified as a regular full-time associate, an associate already eligible for health and welfare benefits coverage, or an individual who is otherwise not eligible for ODP health and welfare benefits (e.g., independent contractors, interns, or temporary associates).

If you are part-time and classified as a Safe Harbor 30-Hour Associate, you will be eligible for the medical options. If you are classified as a Safe Harbor 30-Hour Associate, notification will be sent by the Benefits Administrator indicating your status as a Safe Harbor 30-Hour Associate which will set forth the period for which you will be eligible for coverage. If you are a Safe Harbor 30-Hour Associate, you and your eligible Dependents are eligible to enroll in a medical option for the stability period.

Measurement and Stability Periods

The measurement periods and the stability periods for ongoing associates are the same each year, while the periods for new hires are on a rolling basis. If you are classified as a Safe Harbor 30-Hour Associate under the rules in this section, you may enroll yourself and any eligible dependents (as defined under the regular rules of the benefit plan or program) for the corresponding stability period that applies to you.

Ongoing Associates

There are three phases to determine whether you are classified as a Safe Harbor 30-Hour Associate:

1. The Measurement Period

Eligibility for coverage will be determined based on your hours worked during the measurement period, also called the “look back period.” This is the 12-month period that generally runs from October of the prior year to October of the current year. Note that the definitive dates are based on pay period cycles.

2. The Administrative Period

The administrative period will run from the end of the measurement period and will end on December 31 of that same year. This is the time during which ODP will evaluate the results of the measurement period to determine eligibility, notify all 30-Hour Associates, and provide an enrollment period for 30-Hour Associates.

3. The Stability Period

The stability period is the 12-month timeframe from January 1 through December 31 when all 30-Hour Associates who elected coverage during the enrollment portion of the administrative period will be covered. Once a 30-Hour Associate is determined to be eligible and enrolls in coverage, they are locked in for the 12-month calendar stability period, even if their hours later fall below the 30-hour threshold during that calendar year. Associates are unable to change their annual elections unless they have a mid-year Qualified Change in Status event that allows a change.

Newly Hired Part-Time Associate Rules

Newly hired part-time associates will go through the same three phases as set forth above for ongoing associates. However, your initial measurement period will begin on the first day of month following your hire date and will end twelve (12) months later. (If you are hired on the first day of the month, your initial measurement period will begin on your hire date.) Once your initial measurement period ends, you will enter

the administrative period. Any associate who works an average of 30 or more hours a week during the initial measurement period will be notified of their 30-Hour Associate status and given the opportunity to enroll into medical coverage during that administrative period. The new hire administrative period will be less than 90 days in duration.

If eligible, your benefits eligibility date will begin as of the day after the administrative period ends. Your initial stability period will then run until the end of the calendar year after at least 12 months of benefits eligibility. If you are eligible during your new hire measurement period, notice will be sent by the Benefits Administrator indicating your 30-Hour Associate status for the following new hire stability period. Elections made for your new hire stability period may not be changed during the stability period, unless you have a mid-year Qualified Change in Status event, or during an Annual Enrollment that occurs during your new hire stability period.

New hire measurement periods run on a rolling basis throughout the year, depending on your date of hire. Once you go through your initial new hire measurement period, you also will be assessed during the next standard ongoing measurement period that begins after your date of hire. Thereafter, you will remain on the ongoing measurement and stability periods (subject to the rehire rules discussed below).

Rehired Part-Time Associate Rules

If you terminate employment and are rehired, your eligibility for medical coverage will depend on how long you are gone –

- If you return to work within 13 weeks, you will be put into the standard measurement period currently in effect to determine benefits eligibility for the next stability period. The hours worked during your prior service will be counted and for the weeks you were not employed, no hours will be reported but the number of weeks will be factored into the calculation of average hours for the period. Also, if you are rehired within the same new hire or ongoing stability period, the following will apply upon rehire:
 - If you were previously classified as a 30-Hour Associate for that stability period, you will be eligible to elect benefits coverage as of your rehire date for the remainder of that stability period. You may enroll in benefits coverage for the remainder of the current stability period - even if you had not enrolled for benefits coverage during the stability period previously.
 - If you were previously not classified as a 30-Hour Associate for that stability period, you will remain ineligible for benefits coverage for the remainder of that stability period.
- If you return to work after 13 weeks, you will be treated as a new hire, prior service will be disregarded, and you will go through a new initial measurement period to determine benefits eligibility like any other newly hired part-time associate.

Leaves of Absence

If you go on any type of approved leave of absence, you will remain in the current measurement period that is in progress to determine benefits eligibility for the next stability period. The weeks you are on an approved leave of absence will be excluded from the measurement period in determining whether you meet the 30-Hour per week requirement. For example, if you are on leave for 8 weeks during the measurement period, your hours during the measurement period will be divided by the weeks worked (44 weeks) to determine whether you satisfy the 30-Hours a week rule.

If you go on leave and you are already a 30-Hour Associate and enrolled for benefits coverage during a stability period (new hire or ongoing), your benefits eligibility and enrollment continues for the longer of

- the end of the current stability period in which the leave began, or
- six (6) months after the date the leave began.

Hours of Service

All hours for which you are paid or entitled to payment for actively working will be counted. All hours for which you are paid while not actively working will also be counted if the payment is due to a period of PTO,

holiday, illness, disability, layoff, jury duty, military duty, or other leave of absence. Hours paid while on short-term disability or workers' compensation will be counted, but hours paid while on long-term disability will not be counted.

Changes in Status

Changes in Classification from Full-Time to Part-Time Status

If you change from a regular full-time associate (regularly scheduled to work at least 30-Hours per week) to a part-time associate (regularly scheduled to work less than 30-Hours per week), continued benefits eligibility is based on whether you have met "safe harbor" eligibility for that calendar year.

If you are not "safe harbor" eligible and enrolled in benefits:

- All coverage will automatically terminate because of the change to part-time status. You may have an option to continue certain benefits through COBRA.

If you are "safe harbor" eligible and enrolled in benefits:

- All coverage will automatically terminate because of the change to part-time status **except** for the following:
 - Medical coverage*- ACA legislation requires that medical is a protected benefit through the end of the calendar year for which you are safe-harbor eligible. You will also retain the Wellness Credit if you are currently receiving it.
 - Healthcare Flexible Spending Account / Health Savings Account – your participation in any Healthcare FSA or HSA will continue through the end of the calendar year for which you are eligible; however, you may change your HSA contribution at any time.

If you are a Hawaii resident and enrolled in benefits:

- All coverage will automatically terminate because of the change to part-time status **except** for Medical coverage (based on HI law, part-time associates are eligible for medical coverage as long as they continue to meet the requirement of working at least 20 hours per week).

*** Note:** If you wish to terminate medical coverage as a result of your change to part-time status, you must contact BenefitsTeam@theodpcorp.com within 31 days after your status change effective date to request that a Special Enrollment window be opened to allow termination of medical coverage.

Changes in Classification from Part-Time to Full-Time Status

If your classification changes from part-time (regularly scheduled to work less than 30-Hours) to regular full-time (regularly scheduled to work at least 30-Hours a week), you will be treated as any other regular full-time associate and will be eligible for health and welfare benefits coverage as set forth in this *Benefit Basics* section for regular full-time associates.

Eligible Dependents

If you are an eligible associate and you enroll yourself in coverage, you may also enroll your eligible dependents in the same coverage.

An "eligible dependent" is defined as:

- Your spouse, which includes:
 - Your lawful same or opposite sex spouse under a legally valid existing marriage; or
 - Your lawful common law same or opposite sex spouse, where legally recognized in the state of residence and all requirements have been met.

- Your domestic partner, which includes:
 - Your domestic partner of the same or opposite sex where you have signed and notarized an official domestic partner affidavit based on any requirements that may be established from time to time by the Plan Administrator.
 - Your same or opposite sex domestic partner with whom you have a validly registered domestic partnership under applicable law; or
 - Your same sex domestic partner with whom you have entered into a legal civil union based upon applicable law.
- Your eligible dependent child(ren) up to age 26 if they are:
 - your biological child.
 - your legally adopted child.
 - a child placed with you for legal adoption.
 - your stepchild (biological or legally adopted child of your legal spouse).
 - a biological or legally adopted child of your domestic partner.
 - a child for whom you or your spouse or domestic partner are the legal guardian.
 - your eligible foster child or your spouse's or domestic partner's eligible foster child; or
 - a child who the court has issued a Qualified Medical Child Support Order (QMCSO) for you to provide coverage.

Note: In situations where state law mandates continued coverage for spouses during divorce proceedings, those state laws will take precedence over the standard eligibility provisions for the self-funded UMR medical plan only.

Extended Coverage for Disabled Dependent Children

Coverage for an unmarried, enrolled dependent child (defined above) who is incapable of self-support and is permanently and totally disabled (as defined below) will be continued beyond the age of 26, provided that:

- The enrolled dependent child becomes disabled before reaching the age of 26; and
- The enrolled dependent child is dependent upon you for support and maintenance; and
- Required documentation is provided within 31 days of the date of request for such proof; and
- Payment of any required contribution for the enrolled dependent child is continued.

If you are a new or an existing associate and you have an unmarried dependent child (as defined above) who is incapable of self-support and is permanently and totally disabled (as defined below), your child may be enrolled, provided that:

- You provide proof that the child had continuous major medical coverage through a prior group health plan without a 63-day gap in coverage at the time you try to add the child to your coverage; and
- The disabled child has incurred a loss of major medical coverage within the last 31 days prior to the time you try to add the child to your coverage; and
- You satisfy the conditions in the four bullet points above for continuation of an enrolled disabled child.

An individual is permanently and totally disabled if they are unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or is expected to last for a continuous period of not less than 12 months.

Coverage will be continued so long as the dependent child continues to be disabled and dependent upon the associate for support unless otherwise terminated from coverage in accordance with the terms of the Plan. Before granting this coverage, ODP may reasonably require that a physician designated by ODP examine the dependent child at the expense of ODP. At reasonable intervals, ODP may require satisfactory proof of the enrolled dependent child's continued disability and dependency, including medical examination at the expense of ODP. Such proof will not be required more often than once a year. Failure to provide such satisfactory proof within 31 days of the request by ODP will result in the termination of the enrolled dependent child's coverage.

Ineligible Dependents

- Your child who is in or enters the armed forces.
- Any person covered as a dependent of another ODP associate enrolled in the same coverage.
- Parents and grandparents.
- Grandchildren (unless you are their legal guardian or have legally adopted them).
- Fiancé or fiancée, girlfriend, or boyfriend (unless you satisfy the domestic partner requirements).
- Former spouse or former domestic partner; however, health coverage may be eligible for continuation through COBRA.

Enrollment of Eligible Dependents

Your eligible spouse, domestic partner and/or dependent children are eligible to be covered under the medical, dental, vision, EAP, reimbursement accounts (as applicable), certain voluntary benefits, optional life insurance and AD&D coverages. Each of the insured benefit options may have different eligibility and enrollment rules. You must satisfy these additional rules to enroll your eligible dependents in the insured benefit options. Please refer to the Benefit Summaries for the insured benefit options for additional information.

You may enroll your eligible dependents as part of your initial enrollment as a new hire or newly eligible associate. Thereafter, you may enroll a new eligible dependent within 31 days of a Qualified Change in Status event. An eligible dependent who is not enrolled when you are initially eligible to enroll or during a Qualified Change in Status event may only be enrolled during Annual Enrollment.

Dependent Coverage Effective Date

Eligible dependent(s) will be covered for eligible benefits on the later of the following dates, if you properly enroll them in a timely fashion:

- The date your coverage becomes effective.
- The 1st of the month following the date you acquire a dependent under a Qualified Change in Status event (see *Changing Your Elections During the Year* for more information).
- Newborn children are covered for medical benefits from birth, regardless of hospitalization, for the first 31 days **ONLY**. Coverage will then automatically terminate unless you enroll the newborn for medical benefits within 31 days of the birth.
- Coverage for a newly adopted child shall be effective on the date the child is placed with you for adoption.

When Coverage Ends for Dependents

When your enrolled dependents are no longer eligible for coverage under the Plan, they may elect COBRA. A COBRA enrollment kit will be mailed only after you have timely submitted a life event and removed your dependent through myBenefitsHub at ODP.bswift.com.

Dependent coverage for a child ends upon the last day of the month in which your child turns age 26 (unless they qualify for extended medical coverage due to disability).

Dependent coverage for a spouse, stepchildren, or domestic partner (and any children of your domestic partner) ends upon the day of a:

- Divorce
- Dissolution of a domestic partnership

It is the associate's responsibility to report a change in a dependent's eligibility. Any premiums paid in error due to your delay in reporting a change in your dependent's eligibility will not be refunded.

Removing Dependents who Lose Eligibility

Ex-Spouse or Ex-Domestic Partner

You must remove your ex-spouse/domestic partner from your coverage as soon as the divorce is final, or your partnership is dissolved. Your ex-spouse/domestic partner cannot continue under your active ODP coverage. If you are obligated to continue coverage for an ex-eligible spouse due to the terms of the divorce, coverage can be provided for a limited time under COBRA. If COBRA is elected, your ex-spouse will have their own account and will be responsible for paying premiums directly to the COBRA Administrator. Any premiums paid in error due to your delay in reporting a change in your dependent's eligibility will not be refunded.

Other Dependents

It is your responsibility to remove any other dependents from your coverage as soon as they lose eligibility. If you fail to remove any dependent(s) within 31 days of them becoming ineligible, you may face disciplinary action up to and including termination of employment. In addition, ODP may bar your participation in the Plan and seek reimbursement from you, even if you no longer work at ODP, for all benefits paid by the Plan on behalf of a non-eligible dependent, plus any costs and attorney fees related to obtaining reimbursement. Any premiums paid in error due to your delay in reporting a change in your dependent's eligibility will not be refunded.

Verification of Dependent Eligibility

For any dependent added to medical, dental, vision or life insurance coverage under the Plan, you may be asked to provide documentation providing the relationship of that dependent, and that they meet the definition of "eligible dependent" under the Plan.

Providing false or misleading dependent information could result in loss of elected coverage, repayment to the Plan of any claims paid for that ineligible dependent, and/or disciplinary action up to and including termination of employment. Continuation coverage through COBRA may be available.

If a dependent is removed from coverage, the next opportunity to enroll that dependent in benefits will be during the Annual Enrollment period, unless there is a mid-year Qualified Change in Status event.

Below is a listing of required documentation that must be submitted upon request if you are chosen as part of a random dependent verification audit. All documents must include the date, the associate name and the dependent's name. It is recommended you have these documents available in your important records.

Spouse

- Copy of marriage certificate, **AND** any one of the following:
 - Copy of front page of most current federal tax return confirming dependent is your spouse (please black out Social Security Numbers and all income information)
 - Document dated within the last 60 days showing current relationship status such as a monthly or quarterly household bill or statement of account. Document must list the date, the spouse's name, and the mailing address.

Domestic Partner

- Two forms of documentation listing both parties' names and dated within the last 6 months to establish a common household and financial interdependence such as a quarterly or monthly household bill or statement of account.
- And one of the following:
 - Copy of Certificate of Domestic Partnership (issued by a Domestic Partnership Registry),
 - Civil union documentation, or
 - Notarized official domestic partner affidavit.

Child(ren)

- Copy of the child's birth certificate (or hospital birth record) or adoption certificate naming you or your spouse as the child's parent **OR**
- A copy of the court order naming you or your spouse as the child's legal guardian.
- For a stepchild (including a child of your domestic partner) where your spouse or domestic partner is not a covered Dependent, in addition to providing the parent/child relationship documentation listed directly above, you must also provide documentation of your current relationship to your spouse or domestic partner as requested above under *Spouse or Domestic Partner* above.
- For a disabled dependent, you must provide documentation from Social Security or a physician's certification that total and permanent disability occurred prior to reaching age 26, in addition to the documentation as requested above.

Audits of Enrollments

If you enroll a dependent who is not eligible, provide false or misleading information when enrolling a dependent, or fail to timely remove a dependent who has become ineligible for any benefit under the Plan, it is a violation of ODP policy and will lead to disciplinary actions up to and including termination of employment.

In addition, ODP may terminate your participation in the Plan and seek reimbursement from you, even if you no longer work at ODP, for all benefits paid by the Plan on behalf of a non-eligible dependent, plus any related costs and attorney fees.

It is your responsibility as an eligible associate to report a change in your dependent's eligibility immediately. The Plan Administrator may, at any time, request proof that your dependent satisfies any of the dependent qualifications specified in this section. Any premiums paid for an ineligible dependent will not be refunded.

This right to audit also includes whether a separate surcharge, additional contribution or additional premium should apply with respect to any health and welfare benefits coverage. The application of a surcharge or additional contribution/premium is always and completely subject to audit. ODP may apply a surcharge or additional contribution/premium retroactively (due to an audit or otherwise).

Qualified Medical Child Support Orders (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a judgment, decree, or order (including approval of a settlement agreement) that is issued by a court of competent jurisdiction or state agency and satisfies all the following:

- Specifies your name and last known address and the child's name and last known address
- Describes the health coverage to be provided, or the way the type of health coverage is to be determined
- States the period to which it applies and the plan to which it applies
- Does not require the Plan to provide coverage for any type or form of benefit or option not otherwise provided under the Plan

If you are required by a QMCSO to provide coverage for your child(ren), deductions for such coverage will be taken directly from your paycheck. You will be notified if the Plan Administrator receives notice of a QMCSO that affects your participation in healthcare coverage. You may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

If Your Spouse/Domestic Partner Also Works for ODP

Married couples working at ODP may choose to cover their spouse as a dependent. You cannot have duplicate coverage. For example, enrolling in medical coverage as both a dependent and an associate is not allowed, and will not provide additional coverage. You also cannot enroll a benefits-eligible associate as a dependent for life insurance coverage. You must each enroll in your own coverage.

Health and Welfare Benefits

The following benefits are an important part of your benefits package.

Benefit	Your Benefit Options	Coverage Options	SPD/Benefit Summary
Basic Life / Basic AD&D	No electable option. Available to associate only.	You Only	Details in a Separate Benefit Summary
Basic Short-Term Disability	No electable option. Available to associate only.	You Only	Details in this Flex SPD
Child Life Insurance	Up to \$25,000, in multiples of \$5,000	Dependent Children	Details in a Separate Benefit Summary
Dental	- Dental with orthodontia - Dental no orthodontia	- You Only - You + Spouse/Partner - You + Child(ren) - You + Family	Details in a Separate Benefit Summary
Dependent Care Flexible Spending Account (FSA)	Elect an amount up to the annual \$5,000 limit	Account may be used for qualifying expenses	Details in this Flex SPD
Employee Assistance Program (EAP)	Does not require enrollment. Automatic eligibility.	Applies to all household members.	Details in this Flex SPD
Executive Long-Term Disability	- Individual Disability - Group Disability	Associate only in VP or above level	Details in this Flex SPD
Health Care Flexible Spending Account (FSA)	Elect an amount up to the annual limits set by the IRS	Account may be used for qualifying expenses.	Details in this Flex SPD
Health Savings Account (HSA)	Available only with HSA or HSA 2 medical option	- Individual - Family	Details in this Flex SPD
Long-Term Disability	- A 2-year period - Up to age 65 period	You Only	Details in a Separate Benefit Summary
Medical (bundled with prescription drugs)	- Protection HSA - Protection HSA 2 - Traditional PPO California associates also have access to Kaiser Hawaii associates have access to HMSA only	- You Only - You + Spouse/Partner - You + Child(ren) - You + Family	Details in a Separate Benefit Summary
Prescription Drugs (applicable to UMR medical plans)	This coverage is bundled with the medical plan	Coverage matches the medical tier	Details in a Separate Benefits Summary
Spouse/Partner Life Insurance	Up to \$250,000, in multiples of \$50,000	Spouse / Partner	Details in a Separate Benefit Summary
Supplemental Employee Life Insurance	Up to 7x base salary	You Only	Details in a Separate Benefit Summary
Vision	Vision Service Plan	- You Only - You + Spouse/Partner - You + Child(ren) - You + Family	Details in a Separate Benefit Summary

Benefit	Your Benefit Options	Coverage Options	SPD/Benefit Summary
Voluntary Accidental Death & Dismemberment (AD&D)	Up to 7x base salary. Different limits apply to spouses and children.	- You Only - You + Family	Details in a Separate Benefit Summary
Voluntary Legal Services & ID Theft Protection	- Legal Services Plan - ID Theft Protection Plan	Options based on status (full-time vs. part-time).	Details in a Separate Benefit Summary
Voluntary Short-Term Disability Buy-up	Purchase up to an additional 20% over the ODP-provided benefit (if eligible)	You Only	Details in a Separate Benefit Summary
Voluntary Supplemental Benefits	- Accident Insurance - Critical Illness - Hospital Confinement	- You Only - You + Spouse/Partner - You + Child(ren) - You + Family	Details in a Separate Benefit Summary
Voluntary Work/Life Benefits	- Auto / Home Insurance* - Pet Insurance* - Infertility Discount Plan	Available only through direct payment to vendors	Details in a Separate Benefit Summary

During Annual Enrollment, which is generally in the fall, you typically have a two-week window to make your health and welfare benefits elections. As a new hire or newly eligible associate, you generally must make your benefit elections prior to your benefits effective date.

You may change some or all your benefit choices during Annual Enrollment. For a mid-year Qualified Change in Status event, you may change only your benefit choices that relate to the Qualified Change in Status event.

Default Benefits

Participation in most of the health and welfare benefits requires an enrollment during the initial enrollment window. However, some benefits are provided automatically and do not require enrollment. If you are a regular full-time associate, the following benefits are provided by ODP automatically on the 1st of the month following 30 days of active service; however, for any life insurance or disability coverage, you must be in active employment as set forth in the applicable Summary (e.g., not on leave of absence) on the benefits effective date. This section does not apply to part-time Safe Harbor 30-Hour Associates.

Benefit	Coverage Provided
Basic Life Insurance	One times your annual base salary, up to a maximum of \$250,000 (\$500,000 maximum for VP+). Coverage amount is rounded up to the next \$1,000. The value of coverage more than \$50,000 is subject to income taxation under IRS rules. Age reduction rules apply beginning at age 65, and each 5-year age band thereafter.
Basic Accidental Death and Dismemberment Insurance	An amount equal to your Basic Life Insurance is paid to your beneficiaries after your accidental death. Benefits are also available to you for loss of limb or eyesight resulting from a covered accident. Age reduction rules apply beginning at age 65, and each 5-year age band thereafter.
Basic Short-term Disability	You receive up to 50% of your annual base salary if you experience a qualified injury, illness or pregnancy and are unable to work. Payments begin after a 7-calendar day waiting period of continuous disability. Benefits end after 25 weeks.
Employee Assistance Program (EAP)	You and your family members have up to five (5) free confidential in-person or telephonic sessions per issue or incident with a counselor. Sessions are available for help with legal, health care, childcare, elder care, and many other issues.

Paying for Benefits

ODP pays the full cost of the following benefits:

- Basic Life & Basic Accidental Death and Dismemberment Insurance
- Basic Short-term Disability
- Employee Assistance Program

Your Contributions

You do not pay federal, Social Security and, in most cases, state or local income taxes on the pre-tax money you use to pay for most of your benefits. You may generally use pre-tax money to pay for your cost for medical, dental and vision. However, life insurance, AD&D, long-term disability, and voluntary benefits (STD buy-up, critical illness, hospital confinement and accident insurance) are all paid on an after-tax basis.

Through the health care flexible spending account, you can use pre-tax dollars to pay for eligible health care expenses (medical, dental, vision and prescription drugs). Contributions are made by you from each paycheck (bi-weekly or weekly, as applicable), based on your annual election amount. If you participate for the full plan year, you may contribute on a pre-tax basis up to the annual limits set by the Internal Revenue Service (IRS) to pay for eligible health care expenses. This annual contribution limit is subject to change by the IRS each year.

Through the dependent care flexible spending account, you can use pre-tax dollars to pay for eligible day care and other dependent care expenses. Contributions are made by you from each paycheck (bi-weekly or weekly, as applicable), based on your annual election amount. If you participate for the full plan year, you may contribute on a pre-tax basis up to \$5,000 to pay for eligible day care expenses.

Participants in the Protection HSA and Protection HSA2 medical options are not eligible to participate in a health care flexible spending account but may choose to contribute pre-tax dollars into a Health Savings Account (HSA) and use the funds to pay for eligible health care expenses (medical, dental, vision and prescription drugs). Each year, the maximum contribution limits are subject to change by the IRS. The HSA enrollment option on *myBenefitsHub* at ODP.bswift.com will always have the current year's contribution limits, including the opportunity to make an additional catch-up contribution into your HSA if you will be age 55 or older during that Plan Year. **Note:** The maximum limits in the enrollment site will automatically be reduced if you are receiving the Wellness Credit and eligible to receive employer matching contributions. These amounts are subject to change each year by the IRS.

Once any premium or contribution for coverage is collected or deducted from your pay, you are not entitled to a refund of premiums or contributions, even if coverage terminates prior to the end of the period for which premiums or contributions are paid.

Domestic Partner Coverage

The tax treatment of your domestic partner's coverage is different from that of other dependents, as follows:

- Your premiums for domestic partner coverage will be paid on an after-tax basis. This is accomplished by deducting associate contributions for your domestic partner's coverage on a pre-tax basis and then imputing this amount back to your W-2 wages. The result is the same as if the contributions were deducted from your pay on an after-tax basis.
- ODP's share of the cost of medical coverage for your partner is taxable to you as imputed income. (Imputed income is an amount that is reported on your W-2 to reflect the value of taxable non-cash benefits you receive from ODP).
- Reimbursements from your health care and dependent care flexible spending accounts are not available for your domestic partner's (and their dependent children's) expenses.

The tax treatment of your domestic partner's dependent children will also be the same as your domestic partner noted above.

Qualified Change in Status Events

If you experience an IRS-Qualified Change in Status event during the year, you may change certain benefit choices within the 31-day period following the actual event date. Examples of a Qualified Change in Status event include:

- Marriage
- Divorce
- Birth or adoption (or placement for adoption)
- Death of your spouse, domestic partner, or dependent child
- Dependent child becomes ineligible (e.g., because they turn age 26)
- Spouse, domestic partner, or dependent child gains medical coverage
- Spouse, domestic partner, or dependent child loses coverage due to a job status change, but not due to dropping coverage through annual enrollment
- A change is made during Annual Enrollment in the employer plan of a spouse, domestic partner or dependent child, and the other employer plan uses a non-calendar year
- Change of job category that affects eligibility for coverage
- Change of address where you lose your medical option or become eligible for a new medical option
- Formation of a domestic partnership
- Termination of a domestic partnership
- For the dependent care flexible spending account only, commencement of leave of absence, and returning to active work after the end of a leave of absence
- For the dependent care flexible spending account, any change in a dependent care provider or the amount of dependent care services

Note: For a list of changes allowed when a Qualified Change in Status event occurs, visit *myBenefitsHub* at ODP.bswift.com or contact the Benefits Department at BenefitsTeam@theodpcorp.com. Your changes may be restricted in the event of a Qualified Change in Status related to a domestic partner or a domestic partner's dependent. Further, you cannot eliminate coverage for your spouse in anticipation of a pending divorce.

Changes You Can Make

You will be eligible to make benefit changes within a 31-day period after a Qualified Change in Status event. The enrollment changes you can make with a Qualified Change in Status event are subject to IRS rules. These rules limit what can be a Qualified Change in Status event, govern when an enrollment change can be effective and require your change in enrollment to be consistent with the Qualified Change in Status event. Modifications in the IRS's rules or the rules' interpretations could restrict your ability to make the enrollment changes described in this section.

The Benefits Administrator or ODP may request documentation to verify a Qualified Change in Status.

Most changes will be effective the 1st of the month following the date you report your Qualified Change in Status event. However, for a newborn or an adoption, medical, dental and vision coverage will begin on the date of birth, or the date of adoption or placement for adoption, providing you enroll your new dependent(s) into coverage on myBenefitsHub at ODP.bswift.com within 31 days following the birth or adoption/placement for adoption date.

Increases made to your life insurance and disability coverage (if you are eligible) while you are not actively at work (e.g., on a leave of absence) will not become effective until you return to full-time active service. Further, you may be required to provide Evidence of Insurability (EOI) when you change your elections or select for the first time a benefit option on account of a Qualified Change in Status Event. For additional

information regarding the requirement to provide EOI, you should review this Flex SPD and the Benefit Summary for each benefit option.

How to Report a Qualified Change in Status Event

- Log on to *myBenefitsHub* at ODP.bswift.com and click on Birth, Marriage or Other Life Event, and follow the online instructions.
- If your Qualified Change in Status event is not listed, contact the Benefits Department at BenefitsTeam@theodpcorp.com for assistance.
- Whether you process the event online or request assistance from the Benefits Department, you must complete the change within the 31-day period following the date of the event (or earlier if the 31st day falls on a weekend or a holiday). You may be required to submit additional information to support the requested change.

You cannot request changes before the event takes place (for example, you cannot request that your spouse be added before you get married).

If you miss the 31-day deadline, you will not be able to change your elections until the next Annual Enrollment period (unless you experience another Qualified Change in Status event).

Changes in your benefit premiums will go into effect as soon as administratively possible after you process your Qualified Change in Status event, subject to applicable IRS rules. If arrears apply, your direct billing invoices will be adjusted (if on leave of absence) or deducted from future paychecks until paid in full.

Flexible Spending Account (FSA) and Health Savings Account (HSA) Changes

Flexible Spending Account and Health Savings Account changes are effective as soon as administratively possible after you report the change (generally within two pay cycles). Further, changes can only be made to coverage amounts if there is ample processing time left in the calendar year. FSA changes are limited to Qualified Change in Status events noted above.

HIPAA Special Enrollment Rules

If you decline medical coverage for yourself or your dependents or spouse because of other coverage, you may be able to enroll yourself and your dependents and spouse for medical coverage if your or your dependents or spouse lose eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, you must request enrollment within 31 days after you or your dependents' or spouse's other coverage ends (or after the employer stops contributing towards the other coverage).

If you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

In addition, you may be able to enroll yourself and your dependents in medical coverage: (1) if your or your dependent's coverage under a Medicaid plan or a State Children's Health Insurance Program ("CHIP") plan terminates due to loss of eligibility for such coverage; or (2) if you or your dependents become eligible for premium assistance with respect to ODP's medical coverage under a Medicaid plan or a CHIP plan. However, you must request enrollment within 60 days after the date of termination of such coverage or the date you or your dependent are determined to be eligible for such assistance, whichever is applicable.

To request an enrollment opportunity under Special Enrollment, or obtain more information, contact the Benefits Department at BenefitsTeam@theodpcorp.com.

If you are already enrolled in medical coverage for yourself, you may change your own medical coverage election in connection with enrolling a dependent child or spouse under the above special rules.

Special Extensions of Coverage

Depending on the situation, you and your covered eligible dependents may be eligible for certain continued coverage. Situations in which an extension of coverage is available are described below.

During an Approved Leave of Absence (LOA)

During an approved LOA, your benefits coverage (medical, prescription drug, dental, vision, supplemental life, supplemental AD&D and long-term disability) will remain in effect through the term of your approved LOA to a maximum period of six (6) months. Your ODP-paid benefits (short-term disability, basic life/AD&D) will also remain in effect. During this time, you are required to continue to make benefits premium payments timely to the bswift Direct Billing Service Center to avoid termination of coverage due to non-payment.

The health care flexible spending account may be continued during LOA if you want to be able to submit for expenses incurred during the LOA. The dependent care flexible spending account cannot be continued during an LOA; this account is automatically terminated as of the LOA effective date.

If the Leave Administrator determines that your LOA is “unapproved” because of not submitting the required documentation, your benefits coverage may automatically terminate on the 1st of the month following the date the leave is determined to be “unapproved.”

Special rules (discussed below) apply if you take a leave of absence pursuant to the Family and Medical Leave Act of 1993 (FMLA) or the Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA).

Benefit deductions will stop as of the beginning of the pay cycle following the LOA Start Date. If you used any available PTO (or sick time, where available) at the start of your LOA, your required benefit contributions will be deducted from the pay that you receive, except in certain circumstances. Once the benefit deductions stop, a notice with payment coupons will be sent by the bswift Direct Billing Service Center based on your communication preferences, or you may log into myBenefitsHub at ODP.bswift.com and click the “Manage Billing and Payments” link.

Benefit premiums while on LOA are due on the first (1st) of each month. Non-payment of benefit premiums will result in termination of benefits for non-payment. You will be provided with a thirty (30) day grace period to pay the benefit premiums. A termination of coverage notice will be sent based on your communication preferences after thirty (30) days of non-receipt of payment.

Any coverage cancelled due to non-payment will be terminated on the last day of the grace period retroactive to the last paid through date. If your coverage is terminated for non-payment, you will have no coverage (other than COBRA, if applicable and if you enroll) during the period that the coverage was terminated, and you will not be permitted to re-enroll in the Plan until you return to active employment, assuming you satisfy the eligibility requirements at that time and re-enroll in coverage. If supplemental life insurance, long-term disability, and/or voluntary AD&D was terminated either voluntarily or because of non-payment, any subsequent enrollment may require Evidence of Insurability.

When you return to active employment, your coverage is automatically reinstated, providing you continue to be eligible and providing you were not previously terminated from coverage for non-payment of invoices. Upon returning to active employment, if it is determined that you have any arrears due, your arrears will automatically be deducted from future paychecks. Arrears will generally be calculated at the rate of ½ the deduction amount (in addition to your regular paycheck deduction amount) until paid in full.

Family and Medical Leave Act of 1993

If you take LOA pursuant to the FMLA, you may continue your coverage, and your dependent's coverage, under this Plan as if continuously employed during the entire FMLA leave period. Alternatively, you may elect to discontinue your participation in the Plan while you are on FMLA leave.

If your coverage continues while you are on FMLA leave, you must continue to pay your share of the benefit premiums. Additional information regarding payment of the benefit premiums during an LOA is provided on the previous page. If your coverage ceases during the FMLA leave period, you may resume your coverage upon return from FMLA leave on the same terms as before the leave began (*i.e.*, no new conditions or waiting periods will apply to the coverage upon your return to work). If you do not return to work at the end of your FMLA leave, you will have an opportunity to enroll in COBRA to continue your coverage under the Plan, providing your coverage was not voluntarily terminated or terminated for non-payment while on FMLA leave.

You may be entitled to FMLA leave for the following reasons:

- birth of a child, and to care for such child.
- placement of a child with you for adoption or foster care.
- to care for your seriously ill spouse, child, or parent.
- a serious health condition that makes you unable to perform your job functions.
- a "qualifying exigency" arising because your spouse, child or parent is on active duty or has been notified of a call or order to active duty in the armed forces; or
- to care for a service member of the armed forces who is your spouse, child, parent or next of kin.

For additional information regarding your entitlement to FMLA leave, you should contact the Leave Administrator at (888) 954-4636 and choose the option for Leave of Absence. The Leave Administrator is responsible for the determination of your eligibility, rights, or the length of leave under FMLA, and shall notify the Plan for purposes of continuing your coverage under this Plan.

Uniformed Services Employment and Re-Employment Rights Act of 1994

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment regarding military LOA. These requirements apply to medical (including prescription drugs), dental and vision coverage for yourself and your dependents.

If you are absent from work due to a qualifying military LOA, your coverage will continue (including coverage for your enrolled dependents) if you continue to pay your benefit premiums, subject to the maximum period allowed under USERRA (generally 5 years). Additional information regarding payment of the benefit contributions during an LOA is provided on the previous page.

USERRA continuation coverage will end on the earliest to occur of the following:

- The date you fail to return from protected military service or apply for a position of employment as provided under USERRA.
- The end of the required continuation period under USERRA.
- Your failure to make a timely payment for your continuation coverage.
- The date you are discharged from military service under other than honorable conditions or if you are dismissed or dropped from military rolls under conditions that result in a loss of re-employment rights under USERRA, or
- Termination of the Plan.

You may choose to discontinue your coverage while you are on a military LOA. If you choose to discontinue coverage, or if your coverage is terminated due to non-payment, a right to continuation coverage under

COBRA may be triggered, and you and your covered dependents may be eligible to elect to continue group health coverage under COBRA.

Returning from a Military Leave of Absence

Whether or not coverage was continued during your military LOA, your coverage will be eligible for reinstatement upon your return from leave and re-employment in accordance with USERRA. The coverage will have no pre-existing condition exclusions or waiting periods, unless you have an injury or illness that the Secretary of Veterans Affairs has determined to have been incurred in, or aggravated during, performance of military service.

You must contact the LOA Administrator at (888) 954-4636 to report your return from leave. Within 2-3 days after reporting your return from leave, a life event window will open on *myBenefitsHub* at [ODP.bswift.com](https://odp.bswift.com) to allow you an enrollment opportunity to enroll in benefits coverage. Benefit elections must be made by the deadline indicated on the *myBenefitsHub* portal.

When Coverage Ends

Except when noted otherwise in this Flex SPD or in any Benefit Summary, coverage under ODP's health and welfare benefits programs ends when the earliest of the following occurs:

- Your employment ends
- The Plan ends, or the coverage is discontinued or terminated
- You fail to make your required contributions
- You no longer meet the eligibility requirements
- You are no longer actively at work and your eligibility for continued benefits terminates (e.g., after 6 months of a leave of absence)
- Your disability ends and you do not directly return to eligible active employment*
- You fail to cooperate with the Plan or Claims Administrator with respect to the administration of your benefits
- Your leave of absence is determined to be "unapproved"

* Special rules apply if you are receiving STD or LTD benefits. See the *Disability* section in this Flex SPD document and the separate *LTD Benefit Summary* for additional information.

Coverage for your enrolled dependents (spouse/domestic partner and children) ends when your coverage ends. However, your dependent's coverage will end earlier than your coverage upon:

- The date that your enrolled dependent no longer meets the eligibility requirements.
- The date that you remove the enrolled dependent from coverage.
- Failure to cooperate with the Plan/Claims Administrator with respect to the administration of benefits.
- Discontinuation or termination of the coverage.
- Failure to respond to or satisfactorily provide requested documentation if you are included in a random dependent verification audit.

Special rescission of coverage rules applies to medical coverage for associates and enrolled dependents.

It is your responsibility to report a change in a dependent's eligibility. Premiums paid in error due to your delay in reporting a change in eligibility will not be refunded. Your coverage and your dependent's coverage may also be terminated or suspended for engaging in misrepresentation or fraud against the Plan, including filing or participating in filing a false, misleading, or fraudulent claim for benefits, or allowing your ID card to be used by an individual who is not enrolled in the Plan. Your coverage and your dependent's coverage

may also be terminated or suspended for providing false or misleading information in connection with enrollment, including enrolling an individual who does not satisfy the eligibility criteria or failing to drop an enrolled individual in a timely manner when they no longer satisfy the eligibility criteria.

If your health care coverage ends, you may be eligible to extend coverage for you and your dependents under COBRA continuation coverage. See the *COBRA Continuation Coverage* section for further details.

Rescission of Coverage

Rescission of coverage is a cancellation or discontinuation of coverage that has retroactive effect. However, a cancellation or discontinuation of coverage is not a rescission if it:

- Is one that you voluntarily request with a retroactive effective date.
- Is only effective prospectively.
- Is attributable to a failure to pay required premiums or contributions in a timely manner.
- Results from a participant's termination of employment; or
- Results from the dependent's failing to satisfy the applicable eligibility requirements to be a dependent.

The Plan will not rescind coverage under a medical or prescription drug option for a participant or covered dependent unless the participant or covered dependent performs an act, practice or omission that constitutes fraud (as defined by the Plan) or intentionally misrepresents a material fact with respect to the medical or prescription drug coverage. The Plan shall provide the participant or covered dependent with at least 30 days' advance written notice of any rescission. All rescissions are subject to the claims and appeals procedures applicable to the medical or prescription drug coverage, as set forth in the Administrative Information section.

The above rescission rules apply only to the medical and prescription drug options. They do not apply to any other health and welfare benefit.

Administrative Information

This section of the booklet includes information about the administration of the plans and your rights under the Employee Retirement Income Security Act of 1974 (ERISA). The information contained in this Flex SPD is taken from the official plan documents and is written in summary form. The summaries are intended to be thorough but are not intended to augment the provisions of the official plan documents.

This Flex SPD, the applicable Benefit Summaries, and any materials on the ODP Benefits SharePoint website or Resource Library on *myBenefitsHub* are intended to provide a summary of the major provisions of the benefit plans. Your benefits are described as clearly as possible, with minimal use of the technical words and phrases appearing in the official plan documents. However, if there is a conflict between these summaries and the respective plan documents, the terms of the official plan documents will control.

If you wish to receive a copy of the official plan documents, a copy may be obtained from the Plan Administrator. A reasonable charge may be made to cover the cost of reproduction and postage.

Employer Information

Name, Address, and Identification Number

The Plan Sponsor is ODP International, LLC and the Employer Identification Number (FEIN) is 87-2687219. You can contact the Plan Sponsor as follows:

ODP International, LLC
Attn: Benefits Department
6600 N Military Trail
Boca Raton, FL 33496
Phone: (888) 954-4636, Option 4
BenefitsTeam@theodpcorp.com
Fax: (561) 438-3247

Plan Administrator

The Office Depot Employee Benefits Committee is the Plan Administrator of the benefit plans governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA). These plans are listed in the *Other Administrative Facts* section. The Plan Administrator for all other plans is ODP or its delegate.

Administration of the entire benefit program is the responsibility of the Plan Administrator. Contact information for the Plan Administrator is as follows:

Chair, Office Depot Employee Benefits Committee
6600 N Military Trail
Boca Raton, FL 33496
Phone: (888) 954-4636, Option 4
Fax: (561) 438-3247

Agent for Service of Legal Process

Process can be served on the Office Depot Employee Benefits Committee by directing service to:

Chair, Office Depot Employee Benefits Committee
Attn: Benefits Department
6600 N Military Trail
Boca Raton, FL 33496
Phone: (888) 954-4636

Service of legal process may also be made upon the Plan Sponsor by directing service to the General Counsel.

Benefits Administrator

bswift
10 S. Riverside Plaza, Suite 1100
Chicago, IL 60606
Phone: (866) 365-2413

Plan Funding

The benefit plans are funded in different ways, depending upon the type of plan, as described below. In all cases, ODP makes the decisions about how the plans are designed, including associate and dependent eligibility and participation in the benefit options.

Contributions to the benefit plans are made by ODP and participating associates, as applicable. In general, in the case of insured health and welfare programs, associate contributions are based on premiums established by the insurers and other costs of coverage as determined by ODP, reduced to reflect any employer contributions. In the case of self-insured health and welfare programs, associate contributions are based on the total cost of providing coverage as determined by ODP, reduced to reflect any employer

contributions. In all the health and welfare plans, applicable administrative expenses are included in the price of coverage.

Additional details about the funding of the health and welfare programs are set forth below.

ODP-Funded Health Plans

The cost of benefits under the Protection HSA, Protection HSA2 and Traditional PPO medical options are self-insured. The cost of benefits under the dental options, employee assistance program and prescription drug program are also self-insured. Benefits for all self-insured programs are paid out of the general assets of ODP, are not pre-funded. The programs are administered through contracts with a third party. The name and address of each Claims Administrator can be found in the *Other Administrative Facts* pages later in this section. In each program, the Claims Administrator has the discretionary authority to determine all benefits in accordance with the official plan documents. The administrative services provided by the Claims Administrator include claims processing and payment.

Third-Party Insured Plans

Health benefits under Kaiser California and Hawaii Medical Service Association are insured by the respective insurer. The insurer has the discretionary authority to determine all benefits according to the terms of the official documents. All ODP and associate contributions are paid directly to the respective insurer, which is responsible for paying all benefits.

Benefits under vision, ODP-provided basic life and AD&D insurance, supplemental life insurance, dependent life insurance, and voluntary AD&D insurance are fully insured by a third party. The insurer has the discretionary authority to determine all benefits according to the terms of the official documents. All ODP and associate contributions are paid directly to the respective insurer, which is responsible for paying all benefits.

Other voluntary insurance, such as the legal services plan, ID theft protection, pet insurance, auto and home insurance, and voluntary supplemental benefits are fully insured by a third-party. The insurer has the discretionary authority to determine all benefits according to the terms of the official documents. All associate contributions are paid directly to the respective insurer, which is responsible for paying all benefits.

The name and address of each insurer can be found in the *Other Administrative Facts* pages later in this section. In each plan or program, the administrative services provided by the insurer include claims processing and payment. The master contract for coverage specifies the time when and the circumstances under which the insurer is to pay for benefits. For example, the insurer would not have to pay claims after the contract is terminated. The insurer has the discretionary authority to determine all benefits according to the terms of the official plan documents and applicable insurance policies. All ODP and associate contributions are paid directly to the insurer, which is responsible for paying all benefits.

Disability Benefits

Benefits for short-term disability are self-insured. Benefits for self-insured programs are paid out of the general assets of ODP and are not pre-funded. The programs are administered through contracts with a third party. The name and address of the Claims Administrator can be found in the *Other Administrative Facts* pages later in this section. The Claims Administrator has the discretionary authority to determine all benefits in accordance with the official plan documents. The administrative services provided by the Claims Administrator include claims processing and payment.

Benefits for long-term disability are fully insured by a third-party. The insurer has the discretionary authority to determine all benefits according to the terms of the official documents. All associate contributions are paid to the insurer, which is responsible for paying all benefits. The name and address of the insurer can be

found in the *Other Administrative Facts* pages later in this section. The administrative services provided by the insurer include claims processing and payment. The master contract for coverage specifies the time when and the circumstances under which the insurer is to pay for benefits. For example, the insurer would not have to pay certain claims after the contract is terminated. The insurer has the discretionary authority to determine all benefits according to the terms of the official plan documents and applicable insurance policies. All contributions are paid directly to the insurer, which is responsible for paying all benefits.

You may be eligible for disability benefits under a state disability program. You may also be eligible for a combination of state disability program benefits and ODP disability benefits. (See the *Disability Benefits* section for eligibility and additional information on state disability benefits.) To the extent you are eligible for state disability benefits, such state benefits are administered and paid by the state or related state agency. State disability benefits are neither administered nor paid by ODP and are not funded by ODP.

Flexible Spending Accounts

The flexible spending accounts are self-insured and are administered on a contract-administration basis by the FSA Administrator. Under federal tax law, participants' flexible spending account contributions are treated as company contributions for their benefit and are intended to be non-taxable to the participant when used for eligible expenses.

The FSA Administrator has the discretionary authority to determine all benefits in accordance with the terms of the plan documents and IRS rules. The flexible spending accounts are funded by participating associates. ODP establishes a reserve on its books for the amount directed to the participant's flexible spending account. While no trust is created to hold the contributions, ODP does have an obligation to make payments when due, and the participant has all the rights of a general creditor.

Health Savings Accounts

Health savings accounts are not ERISA plans and are not sponsored in any way by ODP. Rather, an HSA is an individual account that is owned by the respective associate.

Situations Affecting Your Benefits

General Information

Some situations could affect benefits under the Plan, as summarized here:

- If you choose "waive" when first hired or during any Annual Enrollment period, no benefits are payable.
- Coverage may be stopped, changed, or delayed if you leave ODP, take a leave of absence, or experience an employment status change such that you are classified as benefits-ineligible.
- If you do not apply for benefits or provide the necessary claim information, benefits may be delayed.
- You may change your coverage during the year only if you report a Qualified Change in Status within the specified time.
- Coverage for a spouse ends if you and such spouse are divorced or legally separated.
- Coverage for a domestic partner will end if they are no longer a domestic partner, as defined in the *Eligible Dependents* section.
- Coverage for a dependent will end if they no longer meet the definition of an eligible dependent.
- Coverage for you and your eligible dependent(s) will be suspended or terminated if you are on a leave of absence from work and do not submit timely payments to the bswift Direct Billing Service Center.

Right to Exchange Information

To coordinate benefit payments, the respective Claims Administrator needs certain information. It may get needed facts from or give them to any other organization or person. Subject to the HIPAA privacy rules, the respective Claims Administrator need not tell, or get the consent of, any person to do this.

An associate must give the respective Claims Administrator the information it asks for about other plans. If the associate cannot furnish all the information the respective Claims Administrator needs, it has the right to get this information from any source. If any other organization or person needs information to apply its coordination provision, the respective Claims Administrator has the right to give that organization or person such information. Information can be given or obtained without the consent of any person to do this.

Facility of Payment

It is possible for benefits to be paid first under the wrong plan. The respective Claims Administrator may pay the Plan or organization or person for benefits that it determines it should have paid. That amount will be treated as if it was paid under the ODP plan. Neither ODP nor the Plan will have to pay that amount again.

Health and Welfare Eligibility & Enrollment Appeals

The Eligibility and Enrollment appeals process is used for determinations relating to eligibility for coverage, participation, contributions, or other administrative aspects of the Plan. The claims and appeals process for the payment of benefits is in a separate section that follows this section.

The process includes an “Informal Inquiry Process” and two formal levels of review - a “Formal Claims Process” and a “Formal Appeals Process.” These health and welfare eligibility and enrollment claim procedures do not apply to Kaiser California and Hawaii Services Medical Association. Please see below under *Certain Eligibility Claims and Appeals Prohibited for Kaiser and HMSA* for further information.

The Informal Inquiry Process

Any claim, dispute or grievance regarding eligibility, enrollment and/or other administrative aspects of the Plan must be filed **within ninety (90) days** from the effective date of coverage for which the eligibility and/or enrollment relates. Thus, and as an example, for purposes of Annual Enrollment, your effective date of coverage is January 1st, and any claims regarding that eligibility and/or enrollment must be filed within ninety (90) days thereafter (or by March 31). This limitation covers any claim or dispute you may have regarding any enrollment election you have made (or not made as the case may be), including health coverage, dependent status, enrolled dependents and/or contributions to the flexible spending accounts.

Within the timing as outlined above, you or your authorized representative should immediately contact the Benefits Department at BenefitsTeam@theodpcorp.com, which begins the Informal Inquiry Process. During the Informal Inquiry Process, the authorized Benefits team member may be able to resolve the issue, eliminating the need for further action. If the issue cannot be resolved immediately, the Benefits team member will request additional research and will notify you of the resolution within 31 days.

If a resolution is not possible through the Informal Inquiry Process, or if the response is unfavorable, you have the right to submit a Formal Claim.

The Formal Claims Process (1st Level Appeal)

If you are not satisfied with the resolution or decision made during the Informal Inquiry Process, you may begin the Formal Claim Process for further review and consideration.

A Formal Claim request must be received by the Benefits Department **no later than 30 days** after the date you were notified of the Informal Inquiry decision. A Formal Claims request received beyond this date is not eligible for further consideration. Although email or fax are the fastest and preferred methods of sending Formal Claims, you can also send a Formal Claim via U.S. mail to:

The ODP Corporation, Benefits Department
6600 N. Military Trail, Boca Raton, Florida, 33496
Email: BenefitsTeam@theodpcorp.com
Fax: (561) 438-3247

Your Formal Claim should include any comments, documents, records, and other information you would like to have considered by the designated individual(s) with authority to investigate and make decisions following the terms of the Plan. The investigation will include any correspondence, communications, call recordings, access or transactions processed on the self-service enrollment system which may indicate your current or historical benefit elections, enrollment and payroll deductions and any other information available to assist in deciding your Formal Claim.

The designated individual will make a full and fair review of your Formal Claim. You will be notified of the decision within 31 days of the receipt of your written Formal Claim. Response to your Formal Claim will be delivered in writing either via email or sent via UPS 2-day delivery to the address of record.

If your claim is denied, in whole or in part, the denial notice will include:

- The specific reason(s) for the claim decision
- A reference to the specific provisions on which the decision was based
- A statement that you are entitled to receive, upon request and without charge, reasonable access to or copies of all documents, records, and other information relevant to the determination
- A statement indicating entitlement to receive, upon request and without charge, a copy of any internal rule(s), guideline(s), protocol, or similar criterion relied on in making the adverse decision
- A statement regarding your right to obtain copies of documents relevant to your claim, without charge

If the Formal Claim is denied, in whole or in part, you have the right to submit a Formal Appeal.

The Formal Appeals Process (2nd Level Appeal)

If your Formal Claim is denied, you have a right to have this decision reconsidered by filing a Formal Appeal. You or your duly authorized representative must submit a formal written request within 180 days from receiving notification of a denial for eligibility, participation, or contributions. Formal Appeals must be submitted to the Benefits Appeals Committee of the Plan Administrator. Although email or fax are the fastest and preferred methods to file your Formal Appeal, you may also file via U.S. mail to:

ODP
Attention: Benefits Appeals Committee
6600 North Military Trail
Boca Raton, Florida, 33496
Fax: (561) 438-3247
Email: BenefisTeam@theodpcorp.com

Your Formal Appeal must include your name, a copy of your Formal Claim denial, and any additional comments, documents, records, or other information you would like to have considered by the Benefits Appeals Committee, represented by senior benefits management and internal legal counsel.

When the Formal Appeal is reviewed, all documents, records, and other information that you submitted will be considered without regard to whether the information was considered in the Initial Informal Inquiry process or the Formal Claim process. In addition to the documentation you submit, the Committee will also research regulatory and taxation guidance, as well as ODP policies, procedures and previous decisions rendered for the same or like situation.

Notification of a Formal Appeal Decision

The Appeals Committee will make a full and fair review of your Formal Appeal. You will be notified of the decision within 31 days of the receipt of your Formal Appeal. Response to your Formal Appeal will be delivered in writing either via email or sent via UPS 2-day delivery to the address of record.

If your Formal Appeal is denied, in whole or in part, you will be notified in writing. Your denial notice will include:

- The specific reason(s) for the appeal decision
- A reference to the specific provisions on which the decision was based
- A statement that you are entitled to receive, upon request and without charge, reasonable access to or copies of all documents, records, and other information relevant to the determination
- A statement indicating entitlement to receive, upon request and without charge, a copy of any internal rule(s), guideline(s), protocol, or similar criterion relied on in making the adverse decision
- A statement regarding your right to obtain copies of documents relevant to your claim, without charge

If you fail to submit a Formal Appeal within the 180-day period, you will not be permitted to seek an appeal and will have failed to have exhausted all administrative remedies. This failure will result in your inability to bring legal action to determine your eligibility.

The Appeals Committee has discretionary authority to review and resolve any Formal Appeals. In reviewing your appeal, the Appeals Committee applies the terms of the Plan and uses its discretion in interpreting those terms. Participation in the Plan is allowed only if you meet eligibility and participation requirements. The decision of the Appeals Committee on any Formal Appeal for eligibility and/or enrollment is final and binding.

Certain Eligibility Claims and Appeals Prohibited for Kaiser and HMSA

If you have a new dependent because of marriage, domestic partnership, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents and spouse/domestic partner. However, you must request enrollment within 31 days after the marriage or entering a domestic partnership, or 31 days after the birth, adoption, or placement for adoption.

If you are newly enrolling or changing an existing enrollment in Kaiser California or Hawaii Medical Services Association and you miss the 31-day enrollment deadline, you will not be able to appeal your missed enrollment deadline. Rather, you will be required to wait until the following Annual Enrollment or a subsequent Qualified Change in Status Event to enroll your new dependent. This is based on California and Hawaii state insurance rules, which cannot be changed by ODP.

Filing a Health and Welfare Benefits Claim

Note: If you are enrolled in Kaiser, Hawaii Medical Services Association, Hartford voluntary benefits, or other voluntary benefits (e.g., auto/home insurance, pet insurance), the following claim and appeal procedures do not apply to you. You will receive information about the claim and appeal procedures directly from the carrier.

Usually, benefits are paid in the ordinary course using the forms and procedures described in the specific benefit section. Please see the *Filing Claims* section of this Flex SPD or the applicable Benefit Summaries for more details. However, occasionally you may wish to file a formal claim for benefits.

The Plan Administrator, or its delegate, has the exclusive discretionary authority to construe and to interpret the plans, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and its decisions on such matters are final and conclusive. If any exercise of this discretionary authority is reviewed by the court, arbitrator, or any other tribunal, it shall be reviewed under the arbitrary and capricious

standard (e.g., the abuse of discretion standard). Benefits will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them. The Plan Administrator has periodically exercised its authority to delegate discretionary authority in contracts, letters and plan documents to the various Claims Administrators and insurers listed in the *Other Administrative Facts* later in this section, and to their predecessors and successors.

The health and welfare plans distinguish between internal claims and appeals and external appeals. Internal claims - which differ for benefits and eligibility - are handled internally by the Plan, its carriers, and other third-party administrators. With external appeals, the decision is made by an independent review organization (IRO), rather than the Plan and its medical carriers. External appeals are only available for certain types of medical claims. This section discusses procedures for filing Internal Claims and Appeals for Health and Welfare Benefits.

Internal Claims and Appeals for Health and Welfare Benefits

To make an internal claim for benefits, you must file a written claim with the Claims Administrator at the address shown in the *Other Administrative Facts* later in this section or on the claim form (if any) prescribed by the Claims Administrator. For certain benefits, your service provider may file a claim for you (e.g., your network medical provider may file a claim for benefits on your behalf). However, it is always your responsibility to make certain a formal claim for benefits has been filed with the appropriate administrator. For purposes of these procedures, in the case of insured programs, "Claims Administrator" means the insurer or its delegates. In the case of programs that are not insured, "Claims Administrator" means the Plan Administrator or a delegated Claims Administrator. See the *Plan Funding* information in this section to determine if a program is insured.

Internal Benefit Claims for Precertification

Certain internal claims for benefits under the medical options must be pre-certified. You must call your medical plan carrier to request precertification for services or treatments.

Internal Benefit Claim Denial

If your internal claim for benefits is denied in whole or in part, written notification will be sent of the denial as described more fully below. This claim denial notice will include: specific reasons why the claim was denied; specific references to applicable provisions of the Plan document or other relevant records or papers on which the denial is based, and information regarding where you may review them; an explanation of how to appeal for reconsideration of the Claims Administrator's decision, including your right to submit written comments and have them considered, your right to review, upon request and free of charge, relevant documents and other information, and your right to file suit under ERISA with respect to any adverse determination after appeal of your claim; and a description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary. For non-health and non-disability benefit plans, you will receive this denial notice within 90 days of the date the claim is received (or 180 days if special circumstances arise and you are notified in writing that an extension period is required).

However, special rules apply to any claims arising under:

- Medical, dental, vision, employee assistance program and/or health flexible spending account benefits (collectively "Health Benefits"); and
- Short-term disability and long-term disability benefits (collectively, "Disability Benefits").

Health Benefits

If your internal claim is for Health Benefits, notice will be sent from the Claims Administrator about your claim according to the type of claim you have filed.

Urgent Care Claims. Notice will be sent, in writing or by telephone, facsimile or other electronic method, as soon as possible considering the severity of your condition, but not later than 72 hours after the receipt of your claim. Your treating physician will determine if the urgent care procedures apply and will inform the Claims Administrator.

Pre-Service Claims. Written notice will be sent within 15 days for a non-urgent claim for health benefits where precertification is required before care is provided - unless an extension of time is required to review your claim, in which case you will be notified in writing of the need for an extension of up to 15 additional days.

Post-Service Claims. Written notice will be sent within 31 days for a non-urgent claim for health benefits where precertification was not required and care has already been provided - unless an extension of time is required to review your claim, in which case you will be notified in writing of the need for an extension of up to 15 additional days.

Concurrent Care Claims. If your request to extend a course of treatment is an Urgent Care Claim, written notice will be sent within 24 hours provided the request is received at least 24 hours prior to the end of the approved treatment. If a request to extend approved treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be processed according to the above time frame for an Urgent Care Claim. If the ongoing course of treatment is not an Urgent Care Claim, a request to extend the treatment will be considered a new claim and processed according to the Pre-Service Claim or Post-Service Claim procedures, whichever is applicable. However, you will be notified of any reduction or termination of the course of treatment sufficiently in advance to permit a full appeal before the termination or reduction takes effect.

The Claims Administrator may secure independent medical or other advice and require such other evidence, as it deems necessary to decide your claim. If an extension is required because there is insufficient information to review your claim, notice will be sent explaining the unresolved issues that prevent a decision on the claim and a listing of the additional information needed to resolve those issues. You will be given 45 days (48 hours in the case of an urgent care claim) from the receipt of that notice to provide the additional information to the Claims Administrator. During the time that a request for information from you is outstanding, the running of the time in which the Claims Administrator must decide your claim is suspended.

If you reside in a county where 10 percent or more of the population is literate in a non-English language, your ODP medical option must provide foreign language assistance for benefit questions, claims, appeals, and external review. If you have questions about foreign language assistance, please see the statements on your ODP medical option explanation of benefits (EOB) or contact a Quantum Health Care Coordinator using the phone number on the back of your medical identification card.

Disability Benefits

If you have made an internal claim for Disability Benefits and your claim is denied, a written denial notice will be sent within 45 days of the date that the claim was received. This 45-day period may be extended one or more times for up to 60 additional days if necessary and for reasons beyond the control of the Claims Administrator (including in cases where a claim is incomplete). You will be notified of the need for an extension before the expiration of the existing period. However, each extension period will not be longer than 30 days. The Claims Administrator may secure independent medical or other advice and require such other evidence, as it deems necessary to decide your claim.

The disability extension notice will explain the:

- Reasons and unresolved issues that prevent a decision on the claim.
- Additional information needed to resolve the issues; and
- The expected date of the decision.

If you are receiving state disability benefits, these claim procedures do not apply. For state disability benefits, you should contact the state or applicable agency that pays your benefits regarding its claim procedures.

Appealing a Denied Internal Claim for Health and Welfare Benefits

Note: The carriers administering ODP benefits are the claim fiduciaries. Appeals for denied internal claims for benefits should be sent directly to your Claims Administrator's attention. Contact information for your Claims Administrator can be found in the *Other Administrative Facts* later in this section.

If your claim has been denied in whole or in part, you must appeal the denial by submitting a written request for review to the Claims Administrator within 60 days of the date that you receive the claim denial notice (or 180 days for Health Benefits or Disability Benefits claims), or else you will lose your right to appeal your denial. If you do not appeal on time, you will also lose your right to file suit in court, as you will have failed to exhaust your administrative appeal rights, which is generally a prerequisite to bringing suit.

Your right to appeal a denied internal benefits claim includes the opportunity for you or your authorized representative to:

- State the reasons why you feel your claim should not have been denied.
- Submit written comments, documents, additional facts, and other information supporting your claim.
- Ask additional questions.
- Request to receive reasonable access (free of charge) to copies of all documents, records, and other information relevant to your claim; and
- Ask for a review that considers all comments, documents, records, and other information you have timely submitted, whether it was submitted or considered in the initial determination of your claim.

In addition, if your internal benefits appeal relates to medical benefits, the applicable plan will:

- Continue medical coverage for a course of treatment pending the outcome of an internal appeal, if such course of treatment was previously approved; and
- Provide to you, in advance of an internal appeal determination, any new or additional evidence or rationale relied upon or considered in making the determination and give you an opportunity to respond prior to making the internal appeal determination.

If your internal benefits appeal is denied in whole or in part, written notification will be sent of the decision as described below. Such written notification will contain the following information: the specific reasons for the partial or complete denial of your claim; reference to the specific plan provisions on which the benefit determination was based; a statement of your right to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim; and a statement of your right to bring an action under ERISA Section 502(a) as amended.

In addition, if your internal claim is for Health Benefits or Disability Benefits, you also have the right to receive a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in the claim determination, if any, or a statement of your right to receive a copy of such internal rule, guideline, protocol or other similar criterion, upon request and free of charge. If your internal appeal was denied based on a medical necessity or experimental treatment or similar exclusion, you have the right to receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement of your right to receive such explanation upon request.

For non-Health Benefits and non-Disability Benefits, the written decision on appeal will be sent within 60 days of the date the appeal was received (or 120 days if special circumstances arise and you are notified in writing within the initial 60-day period of the need for an extension).

However, special rules apply to any internal benefit appeals arising under:

- Health Benefits; and
- Disability Benefits

Health Benefits

If your internal benefits appeal arises from Health Benefits, you must submit your appeal in writing to the Claims Administrator within 180 days of your receipt of the initial denial of your claim. Notification of the Claims Administrator's decision on appeal will be sent according to the type of claim you have filed.

Urgent Care Claims.

Notice will be made, in writing or by telephone, facsimile or other electronic method, within 72 hours of a claim for benefits where health care is necessary to avoid serious jeopardy to your life or health, or to regain maximum function (or as determined by your treating physician).

Pre-Service Claims.

Written notice will be sent within 31 days for a non-urgent claim for health benefits where precertification is required before care is provided.

Post-Service Claims.

Written notice will be sent within 60 days for a non-urgent claim for health benefits where precertification was not required, and care has already been provided.

Concurrent Care Claims.

Written notice will be sent within the time frame for an Urgent Care Claim, Pre-Service Claim or Post-Service Claim, whichever is applicable. However, you will be notified of the determination on appeal before a reduction or termination of a course of treatment takes effect. If your claim is for medical benefits, the Plan will continue medical coverage for a course of treatment pending the outcome of an internal appeal, if such course of treatment was previously approved.

Disability Benefits

If your internal benefits appeal arises under the Disability Benefits, you must submit your appeal in writing to the Claims Administrator within 180 days of your receipt of the initial denial of your claim. The Claims Administrator will provide you with its decision on your appeal within 45 days of the date that it was received. This decision period may be extended by an additional 45 days if additional information is required to review your appeal if you are notified in writing of the need for the extension before the end of the initial 45-day period.

If you are receiving state disability benefits, these appeal procedures do not apply. For state disability benefits, you should contact the state or applicable agency that pays your benefits regarding its appeal procedures.

General Information for Health and Disability Benefits

In processing your appeal, the Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Claims Administrator in connection with the claim. This evidence must be provided as soon as possible and sufficiently in advance of the date on which the appeal decision is required to be provided to give you a reasonable opportunity to respond. If you respond to the new or additional evidence on a timely basis, the Claims Administrator must consider your response prior to issuing any appeal denial notice.

In issuing any special denial notice, the Claims Administrator will include in the denial notice a discussion of the decision, including an explanation of the basis for disagreeing with or not following (as applicable):

- The views of health care professionals treating you and vocational professionals who evaluated you, that you presented to the Claims Administrator of health care professionals treating the claimant and vocational professionals who evaluated the claimant.
- The views of medical or vocational experts whose advice was obtained on behalf of the Claims Administrator in connection with your appeal denial without regard to whether the advice was relied upon in making the benefit determination; and
- A disability determination made by the Social Security Administration that you presented to the Claims Administrator made by the Social Security Administration.

The individual who decides your internal benefits appeal will not be the same individual who decided your initial internal benefits claim denial and will not be that individual's subordinate. The Claims Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide your appeal, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in connection with your initial claim. The identity of a medical expert consulted in connection with your appeal will be provided.

The Claims Administrator's or his or her delegate's decision on your appeal will be final and binding on all affected parties. Neither ODP or the Plan Administrator will review any claims for which claims administration has been delegated to a carrier or other third-party administrator.

External Review of Medical Benefit Denials

If you have filed a claim and appeal with the applicable Claims Administrator for a Medical benefit, and the claim and appeal have been denied in whole or in part, additional external review procedures may apply. These additional procedures only apply to denials of Medical benefits. External review procedures do not apply to Dental, Vision, FSAs, the EAP, or any other benefit. Further, the external review procedures do not apply to any denial, reduction, termination, or failure to provide payment for a benefit based on a determination that a participant or dependent fails to meet the eligibility requirements for Medical coverage.

External appeals only apply to certain types of appeals, listed as follows:

- **Medical Judgment Appeals:** External appeal procedures apply to adverse benefit determinations that involve medical judgments (including those based on medical necessity, appropriateness, healthcare setting, level of care, effectiveness of a benefit or experimental or investigational determinations).
- **Rescissions of Coverage:** External appeal procedures apply to rescissions of coverage and whether a rescission has any effect on a particular benefit at the time of a rescission. (Subject to certain exceptions, a rescission is a retroactive termination of coverage and is discussed in the Medical section.)

Filing an External Appeal Request

If your internal claim for medical benefits is denied and you have properly filed all internal appeals for that benefit claim which are also denied, an additional external appeal procedure may apply. To file a request for an additional external appeal, you must file the request with your medical carrier or your HMO. Contact your HMO or your medical carrier using the number on the back of your medical ID card.

Your external appeal request must be filed within four months after the date you received your denied internal appeal. If there is no corresponding date four months after the date you received your denied internal appeal, then the request must be filed by the first day of the fifth month following the receipt of the denied internal appeal. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.

Procedures after an External Appeal Request is Filed.

Within five business days following the date your request for an external appeal is received, the carrier or other applicable party will complete a preliminary review of the request to determine whether:

- You are or were covered under a Company medical option at the time the item or service was requested or, in the case of a retrospective review, were covered under a Company medical option at the time the health care item or service was provided.
- The external appeal relates to a medical judgment or rescission of coverage.
- The denied appeal does not relate to your failure to meet the requirements for eligibility under the terms of the Yum! Brands medical plan.
- You have exhausted the internal appeal process; and
- You have provided all the information and forms required to process an external appeal.

Within one business day after completing the above preliminary review, your medical carrier or other applicable party will issue a notification in writing. If the request is complete but not eligible for external appeal, such notification must include the reasons for its ineligibility. If the request is not complete, such notification must describe the information or materials needed to make the request complete, and you will have the later of the remaining time within the four-month filing period or 48 hours following the receipt of the notification to perfect your appeal request.

Procedures After Your Request for External Appeal is Approved.

If your appeal request is approved, your medical carrier or other applicable party will assign it to an independent review organization (IRO) to conduct the external appeal. To ensure independence, your medical carrier or other applicable party will randomly assign the appeal request to one of at least three IROs with whom the medical carrier or other applicable party has contracted for such external appeals.

The assigned IRO will timely notify you in writing of your eligibility and acceptance for external appeal. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date you receive the notice additional information that the IRO must consider when conducting the external appeal. The IRO is not required to but may accept and consider additional information submitted after 10 business days. Any additional information the IRO receives from you will be shared with the medical carrier and the applicable plan. Upon receiving this information, the medical carrier or other applicable party may reconsider its prior appeal decision and reverse the prior denial of the internal appeal. If the medical carrier reverses its decision and fully approves the internal appeal, then your claim will be paid accordingly, and the external appeal will be terminated.

If the external appeal is not terminated as noted above, the IRO will review all information and documents related to your denied internal appeal. The IRO is not bound by any decisions or conclusions reached by your medical carrier or other applicable party during the internal claim and appeal process. The IRO must complete its review within 45 days after the IRO receives the request from you for an external appeal. The IRO will deliver a notice of the final external review decision to you and your medical carrier or other applicable party. If the medical carrier and applicable plan receive notice of a final external appeal decision reversing the internal appeal decision, they will provide the applicable coverage or payment for the claim.

Expedited External Appeal Requests.

You may also make an expedited external appeal request to your medical carrier at the time you receive:

- A denied urgent care internal claim if you have also filed at the same time an internal appeal.
- A denied urgent care internal appeal; or
- A denied internal appeal which concerns an admission, availability of care, conducted stay or medical care item or service for which you have received emergency services and have not been discharged from the facility.

Upon receiving the request for expedited external appeal, your medical carrier must determine whether the request meets the reviewability requirements set forth above. Your expedited external appeal request must also relate to a medical judgment or rescission of coverage. If those requirements are satisfied, the medical carrier will immediately send a notice to you. Upon a determination that a request is eligible for expedited external appeal, the IRO will follow the procedures discussed above with respect to standard external appeals, provided that certain procedures will be expedited as follows:

- The medical carrier or other applicable party must provide all documentation with respect to the denied internal claim or appeal immediately to the IRO; and
- The IRO will provide notice of the external appeal decision, as expeditiously as the circumstances require, but in no event more than 72 hours after the IRO receives the request for the expedited external appeal.

Exhaustion of Administrative Remedies

Before filing any claim (as defined below) in court or in another tribunal with respect to any ERISA benefit plan, you must first fully exhaust all of your actual or potential rights under the claims procedures described above by filing an initial claim and then seeking a timely appeal of any denial, including, with respect to a medical claim only, any external appeal that may be available (referred to generally as the exhaustion requirement).

Upon review by any court or other tribunal, the exhaustion requirement is intended to be interpreted to require exhaustion in as many circumstances as possible. Exhaustion shall not be excused for failure to respond to a claim unless the purported claimant took steps that were sufficient to make it reasonably clear to the Plan that the purported claimant was submitting a claim with respect to the Plan. For a purported failure to fulfill a request for documents, exhaustion shall not be excused, unless all the following are true and correct –

- The claimant is lawfully entitled to receive a copy of the requested documents from the Plan Administrator at the time and in the form requested,
- The claimant requests such documents in writing that is addressed to and actually received by the Plan Administrator,
- The Plan Administrator fails to provide the requested documents within six months after the date the request is received or within such longer period as may be reasonable under the facts and circumstances,
- The claimant took steps that were sufficient to make it reasonably clear to the Plan Administrator that the claimant was actually entitled to receive the requested documents, and
- The documents requested and not provided are material to the determination of one or more colorable claims of which the claimant has informed the Plan Administrator.

In any action or consideration of a claim in court or in another tribunal following exhaustion of the Plan's claims procedures, the subsequent action or consideration shall be limited to the maximum extent permissible to the record that was before the Plan Administrator in the claims procedure process.

This exhaustion requirement applies: (1) regardless of whether other claims, assertions, allegations, disputes, issues, actions or other matters (including those that a court might consider at the same time) are of greater significance or relevance; (2) to any rights the Plan Administrator may choose to provide in connection with novel claims or in particular situations; (3) regardless of whether the rights are actual or potential; and (4) even if the Plan Administrator has not previously defined or established specific claims procedures that directly apply to the submission and consideration of a claim (in which case the Plan Administrator, upon notice of the claim, shall either promptly establish such claims procedures or shall apply or act by analogy to the claims procedures that otherwise apply to claims for benefits). The Plan Administrator may make special arrangements to consider a claim on a class basis or to address unusual

conflicts or concerns, and such minimum arrangements in these respects shall be made as necessary to maximize the extent to which exhaustion is required.

For purposes of this exhaustion requirement, a “claim” is any claim, matter, issue, action, allegation, assertion, or other dispute that involves any one or more of the following:

- The interpretation of the Plan.
- The interpretation of any term or condition of the Plan.
- The interpretation of the Plan (or any of its terms or conditions) considering applicable law.
- Whether the Plan or any term or condition under the Plan has been validly adopted or put into effect.
- The administration of the Plan.
- Whether the Plan, in whole or in part, has violated any terms, conditions or requirements of ERISA or other applicable law or regulation, regardless of whether such terms, conditions or requirements are, in whole or in part, incorporated into the terms, conditions or requirements of the Plan.
- A request for Plan benefits or an attempt to recover Plan benefits.
- Whether any entity or individual with respect to the Plan, including the Plan Administrator, the Company or a Claims Administrator has breached any fiduciary duty under ERISA or otherwise.
- Whether any individual or entity is a participant, former participant, Plan beneficiary, former Plan beneficiary or assignee of any of the foregoing; or
- Any claim, matter, issue, action, allegation, assertion, or other dispute that: (i) is deemed similar to any of the above items by the Plan administrator; or (ii) relates to the Plan in any way.

Failure to follow this exhaustion requirement means that any claim, action, or suit filed in court will generally be dismissed.

Limitations on Actions

Any claim or action that is filed in a court or other tribunal against or with respect to the Company, an ERISA plan, any other health, welfare and/or work/life program and/or the Plan Administrators of those plans or programs must be brought within the following time frames:

- For any claim or action relating to health benefits, the claim or action must be brought and filed within 18 months of the later of: (1) the date you are notified that your internal appeal is denied (in whole or in part); or (2) if applicable, the date you are notified that your external appeal is denied (in whole or in part).
- For any claim or action relating to short term disability (STD) benefits, the claim or action must be brought and filed within 18 months from the date you are notified that your internal appeal for disability benefits is denied (in whole or in part).
- For all other claims (including an eligibility or enrollment claim, a claim related to an alleged interference or violation of ERISA-protected rights or any that is characterized as a fiduciary breach), the claim or action must be brought and filed within two years of the earlier of (i) the date when the claimant knows or should know of the actions or events that give rise to the claim or (ii) the date when the benefit was first paid, provided or denied.

For life insurance, Long Term Disability, AD&D benefits, and any other benefits not discussed above, you should review the applicable insurance policy and/or Benefit Summary for further information.

Any claim or action brought after the above time frames will be void.

Any claim or action filed in a court or any other tribunal against or with respect to the Plan or any other health and welfare plan or program sponsored by ODP can only be brought or filed in the United States District Court for the Middle District of Florida. Additional venue restrictions may be contained in the applicable insurance policy for an insured benefit. You should review the applicable insurance policy and/or Benefit Summary for further information.

No Assignment of Rights and Benefits

Your rights and benefits under a medical option are personal to you and your enrolled family members and they cannot be assigned, sold, or transferred (in whole or in part) to any person, including your health care provider. For this purpose, your plan rights and benefits include, without limitation, the right to file an administrative appeal (internal and external), the right to sue following a denied administrative appeal and any other plan rights and benefits, whether actual or potential. Any purported assignments of rights and/or benefits under the Plan will be void and will not apply to the Plan. Further, a payment or reimbursement of covered services by a Claims Administrator to a health care provider will not waive the application of this provision. The application of this provision does not affect your right to appoint an authorized representative.

The provisions in this section –

- Are deemed to be notice to all individuals to whom notice may be required, and no additional notice of the above provisions is needed to anyone, including a health care provider.
- Shall always apply, including before and after health care services are rendered or the health care products are provided (as applicable).
- Are not waivable, in whole or in part, whether voluntarily or involuntarily, by the Plan, the Plan Administrator or a Claims Administrator; and
- May be raised as a defense to a payment or reimbursement at any time, including after the conclusion of the claim and appeal process.

Limited Authorization of Payments and Health Care Provider Agreements

To the extent allowed by the Claims Administrator for your medical option, you may authorize your Claims Administrator to make payments directly to a health care provider for covered services. Further, even without such authorization, a Claims Administrator may make direct payments to a health care provider for covered services according to the Claims Administrator's rules and procedures at the applicable time. Authorization of payments to a health care provider or direct payments to a health care provider are not assignments of benefits. Even though you may authorize a health care provider to receive a payment or reimbursement of covered services and even though a Claims Administrator may pay a health care provider directly for payments or reimbursements of covered services, in no event will any such authorizations, payments or reimbursements to or on behalf of a health care provider cause the provider to become a plan participant or plan beneficiary (or assignee of a participant or beneficiary) under ERISA.

In addition, sometimes your health care provider requests that you sign various agreements and other documentation as a condition of receiving health care services from the provider. Any agreement, assignment or other document executed by you and a health care provider (or executed by parties that include you and a health care provider but that do not include the Plan Administrator or ODP) are not binding on and will have no legal effect whatsoever on any terms, conditions or requirements of the Plan or any Claims Administrator. Further, a payment or reimbursement of covered services by a Claims Administrator to a health care provider (whether pursuant to an authorization or otherwise) will not waive the application of this provision.

The provisions in this section –

- Are deemed to be notice to all individuals to whom notice may be required, and no additional notice of the above provisions is needed for anyone, including a health care provider.
- Shall always apply, including before and after health care services are rendered or the health care products are provided (as applicable).
- Are not waivable, in whole or in part, whether voluntarily or involuntarily, by the Plan, the Plan Administrator or a Claims Administrator; and
- May be raised as a defense to a payment or reimbursement at any time, including after the conclusion of the claim and appeal process.

Authorized Representative Rules

If you need to appoint an authorized representative for purposes of an internal claim or appeal for health and welfare benefits or for purposes of an external appeal for medical benefit claims, you must follow the rules and procedures of the applicable Claims Administrator for such claim or appeal. To the extent a Claims Administrator has no rules or procedures, then the rules and procedures of this section will apply.

If you need to appoint any authorized representative for any purpose other than as listed in the prior paragraph, your appointment of an authorized representative must:

- Be in writing and dated.
- Clearly indicate the authorized representative, the scope of the appointment and any limitations on the authorized representative.
- Be signed by you and must be notarized by a notary public.
- Satisfy any other legal requirement applicable to appointments under state or federal law, AND
- Be approved by the Plan Administrator, or delegate, in writing.

A plan will also recognize a court order appointing a person as your authorized representative. The Plan Administrator may also provide different rules and procedures for an appointment of an authorized representative in emergency situations or for attorneys.

Appointing an individual or entity as your authorized representative is not an assignment of rights or benefits under the Plan and any such appointment (whether pursuant to the rules of a Claims Administrator or the Plan Administrator) does not waive the Plan's anti-assignment provisions.

HIPAA Privacy Notice

The HIPAA privacy rules protect your health information that is created or received by a health plan. The health plans are required to publish a HIPAA Privacy Notice that explains the HIPAA privacy rules. This notice is provided on an annual basis, generally in October within the legal packet offering through *myBenefitsHub*. If you would like a printed copy of the HIPAA Privacy Notice, contact the Benefits Department at BenefitsTeam@theodpcorp.com.

Other Administrative Facts

The chart below shows: (1) the formal name of the Plan; (2) the insurer, Claims Administrator, or record keeper; (3) the Plan number; and (4) the last day of the Plan year.

This Flex SPD, the applicable Benefit Summaries, and the Resource Library on *myBenefitsHub* at ODP.bswift.com are intended to provide a summary of the major provisions of certain benefit plans in which you may be eligible to participate. Your benefits are described as clearly as possible, with minimal use of the technical words and phrases appearing in the legal documents. However, the official documents remain the final authority and, in the event of conflict with this section or the website, the official plan documents will govern in all cases.

Any benefit questions may be addressed to the Benefits Department at BenefitsTeam@theodpcorp.com.

Type of Benefit/Service Provider	Claims Administrator and Insurer
Plan: ODP International Welfare Benefits Program Plan Number 501 End of Plan Year: December 31 st	
Benefits Administrator	bswift 10 S. Riverside Plaza, Suite 1100 Chicago, IL 60606
Medical	UMR, Inc. Claims Administration PO Box 30541 Salt Lake City, UT 84130 Kaiser California Claims Administration Department P.O. Box 7004, Downey, California 90242-7004 Phone: (800) 464-4000 HMSA Hawaii Claims Administrator P.O. Box 860, Honolulu, HI 96808-0860 Phone: (800) 766-4672
Prescription Drugs	RxBenefits P.O. Box 382377, Birmingham, AL 35238-2377 Phone: (800) 334-8134 <u>Claims:</u> P.O. Box 382377, Birmingham, AL 35238-2377 Phone: (855) 649-3641 Mail Order Inquiries: (800) 334-8134 Email: CustomerCare@rxbenefits.com <u>Appeals:</u> P.O. Box 382377 3641 Birmingham, AL 35238-2377 (800) 334-8134

Type of Benefit/Service Provider	Claims Administrator and Insurer
Dental	Delta Dental Insurance 1130 Sanctuary Parkway, Suite 600, Alpharetta, GA 30009 Phone: (800) 521-2651 <u>Claims:</u> Delta Dental Insurance P.O. Box 1809, Alpharetta, GA 30023 <u>Appeals:</u> Delta Dental Insurance P.O. Box 1860, Alpharetta, GA 30023
Vision	VSP Vision P.O. Box 997105, Sacramento, CA 95899-7105 Phone: (800) 877-7195 <u>Claims:</u> Vision Service Plan Attention: Claims Services P.O. Box 495918, Cincinnati, OH 45249-5918
COBRA Administrator	bswift COBRA Service Center 10 S. Riverside Plaza, Suite 1100, Chicago, IL 60606 Phone: (866) 365-2413
Employee Assistance Program	Magellan Healthcare PO Box 2185, Maryland Heights, MO 63043 Phone: (800) 789-2273
Health Care Flexible Spending Account	Inspira Financial (formerly PayFlex) P.O. Box 8396, Omaha, NE 68108 Phone: (855) 516-8593
Leave of Absence Administrator	Voya Financial P.O. Box 9757, Portland, ME 04104-9757 Phone: (888) 973-3652 Fax: (888) 305-0605
Short-term Disability Short-term Disability Buy-up	Voya Financial P.O. Box 9757, Portland, ME 04104-9757 Phone: (888) 973-3652 Fax: (888) 305-0605
Long Term Disability	Voya Financial P.O. Box 9757, Portland, ME 04104-9757 Phone: (888) 973-3652 Fax: (888) 305-0605
Life Insurance / Accidental Death & Dismemberment	Voya Life Claims P.O. Box 1548 Minneapolis, MN 55440 (888) 238-4840

Type of Benefit/Service Provider	Claims Administrator and Insurer
Voluntary Benefits - Accident - Critical Illness - Hospital Confinement	The Hartford P.O. Box 99906, Grapevine, TX 76099 Phone: (844) 473-7527 Fax: (469) 417-1952
Non-ERISA Plans	
Dependent Care Flexible Spending Account	Inspira Financial (formerly PayFlex) P.O. Box 8396 Omaha, NE 68108 Phone: (855) 516-8593
Health Savings Accounts	Inspira Financial (formerly PayFlex) P.O. Box 8396, Omaha, NE 68108 Phone: (855) 516-8593
Voluntary Benefits - Group Auto/Home - Pet Insurance - Legal Services - ID Theft Protection - Win Fertility Discount	Arthur J. Gallagher & Co. The Gallagher Centre 2 Pierce Place, Itasca, IL 60143 Phone: (800) 873-4636

Plan Termination and Amendment

ODP reserves the right to discontinue or terminate any plan or program, to modify the plans or programs to provide different cost-sharing between ODP and participants, or to reduce, amend or modify the plans or programs, in any respect. This may be done at any time and without advance notice. Any such action may be taken by ODP and any officer of ODP who has the authority or who has been delegated the authority to take such action.

Benefits for claims occurring after the effective date of a plan amendment or termination are payable in accordance with the terms of the plan as modified by the amendment or termination.

All statements in this Flex SPD, the applicable Benefit Summaries or on the Benefits SharePoint website and all representations by ODP or its personnel are subject to this right of termination and amendment. This right applies without limitation, even after an individual's circumstances have changed by retirement, disability or otherwise.

No Guarantee of Employment

Nothing in this Flex SPD, the applicable Benefit Summaries or on the Benefits SharePoint website may or can be construed or interpreted as a guarantee of future employment with ODP or continued employment for any duration.

General Provisions

Your ERISA Rights

As a participant in the ODP International Welfare Benefits Program (the “Plan”), you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all Plan participants are entitled to:

Right to Receive Information About Your Plan

Examine, without charge, at the Plan Administrator’s office and at other specified locations such as websites, all Plan documents, including insurance contracts, collective bargaining agreements, if any, and copies of all documents filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, such as detailed annual reports (Form 5500 Series) and Plan descriptions.

Obtain, upon written request to the Benefits Department, copies of all Plan documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated SPD. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan’s annual financial report. If the Plan covered 100 or more participants at the beginning of the year, the Benefits Department is required by law to furnish each participant with a copy of the Summary Annual Report (SAR).

Continue Group Health Plan Coverage

You have a right to continue health care coverage for yourself, your covered spouse, and your covered dependent children if there is a loss of coverage under the Plan because of a qualifying event. You, your covered spouse, or your covered dependent children are required to pay for such coverage. Review this Flex SPD and the applicable Benefit Summaries on the rules and eligibility of COBRA continuation rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people responsible for the operation of the Plan. The people who operate the Plan, called “fiduciaries” of the Plan, have a duty to do so prudently in the interest of you, other Plan participants, and beneficiaries. No one, including your employer 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 example, if you request materials from the Plan and do not receive them within thirty (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 per 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 that is denied or ignored, in whole or part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, if applicable, you may file suit in federal court. However, in no event will you be allowed to file suit in state or Federal court until you have exhausted the administrative remedies available under the Plan, including following the appropriate claims

procedure as described above. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court.

If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from 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 the costs and fees. If you lose, the court may order you to pay the costs and fees (e.g., if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Benefits Department. If you have any questions about this statement, or about your rights under ERISA, or if you need assistance in obtaining documents from the Benefits Department, 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, D.C. 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.

Contact and Website Information (as of January 1, 2025)

Resource	Carrier	Phone	Website
Benefits Enrollment	bswift		https://odp.bswift.com
Medical (UMR)	UMR (UnitedHealthcare)	800-207-3172	https://www.umar.com
- Ongoing Condition Care	UMR	844-604-6246	https://www.umar.com
- Maternity Care	UMR	844-604-6244	https://www.umar.com
- Specialist Care	UMR	833-792-0501	https://www.umar.com
- Diabetes Management	Livongo	800-945-4355	Join.livongo.com/odp/register
- Virtual Health	Teladoc	800-835-2362	Teladoc.com
Medical – HMSA	HMSA HI	800-776-4672	Hmsa.com
Medical – KAISER	Kaiser CA	800-464-4000	Kp.com
Prescription Drugs (UMR plans)	RxBenefits	800-334-8134	Email: Customercare@Rxbenefits.com
Dental	Delta Dental	800-521-2651	deltadentalins.com
Vision	VSP	800-877-7195	vsp.com
FSA, HSA, Commuter	Inspira Financial	844-729-3539	https://inspirafinancial.com
Basic Life / Basic AD&D	Voya	888-238-4840	https://presents.voya.com/EBRC/ODP
Disability (Long-Term, Short-Term, Short-Term Buy-up, State Disability for NY, NJ, HI)	Voya	888-973-3652	https://presents.voya.com/EBRC/ODP
Voluntary Supplemental Benefits (Accident, Critical Illness, Hospital)	The Hartford	866-547-4205	myhealthhub.app/thehartford
Employee Assistance Program	Magellan Healthcare	800-789-2273	Member.MagellanHealthcare.com Company Search: The ODP Corp
Legal Services/ID Theft Protection	LegalShield	888-807-0407	benefits.legalshield.com/ODP
Leaves of Absence	Voya	888-973-3652	https://presents.voya.com/ebrc/odp
Direct Billing (while on LOA)	bswift	866-365-2413	https://odp.bswift.com
Voluntary Work/Life Benefits • Auto/Home Insurance • Pet Insurance • WINFertility Discount	• Travelers (Auto/Home) • Farmers (Auto/Home) • Liberty Mutual (Auto/Home) • Nationwide Pet Insurance • WINFertility Discount	888-695-4646 855-893-2803 800-290-3584 877-738-7874 855-705-4483	• Provide the Discount Code: 2444 • Provide the Discount Code: BBT • Provide the Client Code: 124804 • Benefits.petinsurance.com/odp • Winfertility.com
COBRA Continuation Coverage	bswift	866-365-2413	https://odp.bswift.com
ODP Benefits Team			BenefitsTeam@theodpcorp.com
401(k) Service Center	Fidelity Investments	888-954-4636	Netbenefits.com/odp

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) allow you to set aside tax-free dollars from your paycheck to pay for eligible healthcare and dependent care expenses -- which means that you keep more money in your pocket.

ODP offers eligible associates two types of FSAs:

- The Healthcare FSA
- The Dependent Care FSA

The FSAs are designed to help you save on certain eligible healthcare and dependent care expenses and allow you to set aside a portion of your pay each month. The amount that you set aside is credited to the applicable account (e.g., Healthcare FSA or Dependent Care FSA). You can then use this money during the year to reimburse yourself for qualified healthcare and dependent care expenses. Your taxable pay is reduced by the amount you set aside in your account(s), which reduces your federal income taxes, most state and local income taxes, and your Social Security (FICA) taxes (if you earn less than the Social Security wage base).

Because you do not have to pay taxes on the money you set aside, the Internal Revenue Service (IRS) requires that you forfeit any money that you do not use for the year in which you participate. This is known as the “use it or lose it” rule. Keep this in mind when you decide how much to contribute.

You can participate in one or both accounts. You decide whether you’d like to participate and how much money you’d like to set aside in each account each year.

FSA Type	Examples of What You Can Use it for	How Much You Can Set Aside in an FSA	Annual Submission Deadline*
Healthcare	• Deductibles and co-pays • Eligible expenses not covered by medical, dental or vision coverage • Orthodontia • Prescription drugs • Chiropractic visits • Saline solution/contact lens cleaners • Doctor prescribed weight loss programs (excluding food) prescribed by a physician for a specific health condition	The amount is subject to change each year by the IRS. Refer to the Benefits Guide or myBenefitsHub for the current Plan Year’s amounts. These funds can be used by you and your eligible dependents.	Filing deadline to submit expenses incurred during the Plan Year is March 31 of the following year. Pursuant to IRS regulations (the “use it or lose it” rule), you will forfeit any money for any expenses not submitted timely.
Dependent Care	• Services provided by most babysitters or caregivers • Expenses for a housekeeper whose services include care of an eligible dependent • Services provided by a licensed elder care or childcare center, day camp or nursery school	The amount is subject to change each year by the IRS. Refer to the Benefits Guide or myBenefitsHub for the current Plan Year’s amounts.	Filing deadline to submit expenses incurred during the Plan Year is March 31 of the following year. Pursuant to IRS regulations (the “use it or lose it” rule), you will forfeit any money for any expenses not submitted timely.

General Information

If you meet the eligibility requirements, you may enroll in the FSAs.

If both you and your eligible spouse are ODP associates eligible to participate in the FSAs, each of you may elect to contribute to the Healthcare FSA and/or the Dependent Care FSA. Certain annual limits may apply (refer to the Healthcare FSA and Dependent Care FSA sections for annual contribution limitations).

You cannot elect a Healthcare FSA if you are enrolled in the Protection HSA or Protection HSA2 medical options.

You cannot obtain reimbursement for the expenses of your domestic partner or his/her eligible dependents unless they are your tax dependents.

Your Contributions

When you enroll in an FSA, you authorize the deduction of the contributions you elected to contribute to the Healthcare and/or Dependent Care FSA(s) from your paycheck on a pre-tax basis.

Your FSA elections are binding for the Plan Year for which the elections were made unless a Qualified Change in Status event occurs during the Plan Year (refer to *Changing Your Elections during the Year* for further information). IRS regulations require the FSAs to satisfy non-discrimination standards, which are intended to limit benefits to highly compensated associates. To satisfy these tests, it may be necessary to limit the contributions or benefits available to highly compensated associates. If any such limitation occurs and you are a highly compensated associate who is affected, you will be notified.

If you experience a Qualified Change in Status event, you may not reduce your contribution election below an amount that will result in your total contributions for the Plan Year being less than the total amount of reimbursements you will receive for claims incurred in the same Plan Year prior to the date of the change. If you experience a Qualified Change in Status event and increase your contribution election, the increased contribution amount can only be used to reimburse eligible expenses incurred on or after the date of the Qualified Change in Status event.

“Pre-tax” means that your contribution is taken from your paycheck before federal and Social Security (FICA) taxes (and, in most cases, state and local taxes) are deducted. This reduces your taxable income (your gross pay minus contributions), so you pay less in taxes. Because the contributions to the FSAs are pre-tax, the IRS limits the instances when you may change your contributions to those that are considered Qualified Change in Status events (refer to *Changing Your Elections during the Year* for further information).

“Use it or Lose It-- Choose Your Benefits Carefully!

An FSA is a great way to pay for certain healthcare and dependent care expenses AND save money. However, the FSAs have a “use it or lose it” rule. If you do not submit claims for all the money that you contribute to your FSA for a Plan Year for claims incurred during the Plan Year (and submitted before March 31 of the following year), your remaining funds are forfeited. Be sure to estimate your expenses carefully AND submit your claims by the deadline.

Also, once your enrollment deadline passes, you cannot change your elections until the next Annual Enrollment period unless you have a Qualified Change in Status event (refer to *Changing your Elections During the Year* for further information). Generally, any change that you make must be consistent with, or on account of, your Qualified Change in Status event.

If you experience a Qualified Change in Status event, it is your responsibility to provide proper and timely notification by making your change in *myBenefitsHub* at [ODP.bswift.com](https://odp.bswift.com) within 31 days after the event date; otherwise, you will have to wait until the next Annual Enrollment period to make a change.

FSA Changes You May Be Able to Make When You Report a Qualified Change in Status

The following chart highlights events that may allow you to change coverage under the FSAs, provided you submit the Qualified Change in Status event within 31 days following the event.

The following chart does not include a complete list of allowed Qualified Change in Status events. There are other events that may qualify. If you have questions, contact the BenefitsTeam@theodpcorp.com.

Summary of Qualified Change in Status Events and Your Options		
Event	Type of FSA Account	Changes You May Be Able to Make
Change in Legal Marital Status (Marriage, legal separation, divorce, or annulment)	Healthcare FSA and/or Dependent Care FSA	Start, increase, decrease or stop contributions
Birth, Adoption, or Placement for Adoption	Healthcare FSA and/or Dependent Care FSA	Start, increase, decrease or stop contributions
Loss of Eligible Dependent Status	Healthcare FSA and/or Dependent Care FSA	Decrease or stop contributions
Gain of Eligible Dependent Status	Healthcare FSA and/or Dependent Care FSA	Start or increase contributions
Death of Spouse	Healthcare FSA and/or Dependent Care FSA	Start, increase, decrease or stop contributions
Death of a Dependent	Healthcare FSA and/or Dependent Care FSA	Decrease or stop contributions
Qualified Medical Child Support Order (QMCSO)	Healthcare FSA	Start, increase, decrease or stop contributions
	Dependent Care FSA	No changes allowed
Qualify for Medicare	Healthcare FSA	Decrease or stop contributions
	Dependent Care FSA	No changes allowed
Change in Employment Status (of Associate, Spouse or Dependent Child)	Healthcare FSA and/or Dependent Care FSA	Start, increase, decrease or stop contributions
Change in your Dependent Care Provider / Change in the cost of your Dependent Care / Change in amount of Dependent Care services	Dependent Care FSA	Increase or decrease contributions, as applicable

Note: All election changes made because of a Qualified Change in Status must be consistent with, and due to, the Qualified Change in Status event.

If You Separate from Employment during the Year

If you separate from employment, voluntarily or involuntarily, your FSA contributions will stop.

- You may file claims against your Healthcare FSA account, if the expenses were incurred before your separation from employment date.

- You may file claims incurred for the remainder of the current year against your Dependent Care FSA up to the amount available in your account on your separation from employment date.

Important Notes:

- Your deadline to submit eligible claims is until March 31 of the year following the Plan Year in which you incurred the eligible expense(s).
- Under certain circumstances, you can continue your Healthcare FSA through the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA).

Leaves of Absence

If you are on an approved leave of absence, the following applies:

Healthcare FSA

- You may make after-tax contributions to your Healthcare FSA by paying your direct billing invoices received from the bswift Direct Billing Service Center. If you do not continue to make these contributions, participation will terminate on the date that the last contributions were made.
- You may only receive reimbursements for services incurred during periods when contributions were made to the account. If participation is terminated for non-payment, claims incurred after the termination of your participation in the Healthcare FSA would not be eligible for reimbursement under your Healthcare FSA.
- Subject to certain exceptions, if you return to active employment during the same Plan Year, your Healthcare FSA payroll deduction amounts can be reinstated and amended to make up the missed contributions to claim expenses that were incurred during your leave, up to the amount of your original election for that Plan Year. For assistance, contact BenefitsTeam@theodpcorp.com within 31 days of your return to active work.
- If you return to active employment in a subsequent Plan Year, you may elect to participate in the Healthcare FSA for the remainder of that Plan Year. You must enroll within 31 days of your return to active work.
- If your leave is covered by the Family and Medical Leave Act of 1993 (FMLA) or covered under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), you have a right to discontinue participation in the Healthcare FSA when your leave begins. If this is the case, you cannot file claims for an eligible expense incurred after the date you cease participation.
- Upon your return to active employment from FMLA or USERRA leave, you may resume coverage of the Healthcare FSA at the level in effect immediately prior to the leave. The total annual election amount, less your previous contributions, will be recalculated based on the number of paychecks remaining in the calendar year.

Dependent Care FSA

- Your contributions to the Dependent Care FSA will terminate because of going on a leave of absence. You are not allowed to make after-tax contributions to your Dependent Care FSA.
- You may continue to submit claims for eligible expenses incurred during the Plan Year.
- The amount of the reimbursements will be subject to the available balance in your account.
- If you return to active employment within the same Plan Year, you may choose to re-enroll in the Dependent Care FSA when your enrollment window is reopened on *myBenefitsHub* upon your return from leave (a Qualified Change in Status event). This enrollment must be done within the 31 days after returning from leave.

When Healthcare FSA Benefits End

You can submit claims for eligible expenses incurred before the date your participation ended.

Under certain circumstances, you, your spouse, or your eligible dependents may be eligible to participate and continue making contributions to the Healthcare FSA when participation terminates. If you elect to continue your coverage under COBRA, any contributions for continuation coverage are made on an after-

tax basis. As a result, the pre-tax advantage of contributing into the Healthcare FSA is lost. However, if you do not use your entire account balance by the time your employment ends, the only way you can continue submitting receipts for expenses incurred after your employment ends is to continue Healthcare FSA coverage under COBRA through the end of the plan year in which the qualifying event occurred, as described in the COBRA section of this Flex SPD.

When Dependent Care FSA Benefits End

You can submit claims for expenses that were incurred before the date your participation ended, up to the amount that remains in your Dependent Care FSA. COBRA does not apply to the Dependent Care FSA.

How the FSAs Work

Participation is voluntary. If you choose to enroll, you can contribute pre-tax dollars from your paychecks each year into a Healthcare FSA and/or Dependent Care FSA to pay for eligible out-of-pocket healthcare or dependent care expenses not paid by insurance or reimbursed from any other source. You have the option to make a pre-tax annual election amount when you are first eligible to participate, and during the Annual Enrollment period each year. The amount you elect is based on your best estimate of what your family's healthcare and dependent care needs will be for that year. The amount you elect is:

- Divided equally over the number of remaining pay periods in the year; and
- Deducted from your paycheck before taxes are taken out, and
- Deposited in your applicable FSA(s).

Knowing How Much Is in Your Account(s)

A Confirmation Statement of your elections is available in myBenefitsHub at ODP.bswift.com after you enroll showing the amount(s) you have elected to contribute to each FSA for that Plan year.

You may access detailed information about your FSA(s), including the amounts deposited, the current balance and any claims history, by logging onto your Inspira Financial member website at inspirafinancial.com.

Expenses Must Be Incurred During the Current Plan Year

Any expenses submitted for reimbursement from either the Healthcare FSA or Dependent Care FSA must be incurred during the current Plan Year and while you are enrolled in the applicable FSA. For example, the Plan Year begins on January 1, but if your enrollment is effective on April 1, you may not submit claims for January through March. As another example, if you terminate coverage in an FSA on July 1 because of a Qualified Change in Status event, expenses incurred after July 1 are not eligible for reimbursement.

The Risk of Participating in an FSA

If you do not submit claims for all the money that you contribute to your FSA for a Plan Year for claims incurred by the end of that Plan Year (and submitted before March 31 of the following year), your remaining funds are forfeited. This rule is commonly known as the *"Use It or Lose It"* rule.

Any money that you contribute to the Dependent Care FSA will be reported on your W-2 tax form. You will be required to report the name, address, and tax identification number (or Social Security number) of your dependent care provider on your income tax forms, unless the provider is a tax-exempt entity.

The Healthcare FSA

You may set aside pre-tax dollars up to the IRS annual limit to be credited to your Healthcare FSA to reimburse yourself for eligible medical, dental, vision and prescription drug expenses not covered by insurance or reimbursed under any other source. However, you cannot use the account for healthcare premiums, or expenses for care that are cosmetic in nature or are not medically necessary (refer to *Eligible Healthcare FSA Expenses* and *Ineligible Healthcare FSA Expenses*). Note: the annual maximum limit is subject to change each year by the IRS.

Inspira Financial Debit Card

You may enroll in the Healthcare FSA if you are enrolled in the Traditional PPO medical option, or if you choose to waive medical coverage. If you elect to participate in the Healthcare FSA, you will receive an Inspira Financial Debit Card (“Debit Card”) directly from the FSA Administrator. As you incur eligible healthcare expenses, you present your Debit Card for payment. If you are purchasing services or items from a healthcare-related merchant or one that has implemented an inventory information approval system, your transaction will be automatically validated at the point of sale. If you purchase a prescription drug along with non-qualifying items, be sure to ask the merchant to ring up the prescription separately so that you can use the card. The card is valid for a multi-year period and will contain information regarding your current Plan Year election. Each year when you re-enroll, the card will reflect that Plan Year’s election amount(s).

When you use the Debit Card, the expense will be automatically withdrawn from your Healthcare FSA account. You may use your Debit Card for eligible healthcare expenses – up to the total amount you elected to contribute for the year, minus the amount for any expenses already reimbursed through your Healthcare FSA. The Debit Card’s balance must be enough to cover the entire amount being purchased.

Although the Debit Card minimizes the need for paperwork when using it for an eligible healthcare expense, in some instances, Inspira Financial may require further documentation to validate a purchase. The IRS requires that certain transactions be confirmed in writing after-the-fact, even if the transaction is approved at the point of sale. Therefore, you should always retain documentation of your expenses with the card that includes an itemized receipt listing the merchant’s name, name of the item/product, date of purchase and amount. If your transaction is one that the IRS requires written substantiation, you will be notified by Inspira Financial. If you do not provide the requested documentation to Inspira Financial in a timely manner, Inspira Financial may take certain correction procedures, including, but not limited to, offsetting proper claims against the claims for which you failed to submit documentation, and deactivating the card. It is also possible that your wages will be reduced by the amount of the improper claims. As a last resort, ODP may be required to treat the claims for which you are unable to provide documentation as taxable income.

Eligible Dependents

You can use your Healthcare FSA to reimburse yourself for healthcare expenses that are considered “medical care” under section 213(d) of the Internal Revenue Code, to the extent that the expenses are not covered by insurance or reimbursed by any other source and are incurred during the applicable Plan Year. The expenses must be for your healthcare or the healthcare of your eligible federal income tax dependents.

An eligible dependent for the Healthcare FSA includes:

- Your legal spouse
- Your child (by birth or adoption), stepchild and foster child who as of the end of the taxable year has not attained age 27
- Any other person for whom you can claim as a federal tax dependent

In no event will your domestic partner (or your partner’s children) be an eligible dependent for purposes of the Healthcare FSA unless he or she is your dependent for federal income tax purposes.

Tax rules change, so you should check with your tax advisor about the eligibility of specific expenses. You can get additional information about healthcare expenses that may qualify from the IRS *Publication 502, "Medical and Dental Expenses"* which is available from your local IRS office and on the IRS website in the forms and publications section at www.irs.gov. There is also a listing on the FSA Administrator's website.

Eligible Healthcare FSA Expenses

You can use your Healthcare FSA to reimburse yourself for healthcare expenses that are considered "medical care" under section 213(d) of the Internal Revenue Code, to the extent that the expenses are not covered by insurance or reimbursed by any other source and are incurred during the applicable Plan Year. You cannot receive reimbursement for expenses that were paid by an insurance company or other source. This is true whether the payments were made directly to you, to the patient, or directly to the provider.

Eligible Healthcare FSA Expenses

- For a current listing of eligible Healthcare FSA expenses, go to FSAstore.com. For a final determination on eligible expenses, contact the FSA Administrator directly.

Ineligible Healthcare FSA Expenses

The below items or services are generally not eligible for reimbursement through your Healthcare FSA:

- Expenses for which you have already been reimbursed by other healthcare plans (including Medicare, Medicaid, and ODP or any other medical, dental and vision plans)
- Expenses incurred by anyone other than you or your qualified dependents
- Expenses that would not be deductible on your federal income tax return
- Expenses incurred before you start participating in the Healthcare FSA
- Expenses incurred after you stop making contributions to the Healthcare FSA
- Babysitting, childcare and nursing services for a normal, healthy baby. This includes the cost of a licensed practical nurse (L.P.N.) to care for a normal and healthy newborn.
- Controlled substances (e.g., marijuana, laetrile, etc.), in violation of federal law, even if they are legal in a particular state.
- Cosmetic dental work
- Cosmetic surgery (any procedure to improve the patient's appearance that does not meaningfully promote the proper function of the body, or prevent or treat illness or disease)
- Custodial care in an institution
- Diaper service
- Electrolysis
- Funeral and burial expenses
- Healthcare plan contributions or premiums, including those for Medicare, your spouse's employer's plan, any other private coverage, and COBRA
- Health club dues unless prescribed by a physician for a specific health condition
- Household help, even if such help is recommended by a physician
- Illegal medical services or supplies
- Medical savings account (MSA) or health savings account (HSA) contributions
- Nutritional supplements, unless prescribed by a physician for a medical condition
- Personal use items, unless it is used primarily to prevent or alleviate a physical or mental defect or illness
- Prescription drugs for cosmetic purposes
- Weight loss programs unless prescribed by a physician for a specific health condition
- Special schooling for a child, even if they may benefit from the course of study or disciplinary methods
- Transportation to and from work, even if a physical condition requires special means of transportation
- Upfront patient administration or access fees paid to a physician's practice that is not for medical care
- Vitamins or minerals taken for general health purposes

For a final determination on eligible expenses, contact the FSA Administrator directly.

The Dependent Care FSA

You may set aside from \$100 to \$5,000 each Plan Year to reimburse yourself for eligible dependent care expenses so that you – and your spouse if you're married – can work outside the home or attend school full-time. The amount you choose to set aside may differ based on your tax status and/or family situation (refer to the chart below for scenarios).

You can use the Dependent Care FSA to pay for the care of certain qualifying individuals so that you, or if you are married, you and your spouse can work. A qualifying individual is:

- A qualifying child (as defined below) younger than age 13 who has the same principal residence as you for more than one-half of the year
- Your disabled spouse who has the same principal residence as you for more than one-half of the year; or
- A disabled dependent (as defined below) who has the same principal residence as you for more than one-half of the year.

A qualifying child is your child (including stepchildren, adopted children and certain foster children) or your sister or brother (including stepsisters and brothers) and who have not provided over one-half of their own support for the year. A disabled dependent is someone (such as a disabled parent) you claim on your income tax return as your dependent. If you are divorced or separated and have custody of a qualifying or disabled child, you may use the Dependent Care FSA even if you have agreed to let your spouse claim the child as a dependent for income tax purposes. Your domestic partner and/or his or her dependent child will be considered eligible dependents only if they qualify as your dependent for federal income tax purposes.

Under IRS rules, to be reimbursed through your Dependent Care FSA, dependent care must be provided by a person with a Social Security number, by a dependent care facility with a Taxpayer Identification number or by a tax-exempt entity. Dependent care provided by any individual who you or your spouse claims as a dependent on your tax return cannot be reimbursed through your Dependent Care FSA. This includes dependent care services provided by your children or stepchildren under age 19.

Dependent Care FSA	
Your Family Situation	What You Can Set Aside
If you are single or married, filing jointly	You can set aside up to \$5,000
If you are married, filing jointly and your spouse's employer offers a dependent care account	You and your spouse may each have an account. Together you may set aside up to \$5,000 total in the two accounts
If you are married and filing separate tax returns	You and your spouse may each set aside up to \$2,500
If you and your spouse are both working, but one of you earns less than \$5,000 a year	You may only set aside as much as the spouse with the lower income earns
If your spouse does not work because of a disability or is a full-time student for at least five months during the year	You may set aside up to \$250 per month if you have one eligible Dependent child or up to \$500 per month if you have two or more eligible Dependent children – multiplied by the number of months your spouse is disabled or a full-time student.
If you are unmarried and working and you earn less than \$5,000 a year	You may only set aside as much as you earn

Eligible Dependent Care FSA Expenses

To be considered a reimbursable expense under the Dependent Care FSA, the purpose of care must be for the well-being and care of the eligible dependent, to allow the FSA participant (and, if married, the participant's spouse) to be gainfully employed (including self-employment) or actively looking for work. If married, both spouses must be actively employed (including self-employment), or if one spouse is actively employed the other spouse must be a full-time student or incapable of self-care.

Generally, you can pay the following work-related expenses through your Dependent Care FSA:

- Wages paid to a babysitter or other caregiver if he or she is not a disqualified person, as defined below in the Ineligible Dependent Care FSA Expenses. Care can be provided in or outside of your home.
- Services of a dependent care center (such as a day care center or nursery school) if the facility:
 - Provides care for more than six individuals (other than those who reside there).
 - Receives a fee, payment or grant for providing its services, and
 - Complies with all applicable state and local laws and regulations
- Cost for adult care at facilities away from home, such as family day care centers, if your dependent spends at least eight hours at home
- Wages paid to a housekeeper for providing care to an eligible dependent. Household services, including the cost to perform ordinary services needed to run your home which are at least partly for the care of a qualifying individual, are covered if the person providing the services is not your Dependent under age 19 or anyone you or your spouse claim as a dependent for federal tax purposes
- Application fees, agency fees and non-forfeited deposits that relate to care but are not directly for the care of a qualifying individual. To qualify you must be required to pay the application or agency fee and reimbursements from your Dependent Care FSA may only be made after the care begins.

You can get additional information about eligible dependent care expenses from IRS Publication 503, "Child and Dependent Care Expenses," which is available from your local IRS office and on the IRS website in the forms and publications section at www.irs.gov.

For a final determination on eligible expenses, you should contact the FSA Administrator directly.

Ineligible Dependent Care FSA Expenses

The following are not eligible for reimbursement under the Dependent Care FSA:

- Dependent care provided by a disqualified person, including your child, stepchild, adopted child or foster child that is younger than age 19, even if not claimed as a dependent on your Federal tax return, any other person that you have claimed as a dependent on your Federal tax return for the taxable year, your spouse, and the parent of the qualifying individual.
- Expenses incurred before you began contributing to the account
- Expenses for the child of a domestic partner who does not qualify as your federal tax dependent.
- Expenses for dependent care when you or your spouse are not working
- Transportation expenses to or from the dependent care location, unless provided by the daycare provider
- Child support payments
- Tuition expenses
- Education expenses for kindergarten and above
- All overnight camp expenses
- Food, clothing, and entertainment
- Cleaning and cooking services not provided by the care provider
- Amounts you claim as a dependent care tax credit
- Dependent care expenses for a dependent age 13 or above

In addition, you cannot use your Dependent Care FSA to reimburse yourself for services that:

- Allow you to participate in leisure-time activities

- Allow you to attend school part-time
- Enable you to attend educational programs, meetings, or seminars
- Are primarily medical in nature (such as in-house nursing care)

Important Rules About FSAs

The federal regulations governing Section 125 of the Internal Revenue Code include specific rules that apply to FSAs:

Advance Enrollment

You must decide how much to contribute based on your best estimate of the eligible expenses you and your family will incur during the applicable Plan Year. Once you enroll in an FSA, you will not be able to change your contributions unless you have a Qualified Change in Status that allows an FSA change.

“Use It or Lose It”

Under this IRS rule, if you do not submit claims for all the money that you contribute to your FSA for a Plan Year for claims incurred during the Plan Year (and submitted before March 31 of the following year), your remaining funds are forfeited. You cannot convert this money to cash or roll it over to the next Plan Year.

Uniform Reimbursement Requirement

This rule applies to the Healthcare FSA only and is one of the most attractive features of the Healthcare FSA. Once you have made your initial contribution to the Healthcare FSA, the FSA will reimburse you for the total amount that you have elected for the Plan Year regardless of the actual balance in your account. For example, if you elect \$1,200 for the year, two months into the Plan Year you would have contributed \$200; however, if you submit an eligible expense for \$400, you will be reimbursed \$400. Your Healthcare FSA will then show a negative balance which you will pay back each pay period with your payroll contributions to your FSA. You may be reimbursed up to your full annual election amount even though you have not yet made sufficient contributions to cover the eligible expense.

This rule does not apply to the Dependent Care FSA. For the Dependent Care FSA, you will only be reimbursed up to the amount in your Dependent Care FSA. Any reimbursement requested beyond your current balance will not be paid until further contributions are received.

Enrollment

Your enrollment is for one Plan Year only. Each year during Annual Enrollment, you must re-enroll to continue participating in an FSA.

No Commingled Accounts

Your Healthcare and Dependent Care FSAs are separate accounts. You cannot use funds from your Healthcare FSA to pay for dependent care expenses and vice versa. Further, funds cannot be transferred between the Healthcare FSA and the Dependent Care FSA.

Dependent Care Tax Credit

The federal government offers a dependent care tax credit for your dependent care expenses - and you can't get the tax benefit of both the Dependent Care FSA and the dependent care tax credit for the same expenses. Think about what works best for you - the Dependent Care FSA or the dependent care tax credit provided by federal law. You cannot take the tax credit for any amounts that are reimbursed through the Dependent Care FSA. In some cases, the tax credit may provide more savings than the Dependent Care FSA. Consult your legal or tax advisor before deciding which option is best for you.

Health Savings Account (HSA)

An HSA is for qualified health expenses, and lets you take more control of your health care. You use the HSA to pay for qualified health expenses, or you can save the funds for future expenses. You decide when you use your funds, what expenses you pay with your funds, and you may also invest the funds.

HSAs are portable, which means you keep your HSA, even if you change employers or stop working. There is no “use it or lose it” rule. If you don’t use the funds, they remain in your HSA each year and continue to earn tax-free interest.

To be eligible for the HSA, in addition to enrolling in either the HSA or HSA 2 medical plan, you cannot be enrolled in any other medical coverage (including your spouse’s plan) that is **NOT** a high deductible health plan. (You may, however, have certain limited or supplemental coverage while maintaining HSA eligibility.) It is also important to note that you cannot contribute money into an HSA once you are enrolled in Medicare or if you (or in certain situations, another family member) have a Health Care FSA.

Associate Pre-Tax Contributions

You may make pre-tax contributions into the HSA up to the IRS annual maximum limit. These maximum limits are subject to change each year by the IRS. The limits are set forth in each year’s annual enrollment guide. In addition, associates reaching age 55 or older anytime during the applicable Plan Year may make an additional catch-up contribution for up to \$1,000.

Opening your Health Savings Account

When you enroll in an HSA during the enrollment process, your HSA remains in a “pending” status until your information is verified and passes the Customer Identification Process (CIP). The CIP process confirms your full name, address, date of birth and social security number. If the CIP process fails, you will be notified by the HSA Administrator and must contact them to provide the requested information. Failure to respond after three (3) attempts will result in the account being closed, and any contributions taken from your paychecks will be refunded.

Employer Matching Contributions

If you are receiving the Wellness Credit, you are eligible for employer matching contributions into your HSA, dollar for dollar, up to set limits. The employer matching limits are based on your coverage tier and your medical plan. The current IRS contribution limits and the employer matching limits are available in the Benefits Guide, which can be accessed in the bswift Resource Library or on the Benefits SharePoint website. The IRS annual limits are subject to change each year.

When you enroll in the HSA, the *myBenefitsHub* site is programmed with your annual maximum limit based on your medical plan tier and whether you are receiving the Wellness Credit. If you are eligible for employer matching funds, the IRS annual maximum limit is reduced by the company matching contributions.

Employer matching contributions are made on a quarterly basis, in the month following the quarter end, and coordinated with the regular payroll schedule. You must be in active employment on the last day of the applicable quarter to receive any employer matching contributions. You also must have opened your HSA account (as set forth above) by the last day of the applicable quarter to receive any employer matching contributions for that quarter.

The HSA Triple Tax Savings Advantage

- You make pre-tax contributions through your paycheck.
- Tax-free interest and potential investment earnings
- Tax-free distributions when used for qualified health expenses.

Note: funds must be in your HSA before you can use them or receive reimbursement.

Eligible Dependents and the HSA

The HSA has different tax dependent rules than the medical plans. For the Protection HSA or HSA 2 medical plan, you may enroll your adult dependent children up to age 26 on a tax-free basis. You may also enroll your eligible domestic partner, subject to federal, and in some cases state, income tax imputation requirements. However, for purposes of the HSA, separate rules apply for tax-free reimbursements.

To receive tax-free reimbursements from your HSA for expenses incurred by a dependent child –

- Your child must be under age 19 (or under age 24 for full-time students), or
- Your child must be a federal tax dependent under the IRS financial dependency rules.

To receive tax-free reimbursements from your HSA for expenses incurred by a domestic partner (and their children), your domestic partner (and their children) must be your federal tax dependent under the IRS financial dependency rules.

Contact your legal or tax advisor for additional information.

Using Your HSA for Qualified Expenses

Once your enrollment information passes the verification process, a Welcome Kit and debit card will be mailed from the HSA Administrator within 7-10 business days.

Once your debit card is activated, you can use HSA funds to pay for deductibles, copays, coinsurance, and other qualified out-of-pocket health care expenses that were not paid by insurance. You may use your HSA for expenses incurred by you, your spouse, or your tax dependents, even if you have a self-only high deductible health plan. You may also use your HSA funds to pay for some insurance premiums, such as:

- Long term care insurance (up to limited amounts)
- COBRA health care continuation premiums
- Health care coverage while receiving unemployment
- Medicare Part B, Medicare Part D and Medicare Advantage premiums, but not Medigap premiums.

Non-Qualified Expenses

Below is an example of non-qualified expenses from your HSA. This is not a complete listing.

- Advance payment for a future health care expense
- Cosmetics
- Hair transplant
- Illegally procured drugs
- Medigap premiums
- Bottled water
- Domestic help
- Funeral expenses
- Nutritional supplements
- Life or disability premiums
- Premiums for your HSA-qualified health plan
- Premiums for Accident insurance
- Teeth Whitening

HSAs and Medicare

If you become eligible for Medicare while employed by ODP, you will continue to be covered under your ODP medical option. Generally, you are eligible for Medicare upon reaching age 65, or due to permanent kidney failure. If you are an active associate, it is not necessary to enroll in Medicare Part A or Part B;

however, if you do enroll in Medicare Part A or Part B, you are no longer eligible to contribute to your HSA under IRS rules.

You cannot contribute to an HSA in any month that you are enrolled in Medicare. When you retire and start your Social Security benefits, and if you are already at least six months beyond your full Social Security retirement age, Social Security will provide you six months of “back pay” in retirement benefits. If this occurs your enrollment in Medicare Part A will also be “backdated” by six months. If you made HSA contributions for any portion of the back-pay period, those HSA contributions are invalid.

If you are older than your full Social Security retirement age and you are planning to retire, you should discuss this issue with your legal or tax advisor and consider one of the following two options:

- Stop your HSA contributions six (6) months prior to applying for Social Security retirement benefits. When you do apply, you may ask the Social Security Administration to not backdate your Part A enrollment. If Social Security honors your request, you can make an additional HSA contribution equal to what you would have contributed to the HSA for the six (6) months prior to applying for Social Security retirement benefits. You make this contribution directly to your HSA before December 31 or before you file your federal income tax return for the relevant year.
- If you do not stop your HSA contributions as noted above and you are enrolled in Medicare Part A retroactively, contact the HSA Administrator and request that your HSA contributions during that time be withdrawn and refunded to you. You should do this before December 31 of the year you became ineligible. (However, additional time may be allowed, and you should contact your tax advisor if this applies to you.) If you do not have the ineligible contributions refunded, a special penalty tax applies to that contribution for the year and for each future year that the contribution is not withdrawn.

The above rules only apply if you are eligible for Medicare. If only your spouse is Medicare-eligible, see the double coverage issues below.

Spouse Double Coverage - Special Issues

If you and your spouse are enrolled in one of the Protection HSA medical options at the same time your spouse is also enrolled in other major medical coverage the coordination of benefits rules will apply. In addition, special HSA rules also apply as follows:

- If you and your spouse are both enrolled in one of the Protection HSA medical options, while only your spouse is enrolled in Medicare, you can contribute the maximum HSA family contribution; however, your spouse’s medical claims will be coordinated between the medical option and Medicare. For your spouse’s claims, you can only obtain tax-free reimbursement from the HSA for the portion of the claims not paid by either the medical plan or Medicare.
- If you and your spouse are both enrolled in one of the Protection HSA medical options, while only your spouse is enrolled in another medical plan through his or her employer that is not a high-deductible plan, you can contribute the maximum HSA family contribution; however, your spouse’s medical claims will be coordinated between the ODP medical option and your spouse’s employer plan. For your spouse’s medical claims, you can only obtain tax-free reimbursement from the HSA for the portion of the claims that are not paid by either the ODP medical plan or the spouse’s employer plan.
- If you and your spouse are both enrolled in one of the Protection HSA medical options, while only your spouse is enrolled in another high-deductible health plan through their employer, your spouse is also eligible to contribute to an HSA in their name. Both you and your spouse are treated as having HSA family coverage combined. This means, the maximum HSA contribution must be divided between you and your spouse. For medical claims purposes, your spouse’s claims will be coordinated between the ODP medical plan and your spouse’s employer plan. You and your spouse can only obtain tax-free reimbursement from an HSA for the portion of the spouse’s claims that are not paid by either the ODP medical plan or the spouse’s employer plan.

Beneficiaries of the HSA

You should choose a beneficiary when you set up your HSA. Upon your death, if the named beneficiary is your spouse, an HSA will be created in their name, and all investments, if any, will be liquidated into cash and the entire fund balance will be transferred into the new HSA. If you name someone other than your spouse as the designated beneficiary, upon your death the account will no longer be considered an HSA, and the fair market value of the HSA becomes taxable to the designated beneficiary in the year in which you die. If there is no designated beneficiary, the HSA will become an asset of your estate, and the fair market value will be included on your final income tax return.

Disability (Short-Term & Long-Term)

Disability coverage provides financial protection for you and your family in the event you cannot work because of a qualified accident or medical condition, including a pregnancy-related condition.

The disability coverage has two parts:

- ODP paid Short-term Disability (STD) – provided at no cost to eligible associates, . The STD benefits are described in this Flex SPD.
- Voluntary Long-Term Disability (LTD) – enrollment is required and is paid entirely by you through payroll deductions. There are two options available: Voluntary LTD – 2 years, and Voluntary LTD – Age 65. The voluntary LTD benefits are insured benefits and are described in a separate Benefit Summary.

	Company Paid STD	Voluntary LTD - 2 years	Voluntary LTD - Age 65
Benefit Payable	Up to 50% of base salary, from a minimum benefit of \$30 weekly to a maximum of \$5,000 weekly	60% of base salary, up to a benefit of \$10,000 monthly	60% of base salary, up to a benefit of \$10,000 monthly
When Benefits Begin	After the greater of: ▪ 7 days of continuous disability, or ▪ exhaustion of any available Sick Pay	After 180 days of continuous disability	After 180 days of continuous disability
How Long Benefits Last	Up to 25 weeks	Up to 24 months	Up to age 65*

* Refer to the separate Benefit Summary for the voluntary LTD coverage and how benefits are paid under this option and the Maximum LTD Benefit Period.

STD and LTD benefits coordinate with Other Income Benefits you receive. That means STD and LTD benefits may be reduced by any benefits you receive from other sources such as state disability benefits, state paid leave benefits, Workers' Compensation, Social Security, third-party reimbursements, unemployment, and other employer wages. For additional information, refer to *"How STD Payments Coordinate with Other Income Benefits"* further in this section, and the separate Benefit Summary for the voluntary LTD benefits).

State Disability Benefits

In some cases, you may receive short-term disability benefits from a state disability program (a "State Disability Program"). Benefits from a State Disability Program are not provided by the Plan. This means that the rules set forth in this section do not apply for purposes of the calculation, payment, and termination of State Disability Program benefits. You should contact the applicable State Disability Program concerning the coverage of and benefits provided by the State Disability Program.

If you work in Colorado, Hawaii, New Jersey, New York, California, Oregon, or Rhode Island, you will be eligible for both STD benefits and benefits from a State Disability Program. In that case, your ODP STD benefits will be reduced by the amounts you receive from a State Disability Program.

If you are covered by a State Disability Program, you must contact the state agency responsible for paying your disability benefits to file a claim. It is not done through ODP. For example, if you are employed in California, you must contact the California Employment Development Department to file your claim. Further,

all disability benefits will be paid by the state agency. However, at the same time you must also notify the Claims Administrator whenever you are filing a State Disability Program claim. This step is important:

- To ensure your Family Medical Leave or disability leave is approved.
- To ensure your medical, dental and vision coverage continues during your STD absence.
- To determine if you are eligible for any additional short-term disability benefits.

In addition, several states have paid family and medical leave programs, which may provide paid leave for associates who are disabled. These amounts will also reduce your ODP short term disability benefits. You should contact the applicable state agency for additional information.

Taxes and Disability Benefits

Your STD and LTD benefits are taxable income. Applicable tax withholdings are taken from your disability payments as required by law.

Continuation and Conversion Rights

Continuation and conversion rights do not apply to either the STD or LTD coverage.

Evidence of Insurability Coverage (EOI)

You will be required to submit EOI, at your own expense, under the following circumstances:

- If you previously waived LTD and are enrolling in LTD during an Annual Enrollment period.
- If you are increasing your Disability Coverage (moving from the *LTD 2-year* option to the *LTD - age 65* option). Refer to the separate Benefit Summary for the voluntary LTD coverage for further information on the LTD options.

Coverage will take effect only if such EOI is approved by the Claims Administrator. This applies even if the Claims Administrator has approved your EOI in the past.

Special Circumstances That Affect How Disability Claims Are Paid

Paid Time Off (PTO)

If you become disabled while on PTO, you must report your disability to your manager and the Leave Administrator. By reporting your disability to your manager (or consistent with your location's attendance policy), your remaining PTO can be canceled, and reporting your disability to the Leave Administrator will initiate a leave of absence and a disability claim, if necessary.

You will not be credited with PTO days for which payment has already been received, or if you did not report your disability in a timely manner.

Holidays

If a holiday occurs during an Elimination Period, you may be eligible for Holiday Pay subject to your location's Holiday Pay policy. However, you are not eligible for Holiday Pay for any holiday for which you are eligible to receive STD (even if you are otherwise eligible for Holiday Pay, based on your location's Holiday Pay policy).

Death in the Family

If you experience the death of a family member while you are receiving disability benefits, your disability benefits continue without interruption, subject to the Plan's regular limitations and conditions. Since you are already off work and receiving a benefit, you are not eligible for wage payments made under ODP's Funeral / Memorial Service Observance Policy.

Jury Duty

There is no interruption or offset of your disability benefit if you are summoned for jury duty and are otherwise able to perform jury duty service, subject to the Plan's regular limitations and conditions.

Short-Term Disability

The Short-term Disability (STD) option provides eligible associates with short-term income protection for absences due to a disability, including a qualified accident or illness, or pregnancy-related condition. Coverage is automatic after satisfaction of the service requirement; there is no enrollment requirement.

The following sections summarize the STD option.

Benefit Amounts

The following chart provides a summary of the benefit amount payable for a qualified disability, after meeting the applicable Elimination Period:

Weekly Benefit	50% of your Pre-disability Earnings calculated on a weekly basis
Maximum Weekly Benefit	\$5,000
Minimum Weekly Benefit	\$30
Maximum Weekly Benefit Period	25 weeks (beginning after your Elimination Period)

Elimination Period

You will begin receiving STD benefits after you have satisfied the Elimination Period. The Elimination Period is a waiting period that begins on the first day of disability and continues until the later of:

- The 7th day of continuous absence; or
- The first day after any available Sick Leave has been exhausted.

Benefits Actually Payable

Any weekly benefit payable will be reduced by Other Income Benefits.

If you can work while disabled and you have income from:

- any employer, or
- from any occupation for compensation or profit,

which is more than 20% of your Pre-disability Earnings, your STD benefit will be reduced dollar-for-dollar to the extent the amount of such income and your STD benefit (before any further reduction for Other Income Benefits), exceeds 100% of your Pre-disability Earnings.

Income means income you receive while disabled and working, from ODP and from any other employer. However, any income received from another employer will be considered income only to the extent that it exceeds the amount of income you were receiving from such employer immediately before the date a Period of Disability started.

Period of Disability

A Period of Disability starts on the first day you are disabled as a direct result of a significant change in your physical or mental condition occurring while you are covered under the STD program. You must be under the regular care of a Physician. (You will not be deemed to be under the regular care of a Physician more than 31 days before the date he or she has seen and treated you in person for the disease or injury that caused the disability).

A Period of Disability ends (and STD benefits will no longer be payable) on the first to occur of:

- The date the Claims Administrator finds you are no longer disabled or the date you fail to furnish proof that you are disabled.
- The date you cease to be under the regular care of a Physician.
- The date you refuse to be examined by, or cooperate with, an independent Physician or a licensed or certified health care practitioner, as requested.
- The date an independent medical exam report or functional capacity evaluation fails to confirm your disability.
- The date you reach the end of your Maximum Weekly Benefit Period, or after 25 weeks of STD benefits have been paid.
- The date you are not undergoing effective treatment for alcoholism or drug abuse, if your disability is caused to any extent by alcoholism or drug abuse. Effective treatment for alcoholism and drug abuse means a program of alcoholism or drug abuse therapy that is prescribed and supervised by a Physician and either:
 - has a follow-up therapy program directed by a Physician on at least a monthly basis; or
 - includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.
 - The following are not considered effective treatment:
 - Detoxification. This means solely treating the after-effects of a specific episode of alcoholism or drug abuse.
 - Maintenance care. This means primarily providing an environment free of alcohol or drugs.
- The date you refuse to cooperate with or accept:
 - changes made to a work site or job process to suit your identified medical limitations; or
 - adaptive equipment or devices designed to suit your identified medical limitations which would enable you to perform your own occupation and provided that a Physician agrees that such changes or adaptive equipment suit your medical limitations.
- The date you refuse to receive treatment recommended by your attending Physician that in the opinion of the Claims Administrator would cure, correct, or limit your disability.
- The date your condition would permit you to work or increase the number of hours you work, or the number or type of duties you perform in your own occupation, but you refuse to do so.
- The date you become eligible for benefits under any other disability benefits plan of the same type carried or sponsored by ODP, if such date occurs after the date the group contract terminates.
- The date you fail to cooperate in the administration of your STD benefits or fail to follow the Claims Administrator's reasonable requests with respect to your benefits.
- The date you file or participate in filing a fraudulent, false, or misleading claim for benefits; or
- The date of your death.

Disability Treatment

To receive STD benefits, you must undergo a medically recognized course of treatment administered by a physician for your type of disability that is based on published guidelines currently in effect from at least one Nationally Recognized Authority. For this purpose, a Nationally Recognized Authority is the American Medical Association (AMA) Council on Scientific Affairs, the AMA Diagnostic and Therapeutic Technology Assessment Project, the AMA Board of Medical Specialties, the American College of Physicians and Surgeons, the Food and Drug Administration, the Centers for Disease Control, the Office of Technology Assessment, the National Institutes of Health, the Centers for Medicare and Medicaid Services, the Agency for Health Care Policy and Research, the Department of Health and Human Services, the National Cancer Institute and any additional boards, groups, entities or organizations of similar status and/or reputation, as determined in the sole discretion of the Claims Administrator

Definition of Disability

The Leave Administrator will consult with your doctor to evaluate your disability status at regular intervals during your absence from work. For purposes of this STD benefit, a doctor/physician means an individual who: (a) is licensed and practicing within the scope of his or her license; and (b) is a medical doctor (M.D.), a doctor of osteopathy (D.O.), podiatrist or has a doctoral degree in psychology (Ph.D. or Psy.D.) whose primary practice is treating patients and who coordinates with a medical doctor or doctor of osteopathy if prescribing medications is part of appropriate treatment, subject to any additional rules or limitations determined by the Plan Administrator. A doctor does not include your spouse, any individual related to you through marriage or blood, or any individual living in your household. In accordance with rules issued by the Claims Administrator, you and your doctor may be required to submit continuing evidence of your disability while you are on disability leave. The Leave Administrator is the Claims Administrator for the STD plan and has the sole discretionary authority to determine whether you are eligible for STD benefits and the amount of those benefits. The Leave Administrator will determine whether you are disabled under the STD plan based upon objective medical evidence. Objective medical evidence is evidence that establishes facts and conditions, as perceived without distortion by personal feelings, prejudices or interpretations, and includes X-rays, quantitative tests, laboratory findings and records and reports from an attending and consulting doctor.

How STD Payments Coordinate with Other Income Benefits

Your STD benefits are reduced by the number of other sources of income that are payable to you because of your disability or retirement or other disability benefits for which you may be eligible. Income that will reduce your STD benefits include:

- 50% of any award provided under The Jones Act or The Maritime Doctrine of Maintenance, Wages and Cure.
- Disability, retirement, or unemployment benefits required or provided for under any government law, such as:
 - Unemployment compensation benefits
 - Temporary or permanent, partial, or total disability benefits under any state or federal workers' compensation law or any other like law, which are meant to compensate the worker for any one or more of the following:
 - loss of past and future wages.
 - impaired earning capacity: lessened ability to compete in the open labor market; any degree of permanent impairment; and
 - any degree of loss of bodily function or capacity.
- Benefits under the Federal Social Security Act, the Railroad Retirement Act, the Canada Pension Plan, and the Quebec Pension Plan.
- *Workers' compensation benefits.*
- *Veterans' benefits.*
- Statutory and/or state disability benefits and payments of state paid leave or state sick leave paid on account of your disability or paid at the same time you are not working due to your disability.
- Disability or unemployment benefits under any plan or arrangement of coverage:
 - because of employment by or association with ODP; or
 - because of membership in or association with any group, association, union, or other organization.
- Unreduced retirement benefits for which you are or may become eligible under a group pension plan at the later of:
 - age 62, and
 - the Plan's Normal Retirement Age,but only to the extent that such benefits were paid for by ODP.
- Voluntarily elected retirement benefits received under any group pension plan; but only to the extent that such benefits were paid for by ODP.

- Other Income Benefits include those, due to your disability or ODP-provided retirement, which are payable to: you; your spouse; your children or your dependents.
- Insurance or other recoveries relating to your disability (whether or not for lost earnings).
- Income received from any employer if such income is wages or income in lieu of wages, and income from any occupation for pay or profit, including self-employment.

Note: If you live in California, Colorado, Hawaii, New Jersey, New York, Oregon or Rhode Island, your STD benefits are provided through mandatory state programs. If your state benefits do not provide you a benefit of 50% of your Pre-disability Earnings, you may be eligible for additional STD benefits through this Plan. Contact the Claims Administrator for further information.

The Claims Administrator has the right to require proof that you applied for all other income benefits which you may be eligible to receive because of your disability, you have made a timely appeal of any denial and you have not waived any income benefits without the Claims Administrator's written consent. The Claims Administrator has discretion to suspend your STD benefits for failure to furnish requested documentation.

Your STD benefits will be reduced by any of these benefits that would be available if you applied for them properly even if you do not apply. You are required to notify the Claims Administrator (promptly and as soon as reasonably possible) if you are entitled to any of these income sources. If any of these benefits are payable as a lump sum, your STD benefit will be calculated as if these benefits are paid on a periodic basis, pursuant to rules determined and administered by the Leave Administrator.

If any of the above amounts are paid on a delayed or retroactive basis, your STD benefits will be recalculated for the applicable period and will then become overpaid. If STD benefits are overpaid, and the Leave Administrator is unable to recoup the overpayment of ODP funds after multiple attempts, ODP will contact the appropriate HR Business Partner. After notice from the HRBP, failure to repay the overpayment in a timely manner will result in the Claims Administrator submitting into a credit agency and a potential Performance Correction Document (PCD) placed into your employment file.

Effect of Increases in Other Income Benefits

Increases in the level of Other Income Benefits due to the following will be considered Other Income Benefits:

- a change in the number of your family members.
- a re-computation or recalculation to correct or adjust your benefit level as first established for the Period of Disability; or
- a change in the severity of your disability.

There may be cost of living increases in the level of Other Income Benefits received from a governmental source during a Period of Disability. These increases will not be deemed to be Other Income Benefits.

There may be cost of living or general increases in the level of Other Income Benefits from a non-governmental source during a Period of Disability. These increases will not be considered Other Income Benefits to the extent they are based on the annual average increase in the Consumer Price Index.

Other Income Benefits Which Do Not Reduce Weekly Benefits

The amount of any retirement or disability benefits you were receiving from the following sources before the date a Period of Disability started will not reduce your benefits:

- military and other government service pensions.
- retirement benefits from a prior employer.
- veteran's benefits for service-related disabilities.
- individual disability income policies; and
- Federal Social Security Act.

Also, the amount of any income or other benefits you receive from the following sources will not reduce your benefits:

- profit sharing plans.
- thrift or savings plans.
- 401(k) plans.
- Keogh plans.
- employee stock option plans.
- tax sheltered annuity plans.
- severance pay.
- individual disability income policies; or
- individual retirement accounts (IRAs).

How the Claims Administrator Determines Other Income Benefits

Lump Sum and Periodic Payments from Any Other Income Benefit:

Any lump sum or periodic other income payments that you receive will be prorated on a weekly basis over the period for which the payment was made. If a period is not indicated, the Claims Administrator will prorate the payments over a reasonable period, considering the expected length of disability benefits and other relevant factors.

That part of the lump sum or periodic payment that is for disability will be counted, even if it is not specifically apportioned or identified as such. If there is no proof acceptable to the Claims Administrator as to what that part reasonably is, 50% will be deemed to be for disability.

Any of these "Other Income Benefits" that date back to a prior date during a Period of Disability may be allocated on a retroactive basis and/or prospective basis.

If you receive any other benefits in a lump sum payment, they will be pro-rated on a weekly basis over the period for which payment was made. If a benefit is payable for less than a week, the Plan will count 1/7th of the weekly benefit amount for each day you are disabled.

Estimated Other Income Payments

The amount of Other Income Benefits for which you appear to be eligible may be estimated unless you have signed and returned a reimbursement agreement to the Plan. This agreement contains your promise to repay the Plan for any overpayment of benefits made to you.

If Other Income Benefits are estimated, your weekly benefit will be adjusted when the Claims Administrator receives proof:

- of the exact amount awarded; or
- that benefits have been denied after review at the highest administrative level.

The STD program will pay you if there is any underpayment in your benefits. You will have to repay the Plan if any overpayment of benefits has resulted. Should the Plan have to take legal action against you to recover any overpayment, you will have to pay the Plan's reasonable attorney's fees and court costs, if the Plan prevails.

Required Proof of Income

The Claims Administrator has the right to require proof that:

- you, your spouse, child, or dependent has made application for all Other Income Benefits which you or they are, or may be, eligible to receive relative to your disability and has made a timely appeal of any denial through the highest administrative level; timely appeal means making such an appeal as required, but in no case later than 60 days from the latest denial.

- the person has furnished proof needed to obtain Other Income Benefits, which includes, but is not limited to, Workers' Compensation Benefits.
- the person has not waived any Other Income Benefits without the Claims Administrator's written consent; and
- the person has sent copies of the documents to the Claims Administrator showing the effective dates and the amounts of Other Income Benefits.

In addition to the above, for purposes of Federal Social Security, when a timely application for benefits has been made and denied, a request for reconsideration must be made within 60 days after the denial, unless the Claims Administrator states, in writing, that it does not require you to do so. Also, if the reconsideration is denied, an application for a hearing before an Administrative Law Judge must be made within 60 days of that denial unless the Claims Administrator relieves you of that obligation.

The Claims Administrator also requires proof of income you receive from any occupation for compensation or profit. You do not have to apply for:

- retirement benefits paid only on a reduced basis; or
- disability benefits under group life insurance if they would reduce the amount of group life insurance.
- but, if you do apply for and receive these benefits, they will be deemed to be Other Income Benefits for which proof is required.

If you do not furnish proof of Other Income Benefits, the Claims Administrator reserves the right to suspend or adjust benefits by the estimated amount of such Other Income Benefits.

How Separate Periods of Disability Are Treated

Once a Period of Disability has ended, any new Period of Disability will be treated separately. However, if two or more periods of disability are:

- due to the same or related causes; and
- separated by less than 61 consecutive days in a row.

they will be deemed to be one Period of Disability. Only one Elimination Period will apply. The first period will not be included if it began while you were not covered. If only one Period of Disability applies, STD benefits are payable for any of the weeks remaining in your original 25-week benefit period.

What's Not Covered under Short-term Disability

Benefits will not be paid for any disability that:

- is due to intentionally self-inflicted injury (while sane or insane).
- results from your commission of, or attempting to commit, a criminal act.
- results from driving an automobile while intoxicated (the blood alcohol level of the driver of the automobile meets or exceeds the level at which intoxication would be presumed under state law).
- is due to war or any act of war (declared or not declared).
- is due to the service in the armed forces of any government.
- is incurred during a time that you are not eligible for STD benefits; or
- is due to insurrection, rebellion, or taking part in a riot or civil commotion.

On any day during a Period of Disability that a person is confined in a penal or correctional institution for conviction of a criminal or other public offense:

- the person will not be deemed to be disabled; and
- no benefits will be payable.

Payment of Benefits

Benefits are paid as soon as necessary proof to support the claim is received. All benefits are payable to you. STD Benefits will be paid weekly. They will be processed at the end of each week during the period for

which benefits are payable. Weekly benefits for a period less than a week will be prorated. This will be done based on the ratio to 7 days of the days of eligibility for benefits during the week.

STD may pay up to \$1,000 of any benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you, and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- When employment ceases.
- When you are no longer in an eligible classification; or
- The Plan is amended or terminated.

ODP will notify the Claims Administrator of the date your employment ceases for the purposes of termination of coverage under this Plan. This date will be the date you cease active work. ODP will use the same rule for all associates. If you are not at work on this date due to one of the following, employment may be deemed to continue up to the limits shown below.

If you are not at work due to disease or injury, your employment may be continued until stopped by ODP, but not beyond 12 months from the start of the absence.

If you are not at work due to temporary lay-off or leave of absence, your employment will be deemed to cease on your last full day of active work before the start of the lay-off or leave of absence.

STD Benefits after Termination

If your STD coverage terminates during a Period of Disability which began while you had coverage, any STD benefits will continue if your Period of Disability continues.

Overpayments and Recovery of Excess Payments

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of this plan, the Plan has the right to recover these excess payments from you, any other individual, and any other entity or organization to whom the excess payments were made until the overpayment is recovered.

Current or future plan benefits may be reduced and/or offset (in whole or in part) in the sole discretion of the Plan Administrator at any time to recover any overpayment or excess payment, to recover any debt owed by the participant to any member of the ODP Organization, and to recover any reimbursement or payment owed by the participant to any member of the ODP Organization. The reduction and/or offset in current and/or future plan benefits (in whole or in part) shall be accomplished by the Plan Administrator (in its sole discretion) as a right of administrative set off without the need to initiate any legal action. The Plan Administrator may reduce and/or offset plan benefits from and after a designated date, even if plan benefits were not reduced and/or offset prior to a designated date.

Whenever payments have been made based on inaccurate, misleading, false or fraudulent information, including information provided by you, your family members or your doctor, the Plan has the authority to suspend or terminate payments of future benefits and to collect prior overpayments. The plan will also exercise all available legal rights to recover overpayments made as a result of inaccurate, misleading, false or fraudulent information, including its right to withhold payment on future benefits until the overpayment is recovered. For purposes of the above, "excess payments" include any legal costs, attorneys' fees and court costs incurred as a result of or relating to the recovery of excess STD benefits.

How to File a Disability Claim

When you initiate a Leave of Absence with the Leave Administrator, a claim for short-term disability benefits will be initiated automatically. Prior to reaching 180 days of continuous disability, the Leave Administrator will coordinate filing a long-term disability claim if you are enrolled in Long-Term Disability.

The deadline for filing a disability claim for benefits is 90 days after the end of the Elimination Period, or as soon as possible. A claim submitted more than one (1) year after your Elimination Period will not be covered unless you are legally incapacitated. Please remember your STD Elimination Period is generally 7 days of continuous disability and your LTD Elimination Period is 180 days of continuous disability. You will receive any retroactive amounts for which you are eligible as soon as your claim is approved.

Right of Reimbursement

If you suffer from a disability caused by the actions or omissions of a third party, the Plan has the right to recover from the third party the Plan's disability payments that it made to you. For this purpose, a "third party" or "party" means any individual, entity, person or other party responsible for causing your disability or responsible for making any payment to you due to your disability, including uninsured motorist coverage, underinsured motorist coverage, traditional fault-based automobile insurance coverage, no-fault automobile insurance coverage, homeowner's/renter's insurance, personal umbrella coverage, Workers' Compensation coverage and any first-party insurance coverage. However, a third party does not include any individual or supplementary insurance policy or coverage classified as an individual cancer, individual specific disease, or individual hospital indemnity policy (e.g., individual policies sold by AFLAC). For purposes of any applicable coordination of benefits rules, a third party shall pay primary, and the Plan shall pay secondary. Any amounts paid or received from or on behalf of a third party are referred to as "third party proceeds."

This means that the Plan has the right to obtain reimbursement from group or individual automobile insurance (including uninsured motorist coverage, underinsured motorist coverage, traditional fault-based automobile insurance coverage and no-fault automobile insurance coverage) and any medical, disability or other compensation under homeowner's/renter's insurance. In all cases, these coverages will pay primary to this Plan if any coordination of benefits rules are applicable.

For example, if you are injured in a car accident, the person who caused the accident (and the person's insurer) are the third parties.

You will be required to provide the Plan or its agents information concerning any claim or lawsuit you may have against a third party regarding a disability caused by that party. You must also provide the Plan or its agents any documents or information relevant to the protection of the Plan's rights of reimbursement. You may be asked to sign a repayment agreement as a condition for receiving benefits under the Plan. If the agreement is not signed or you fail to cooperate with the Claims Administrator, you will lose your STD benefits. If you do not cooperate, the Claims Administrator may terminate your disability benefits from the Plan after a certain date even if your disability benefits were approved before that date.

The Plan is not required to enter into a reimbursement agreement. Entering into a reimbursement agreement and the terms and conditions thereof are within the sole discretion of the Claims Administrator (or Plan Administrator). Rather, in order to recover any third-party proceeds, the Plan may, in its sole discretion, reduce and/or offset the payment of current and future disability benefits (in whole or in part) by the amount of the third-party proceeds and may initiate actions to collect prior Plan benefits that were paid. The Plan may reduce and/or offset disability benefits from and after a designated date, even if the disability benefits were not reduced and/or not offset prior to a designated date.

If you decide to sue the person who caused your disability, you must inform the Claims Administrator or Plan Administrator.

The plan may initiate legal action against you (or anyone else holding the third-party proceeds, such as a legal representative or trust) to collect the third-party proceeds and may take any other actions (even if not set forth in this section) to protect the Plan's right of reimbursement. If you receive any type of payment, reimbursement, or legal recovery from a third party or an insurer (i.e., third party proceeds), you are obligated to reimburse the Plan for:

- Any benefits or expenses that the Plan paid for your disability,
- Any projected benefits or expenses the Plan will pay in the future with respect to your disability, plus
- Any related legal and collection costs the Plan incurred.

Your obligation to reimburse the Plan exists for any legal recovery that relates to your disability for which the Plan paid benefits (including any amounts used to pay your legal fees), even if you recover less than initially claimed (or less than your full loss) and even if the legal recovery is designated as not for lost income or your disability. The plan's reimbursement shall not be reduced by any legal or attorney costs or fees you may incur in obtaining the third-party proceeds, unless and only to the extent such reduction is allowed by a signed reimbursement agreement.

In addition, the right of full and unreduced reimbursement shall also apply even if the rights of the Plan are separated and treated as not resolved in the judgment, settlement, verdict, or insurance proceeds (but in this case, the Plan's rights shall be assigned to you to the extent reimbursement is actually received out of the recovery). The plan's right to receive any payment, reimbursement or recovery discussed in this section supersedes and has priority over your right to receive any payment, reimbursement and recovery and supersedes any applicable state laws that otherwise may directly or indirectly conflict with the provisions of this section.

To recover any reimbursement, payment, overpayment or excess payment to which the Plan has a right of reimbursement as provided above, you, as a condition of receiving benefits under the Plan, grant to the Plan the following rights:

- A first priority equitable lien against the third-party proceeds (i.e., any settlement, verdict, insurance proceeds or other amounts) received by you from or on behalf of any third party that may be responsible for a disability for which the Plan incurred expenses or paid benefits. The amount of the lien is equal to the amount of prior and future benefits and expenses paid by the Plan.
- The right to impose a constructive trust on the third-party proceeds (i.e., any settlement, verdict, insurance, or other amounts) awarded, transferred or paid by or on behalf of a third party to you and any other person or entity holding the proceeds, including a legal representative or trust.
- The right of administrative set-off against current and/or future STD benefits without the need to bring any legal action or proceeding.
- The right to bring any legal action or proceeding to enforce the above rights in any court of competent jurisdiction as the Plan may elect, and upon receiving benefits under the Plan, you hereby submit to each jurisdiction regardless of your current or future residence.

Third party proceeds which are held directly or indirectly by you are intangible assets of the Plan and are held by you in a constructive trust for the benefit of the Plan. Any participant who directly or indirectly holds or exercises any control over third party proceeds is an ERISA fiduciary with respect to the third-party proceeds and must hold the third-party proceeds for the exclusive benefit of the Plan. A legal representative is an ERISA fiduciary solely with respect to his or her direct or indirect control of third-party proceeds and not with respect to his or her legal representation of you.

The plan's right of reimbursement shall apply without regard to any equitable defenses that a third party, participant and/or dependent asserts or may be entitled to assert, including any defense of unjust

enrichment. ERISA preempts any state or local law, or any regulation issued thereunder, which prohibits or attempts to limit the Plan's right of reimbursement. Neither the make whole doctrine nor the common fund doctrine apply to the Plan.

Right of Subrogation

When another party is legally responsible or agrees to compensate you for a disability for which you have previously received benefits from the Plan, the Plan has the same rights ("right of subrogation") that you have against the party. For this purpose, a "third party" or "party" means any individual, entity, person or other party responsible for causing your disability or responsible for making any payment to you due to your disability, including uninsured motorist coverage, underinsured motorist coverage, traditional fault-based automobile insurance coverage, no-fault automobile insurance coverage, homeowner's/renter's insurance, personal umbrella coverage, Workers' Compensation coverage and any first-party insurance coverage. However, a party does not include any individual or supplementary insurance policy or coverage classified as an individual cancer, individual specific disease, or individual hospital indemnity policy (e.g., individual policies sold by AFLAC).

The plan expressly rejects and overrides any default rule that the Plan does not have a right of subrogation until you have been fully compensated. If you enter into litigation or settlement with another party, the Plan's right of subrogation will still apply. The plan's rights of subrogation shall supersede any applicable state laws that otherwise may directly or indirectly conflict with the Plan's rights of subrogation in this section.

You will need to provide the Plan or its agents with any relevant information, assistance and documents that help the Plan obtain its subrogation rights. Also, you could be required to sign and deliver to the Plan, or its agents documents to secure the Plan's subrogation rights, and you will be required to obtain the consent of the Plan or its agents before releasing any party from liability for payment. If you fail to cooperate with the Claims Administrator, you will lose your disability benefits. If you do not cooperate, the Claims Administrator may terminate your disability benefits from the Plan after a certain date even if your disability benefits were approved before that date.

Executive Long-Term Disability

The Executive LTD benefit will replace up to 70% of your Pre-disability Earnings, which includes base salary and bonus from ODP. The maximum monthly benefit is \$35,000 and is paid through:

- an individual disability income (“IDI”) policy, which will pay 70% of the first \$171,429 of your total annual base salary plus bonus, up to a \$10,000 maximum monthly benefit, and
- a group insurance policy, which will pay 70% of your total annual base salary plus bonus above \$171,429 per year up to a \$25,000 maximum monthly benefit, subject to the income which will reduce your disability benefits.

While both policies are paid for by ODP, the IDI policy is portable, which means that you can continue the coverage and take advantage of a 30% discount rate for the life of the IDI policy after termination of employment with ODP, provided you continue to pay the premiums directly to the Claims Administrator after your termination of ODP employment.

The following chart provides an example of how the Executive Long-Term Disability benefit is calculated, considering both the group insurance policy and the IDI policy:

An Example of the Executive LTD Benefit	
Annual base salary is	\$250,000
Annual Bonus is:	+ \$125,000
Total Pre-disability Earnings is:	\$375,000¹³
The IDI policy will pay 70% of the first \$171,429 of your pre-disability annual earnings, up to a maximum of \$10,000 a month	\$10,000
The group insurance policy will pay 70% of your pre-disability annual earnings above \$171,429, to a maximum of \$25,000 a month	+ \$11,875
Total Monthly Executive LTD Benefit (before personal income tax)¹⁴	\$21,875

Benefits under the Executive LTD coordinate with Other Income Benefits you may receive. That means benefits may be reduced by any benefits you receive from other sources such as Workers' Compensation, Social Security, third-party reimbursements, unemployment, and other employer wages (refer to *Income Which Will Reduce Your Disability Benefit* for additional information).

Taxes and Disability Benefits

Your Executive LTD benefits are taxable income. Applicable tax withholdings are taken from your disability payments as required by law.

Continuation and Conversion Rights

Continuation rights apply to the individual group income (IDI) policy only.

Elimination Period

The period that must be satisfied, beginning on the day you become disabled before benefits are payable under the Executive LTD coverage is 180 days.

¹³ The IDI policy has a fixed benefit and will not be affected by subsequent increases or decreases in your compensation. However, the group insurance policy benefit may be affected by subsequent increases or decreases in your compensation.

¹⁴ Note: Because ODP pays the premium for your Executive LTD, in the event you become disabled, your monthly benefit amount will be taxable income to you.

Eligibility and Participation

This section explains the Plan rules for eligibility and participation solely with respect to Executive LTD coverage.

You must complete and return the application form to MetLife to activate the IDI portion of your Executive LTD coverage. Failure to submit this form will result in only the group insurance portion of coverage to be activated. Refer to Eligibility - General Information below for further information.

If you have questions about eligibility or participation after reading this section, contact the Benefits Department at BenefitsTeam@theodpcorp.com. If you are eligible for Executive LTD coverage as described in this Flex SPD section, you are not eligible for any other LTD coverage from ODP.

Eligibility – General Information

You are eligible to participate if you are:

- classified by ODP as an active Vice President or above level, and
- a resident of the United States or on international assignment outside of the United States.

If you meet the above requirements, your effective date is based on the following, providing you have completed and submitted the appropriate application form to MetLife:

- the 1st of the month following 30 days of service.

If you are not eligible to participate when you are first hired, you become eligible on the 1st of the month following the date you transfer into an eligible classification (provided you have at least 30 days of service).

It is expressly intended that individuals not treated as benefits eligible by ODP are to be excluded from participation under all circumstances until ODP changes their classification. Therefore, an independent contractor or any other ineligible individual who is reclassified by a court, administrative agency, or other party as an eligible associate (or otherwise eligible for benefits coverage) will not be considered an eligible associate (or otherwise eligible) for periods before ODP implements the reclassification decision, even if the decision by the court, administrative agency or other party applies retroactively.

If You are Rehired

If you separate from employment with ODP and are rehired, you will be considered a new hire and will have to meet the eligibility requirements as stated above.

Associates of Acquired Companies and/or New Participating Subsidiaries

The benefits described in this Flex SPD apply to eligible associates of ODP. For associates of newly acquired companies and/or new participating subsidiaries, the eligibility rules, and the effective date of the coverage (if any) will be provided for each affected location.

If You Are Not Actively at Work

If you are not actively at work on the day that participation in LTD is scheduled to begin, your participation will not take effect until you actively return to employment and work at least one full day.

Evidence of Insurability (EOI)

No EOI is required for participation in the Executive LTD.

Enrolling in Executive LTD Coverage

General Information

If you are eligible for Executive LTD coverage, you will receive notification directly from MetLife at your mailing address of record. To participate in the IDI portion of Executive LTD coverage, the enrollment application must be completed and submitted back to MetLife by the deadlines provided on the application form. Failure to submit the form back to MetLife will result in only the group insurance portion to be activated.

Cost of Coverage

ODP pays the full cost of the Executive LTD coverage.

When to Enroll

Participation in the Executive LTD requires that you complete the *Application for Individual Disability Income Insurance* and return it to MetLife per the instructions on the form within 60 days of receipt. **Enrollment is not automatic.** Your IDI coverage does not become effective until your fully completed, signed application is received and approved by MetLife.

If You Become Newly Eligible

If you become a newly eligible executive (e.g., because of a promotion), you will automatically receive an Executive LTD enrollment packet via U.S. mail. **Enrollment is not automatic;** you must complete and submit the *Application for Individual Disability Income Insurance* for the IDI portion of coverage to become effective.

The Enrollment Process

Upon receiving the *Application for Individual Disability Income Insurance*, **ACTION IS REQUIRED** for coverage under the company-paid Executive LTD to become effective.

The application form will be pre-filled with employment data. Review the information under Items 1, 2 and 3 and answer the questions under Item 4 and 5 (if applicable) and designate your beneficiary under Item 6. **You must include the city and state where the document is being signed, and sign with the current date. If either the city/state or signature is missing, it will be returned to you for completion.**

Note: You may disregard the section asking for a Witness and License Number.

Executive LTD Coverage Details

Monthly Benefit Amounts

	Individual Disability Income (IDI)	Group Insurance Policy
Monthly Benefit	70% of the first \$171,429 of annual base and bonus, up to \$10,000 maximum per month	70% of Pre-disability Earnings above \$171,429 per year, up to \$25,000 maximum per month (Subject to the income which will reduce your disability benefit)
Minimum Monthly Benefit	N/A	\$100 (Subject to the Overpayments and Rehabilitation Incentive)
Maximum Monthly Benefit	\$10,000 (Subject to the income which will reduce your disability benefit)	\$25,000 (Subject to the income which will reduce your disability benefit)
Maximum LTD Benefit Period	If your Period of Disability starts: • prior to the date you reach age 61, it will end at the end of the month in which you reach age 65. • on or after the date you reach age 61 (See <i>Maximum Benefit Period</i> below)	

Both IDI and Group Insurance are insured benefits and subject to the terms and conditions of the applicable insurance policies.

Maximum Benefit Period - Duration Schedule

Age When Period of Disability Starts	Maximum Months of Disability Benefits
Less than 61.....	To Age 65
61 but less than 62	48 months
62 but less than 63	42 months
63 but less than 64	36 months
64 but less than 65	30 months
65 but less than 75	24 months
At or after age 75.....	12

LTD Elimination Period

The elimination period is the first 180 days of a period of disability.

Increase/Decrease in Insurance

- *An increase in insurance due to a change in your earnings will take effect on the date of the increase in your earnings. If you are not actively at work on the date insurance would otherwise take effect, insurance will take effect on the day you resume active work.*
- *A decrease in insurance due to a change in your earnings will take effect on the date of the decrease in your earnings.*
- *Changes in your disability income insurance will only apply to disabilities commencing on or after the date of the change.*

Income Which Will Reduce Your Disability Benefit

Your disability benefit will be reduced by the amount of all other income. Other income includes the following:

- any disability or retirement benefits which you, your spouse or child(ren) receive or are eligible to receive because of your disability or retirement under:
 - Federal Social Security Act.
 - Railroad Retirement Act.
 - any state or public employee retirement or disability plan.
 - any pension or disability plan of any other nation or political subdivision thereof.
- any income received for disability or retirement under an employer's retirement plan, to the extent that it can be attributed to ODP contributions.
- any income received for disability under:
 - a group insurance policy to which ODP has contributed, such as:
 - benefits for loss of time from work due to disability.
 - installment payments for permanent total disability.
 - a no-fault auto law for loss of income, excluding supplemental disability benefits.
 - a government compulsory benefit plan or program which provides payment for loss of time from your job due to your disability, whether such payment is made directly by the Plan or program, or through a third party.
 - a self-funded plan, or other arrangement if ODP contributes toward it or makes payroll deductions for it.
 - any sick pay, vacation pay or other salary continuation that ODP pays to you.
 - workers' compensation or a similar law which provides periodic benefits.
 - occupational disease laws.
 - laws providing for maritime maintenance and cure.
 - unemployment insurance law or program.
- any income that you receive from working while disabled to the extent that such income reduces the amount of your monthly benefit as described in Rehabilitation Incentives. This includes but is not limited to salary, commissions, overtime pay, bonus or other extra pay arrangements from any source.
- recovery amounts that you receive because of claims against a third party by judgment, settlement or otherwise including future earnings.

Reducing Your Disability Benefit by the Estimated Amount of your Social Security Benefit

If there is a reasonable basis for you to apply for benefits under the Federal Social Security Act, you are expected to apply for them. To apply for Social Security benefits means to pursue such benefits until you receive approval from the Social Security Administration, or a notice of denial of benefits from an administrative law judge.

The amount of your disability benefit will be reduced by the amount of Social Security benefits that is estimated that you, your spouse, or child(ren) are eligible to receive because of your disability or retirement. This will start after you have received 24 months of disability benefit payments, unless MetLife has received:

- approval of your claim for Social Security benefits (in which case the offset will start from the date your claim was approved); or
- a notice of denial of such benefits indicating that all levels of appeal have been exhausted.

However, within 6 months following the date you became disabled, you must:

- submit Proof to MetLife that you have applied for Social Security benefits.
- sign a reimbursement agreement in which You agree to repay for any overpayments made to you under this insurance; and
- sign a release that authorizes the Social Security Administration to provide information concerning your Social Security benefits eligibility.

If you do not satisfy the above requirements, your disability benefits will be reduced by such estimated Social Security benefits starting with the first disability benefit payment coincident with the date you were eligible to receive Social Security benefits.

In either case, when you do receive approval or final denial of your claim for Social Security benefits as described above, you must notify MetLife immediately. The amount of your disability benefit will be adjusted accordingly. You must promptly repay any overpayment.

Single Sum and Periodic Payments

If you receive other income in the form of a single sum payment, you must, within 10 days after receipt of such payment, give written proof satisfactory to MetLife of:

- the amount of the single sum payment.
- the amount to be attributed to income replacement; and
- the time for which the payment applies.

When such Proof is received, your disability benefit will be adjusted.

If MetLife does not receive the written proof described above, and MetLife knows the amount of the single sum payment, your disability benefit may be reduced by an amount equal to your disability benefit until the single sum has been exhausted.

If your disability benefit is reduced due to a single sum payment, the amount of the adjustment will not result in a benefit amount less than the minimum amount, except in the case of an overpayment.

If you receive other income in the form of a single sum payment and MetLife does not receive the written proof described above within 10 days after you receive the single sum payment, the amount of your Disability Benefit will be adjusted by the amount of such payment. Such adjustment may be done retroactively, thereby resulting in an overpayment, which you must pay to MetLife.

You must also report any periodic other income benefits you receive following the same rules above for single sum payments. Any payments received on a periodic basis other than the period for which LTD benefits are paid will be converted into the period for which LTD benefits are paid for purposes of the offset rules.

Income Which Will Not Reduce Your Disability Benefit

Your disability benefit will not be reduced to less than the minimum benefit, or by:

- cost of living adjustments that are paid under any of the above sources of other income.
- reasonable attorney fees included in any award or settlement. If the attorney fees are incurred because of your successful pursuit of Social Security disability benefits, such fees are limited to those approved by the Social Security Administration.
- group credit insurance.
- mortgage disability insurance benefits.
- early retirement benefits that have not been voluntarily taken by you.
- veteran's benefits.
- individual disability income insurance policies (other than those paid for by ODP).
- benefits received from an accelerated death benefit payment; or
- amounts rolled over to a tax qualified plan unless subsequently received by You while You are receiving benefit payments.

Period of Disability

A period of disability starts on the first day you are disabled as a direct result of a significant change in your physical or mental condition occurring while you are insured under the Executive LTD program. You must be receiving appropriate care and treatment by a Physician and complying with the requirements of such treatment.

The elimination period (the waiting period that must be satisfied before Executive LTD benefits are payable) begins on the day you become disabled and continues for a period of 180 days. Your disability ends (and thus your LTD benefits will also end) on the earliest of:

- The date the Claims Administrator finds you are no longer disabled or the date you fail to furnish proof that you are disabled.
- The date the Claims Administrator finds that you have withheld information which indicates you are performing, or can perform, the duties of a reasonable occupation.
- The date you refuse to be examined by, or cooperate with, an independent Physician or a licensed or certified health care practitioner, as requested.
- The date you cease to be under the regular care of a Physician.
- The date an independent medical exam report or functional capacity evaluation fails to confirm your disability.
- The date you reach the end of your Maximum Benefit Duration.
- The date you refuse to cooperate with or accept:
 - changes made to a work site or job process to suit your identified medical limitations; or
 - adaptive equipment or devices designed to suit your identified medical limitations which would enable you to perform your own occupation and provided that a Physician agrees that such changes or adaptive equipment suit your medical limitations.
- The date you refuse to participate in a Rehabilitation Program in the Claims Administrator's opinion would:
 - cure.
 - correct; or
 - limit your disability.
- The date your condition would permit you to work, or increase the number of hours you work, or the number or type of duties you perform in your own occupation, but you refuse to do so.
- The date you fail to cooperate in the administration of your LTD benefits or fail to follow the Claims Administrator's reasonable requests with respect to your benefits.
- The date you file or participate in filing a fraudulent, false, or misleading claim for benefits; or
- The date of your death.

What is Disability?

You will be considered disabled if you are unable to perform the material duties of your **own occupation** because of illness or injury, and you are unable to earn more than 80% of your Pre-disability Earnings.

For the purposes of determining whether a disability is the direct result of an accidental injury, the disability must have occurred within 90 days of the accidental injury and resulted from such injury independent of other causes.

If your own occupation requires a professional or occupational license or certification of any kind, you will not be deemed to be disabled solely because of loss of license or certification.

Disabilities can include those caused by pregnancy, prolonged illness or injury, and a Physician's certification that you are disabled by the condition will be required. The *Claims Administrator* may request any additional evidence it believes necessary before deciding that benefits are payable.

Disability Due to Mental or Nervous Disorders or Diseases

Under the IDI Policy, benefits for disabilities resulting from a mental disorder or substance use disorders are limited to an aggregate lifetime benefit of 24 months. This limitation does not apply to any period you are confined to a hospital.

Rehabilitation Incentives

Rehabilitation Program Incentive

If you participate in a rehabilitation program, your monthly benefit will be increased by an amount equal to 10% of the monthly benefit. This will be calculated before your monthly benefit is reduced by any other income.

Work Incentive

While you are disabled, you are encouraged to work. If you work while you are disabled and receiving monthly benefits, your monthly benefit will be adjusted as follows:

- Your monthly benefit will be increased by Your Rehabilitation Program Incentive, if any; and
 - reduced by other income as defined in *Income Which Will Reduce Your Disability Benefit*.
- Your monthly benefit as adjusted above will not be reduced by the amount You earn from working, except to the extent that such adjusted monthly benefit plus the amount You earn from working and the income You receive from other income exceeds 100% of your pre-disability earnings. In addition, the minimum monthly benefit will not apply.

Limit on Work Incentive

After the first 24 months following your elimination period, your monthly benefit will be reduced by 50% of the amount you earn from working while disabled.

How LTD Benefits Will Be Paid

If your claim is approved, benefits will begin to accrue on the day after the day you complete your elimination period. The first monthly benefit will be paid one month after the date benefits begin to accrue.

Subsequent payments will be made monthly, so long as you remain disabled. Payment will be based on the number of days you are disabled during each month and will be pro-rated for any partial month of disability.

Monthly benefits will be paid directly to you. If you die, the amount of any due and unpaid benefits (prior to your death) will be paid as described in the *Who Will Receive Payment* section.

Recovery from Disability

If you return to active work, you will be considered to have recovered from your disability.

The provisions of this subsection will not apply if your insurance has ended, and you are eligible for coverage under another group long-term disability plan.

If You Return to Active Work Before Completing Your Elimination Period

If you return to active work before completing your elimination period for a period of 30 days or less, and then become disabled again due to the same or related sickness or accidental injury, you will not be required to complete a new elimination period. The days you were disabled immediately prior to your return to work will be counted towards completing your elimination period due to the reoccurrence of your disability. For example, if you are disabled for 45 days, return to work for 10 days and then became disabled again due to the same or related cause, the previous 45 days will be counted towards completing your 180-day elimination period when your disability reoccurs.

If you return to active work for a period of more than 30 days and then become disabled again, you will have to complete a new 180-day elimination period, and any previous days you were disabled will not be counted.

For purposes of this provision, the term active work only includes those days that you work.

If You Return to Active Work After Completing Your Elimination Period

If you return to active work after completing your elimination period for a period of 180 days or less and then become disabled again due to the same or related sickness or accidental injury, you will not be required to complete a new elimination period. For the purposes of determining your benefits, such disability will be a part of the original disability and will use the same pre-disability earnings and apply the same terms, provisions and conditions that were used for the original disability.

If you return to active work for a period of more than 180 days and then become disabled again, you will have to complete a new 180-day elimination period, and your pre-disability earnings, terms, provisions and conditions in effect on the day of your second disability will apply (not those in effect for your previous disability).

For purposes of this provision, the term active work includes all the continuous days which follow your return to work for which you are not disabled.

Assignment of Insurance

The rights and benefits under the group policy are not assignable prior to a claim for benefits, as required by law.

Contract Not a Substitute for Workers' Compensation Insurance

Executive LTD is not in lieu of and does not affect workers' compensation benefits. However, any workers' compensation benefits are considered other income benefits.

What's Not Covered

Benefits will not be paid for any disability that:

- is due to intentionally self-inflicted injury (while sane or insane).
- results from your commission of, or attempting to commit, a criminal act.
- attempted suicide.
- is due to war or any act of war (declared or not declared).
- is due to the service in the armed forces of any government.
- is incurred during a time that you are not eligible for Executive LTD benefits; or
- is due to insurrection, rebellion, or taking part in a riot or civil commotion.

On any day during a period of disability that a person is confined in a penal or correctional institution for conviction of a criminal or other public offense:

- the person will not be deemed to be disabled; and
- no benefits will be payable.

Termination of Coverage

- Your insurance will end on the earliest of:
- the date the group policy ends; or
- the date insurance ends for Your eligible classification; or
- the end of the period for which the last premium has been paid for you; or
- the date you cease to be in an eligible classification. You cease to be in an eligible classification on the date You cease active work in an eligible classification, if you are not disabled on that date; or
 - the date you retire in accordance with the date your employment ends; or
 - the date your employment ends; or
 - the date the Plan is amended or terminated to eliminate Executive LTD coverage.

Notwithstanding the foregoing, during an approved leave of absence (whether paid or unpaid), Executive LTD coverage will continue the same terms and conditions as if you had continued to actively work. An approved leave of absence includes any leave period covered by the Family and Medical Leave Act

("FMLA") and the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). If you are on an approved leave of absence or an FMLA or USERRA leave of absence and you do not return to work at the end of such leave, your Executive LTD coverage will terminate at the end of your leave, subject to earlier termination as provided above.

Reinstatement of Disability Income Insurance

If your insurance ends, you may become insured again as follows:

- If your insurance ends because:
 - You cease to be in an eligible classification; or
 - Your employment ends; and
- You become a member of an eligible classification again within 3 months of the date your insurance ended; you will not have to complete a new Waiting Period.
- If your insurance ends because the required premium for your insurance has ceased to be paid due to your being on an approved Family Medical Leave Act (FMLA) leave of absence, and you become a member of an eligible class within 31 days of the earlier of:
 - The end of the period of leave you and the policyholder agreed upon; or
 - The end of the 12-week period following the date your leave began,You will not have to complete a new waiting period.
- In all other cases where your insurance ends because the required premium for your insurance has ceased to be paid; you will be required to provide evidence of your insurability.

How to File an Executive LTD Claim

Obtain a claim form as described below and fill it out carefully. Return the completed claim form with the required proof to the *Plan Administrator*, who will certify your insurance under Executive LTD and send the certified claim form and proof to MetLife.

When MetLife receives the claim form and proof, the claim will be reviewed and, if approved, benefits will be paid subject to the terms and provisions of the Executive LTD plan.

Claims for Insurance Benefits

When a claimant files an initial claim for Executive LTD benefits, both the notice of claim and the required proof should be sent to MetLife within 90 days of the date you are first disabled.

Notice of claim and proof may also be given to MetLife by following the steps set forth below:

Step 1

A claimant may provide notice by calling MetLife at the toll-free number shown in the *Administrative Information* section within 20 days of the date you are first disabled.

Step 2

A claim form will be sent to the claimant with an explanation of how to complete it. The claimant should receive the claim form within 15 days of providing notice of claim.

Step 3

When the claimant receives the claim form, the claimant should fill it out as instructed and return it with the required proof described in the claim form.

If the claimant does not receive a claim form within 15 days after providing notice of claim, proof may be sent using any form sufficient to provide the required proof.

Step 4

The claimant must give MetLife proof not later than 90 days after the period for which the insurer is liable. If notice of claim or proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and proof are given as soon as is reasonably possible.

Items to be Submitted for a Disability Income Insurance Claim

When submitting proof on an initial or continuing claim for Executive LTD benefits, the following items may be required:

- Documentation which must include, but is not limited to, the following information:
 - the date your disability started.
 - the cause of your disability.
 - the prognosis of your disability.
 - the continuity of your disability; and
 - Your application for:
 - Other income.
 - Social Security disability benefits; and
 - Workers' compensation benefits or benefits under a similar law.
- Written authorization for MetLife to obtain and release medical, employment and financial information and any other items that may be reasonably required to document your disability or to determine your receipt of or eligibility for other income.
- All medical information, including but not limited to:
 - x-ray films; and
 - photocopies of medical records, including:
 - histories,
 - physical, mental, or diagnostic examinations; and
 - treatment notes; and
- the names and addresses of all:
 - physicians and medical practitioners who have provided you with diagnosis, treatment, or consultation.
 - hospitals or other medical facilities which have provided you with diagnosis, treatment, or consultation; and
 - pharmacies which have filled your prescriptions within the past three years.

Time Limit on Legal Actions

A legal action on a claim may only be brought against MetLife during a certain period. This period begins 60 days after the date proof of your disability is filed and ends 5 years after the date such proof is required.

General Provisions

Who Will Receive Payment

MetLife will make any benefit payments during your lifetime to you or your legal representative. Any payment made in good faith will discharge MetLife from liability to the extent of such payment.

In the event of your death, MetLife will pay any amount that is or becomes due to your designated beneficiary. If there is no beneficiary designated or no surviving beneficiary at your death, any benefit that is or becomes due will be paid according to the following order:

- Your spouse, if alive.
- Your unmarried child(ren) under age 25; if there is no surviving Spouse; or
- Your estate if there is no such surviving child.

If more than one person is eligible to receive payment, the benefit amount will be divided in equal shares.

Payment to a minor or incompetent will be made to such person's guardian. The term "children" or "child" includes natural and adopted children.

Any periodic payments owed to your estate may be paid in a single sum. Any payment made in good faith will discharge MetLife from liability to the extent of such payment.

Incontestability: Statements Made by You

Any statement made by you will be considered a representation and not a warranty. Such statements will not be used to contest insurance, reduce benefits, or defend a claim unless the following requirements are met:

- the statement is in a written application or enrollment form.
- You have signed the application or enrollment form; and
- a copy of the application or enrollment form has been given to you or your beneficiary.

Your statements which relate to insurability will not be used to contest disability benefits after it has been in force for 2 years during your life. In addition, such statements will not be used to contest an increase or benefit addition to such insurance after the increase or benefit has been in force for 2 years during your life, unless the statement is fraudulent.

Misstatement of Age

If your age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, the benefits and/or premiums will be adjusted.

Physical Exams

If a claim is submitted for insurance benefits, MetLife has the right to ask that you be examined by a Physician(s) of their choice as often as is reasonably necessary to process the claim. MetLife will pay the cost of such exam.

Autopsy

MetLife has the right to make a reasonable request for an autopsy where permitted by law. Any such request will set forth the reasons the autopsy is being requested. MetLife will pay the cost of such autopsy.

Information Which May Be Collected

Our providers rely mainly on the information you file during the enrollment process and when you file claims.

In addition, they may also collect information about you from other sources. This is information necessary for them to perform their function about the insurance transaction in question. For example, if the amount or type of coverage you are entitled to depends on your earnings or job class, the provider would obtain that information from the employer.

Benefits Not Transferable

No person other than an eligible associate is entitled to receive benefits under the Plan. Such rights to benefits are not transferable.

No Guarantee of Employment

Nothing in this Flex SPD or on ODP's websites may or can be construed or interpreted as a guarantee of future employment with ODP or continued employment for any duration.

Overpayments for Disability Income Insurance

Recovery of Overpayments

MetLife has the right to recover any amount that is determined to be an overpayment.

An overpayment occurs if it is determined that:

- the total amount paid on Your claim is more than the total of the benefits due to you; or
- payment should have been made by another group plan.

If such overpayment occurs, you have an obligation to reimburse MetLife. MetLife's rights and your obligations in this regard are described in the reimbursement agreement that you are required to sign when you submit a claim for benefits. This agreement:

- confirms that you will reimburse MetLife for all overpayments; and
- authorizes MetLife to obtain any information relating to sources of other income.

How Overpayments are Recovered

Overpayments may be recovered from you by:

- stopping or reducing any future disability benefits, including the minimum benefit, payable to you or any other payee under the disability sections.
- demanding an immediate refund of the overpayment from you; and
- taking legal action.

If the overpayment results from MetLife having made a payment to you that should have been made under another group plan, such overpayment may be recovered from one or more of the following:

- any other insurance under ODP.
- any other organization; or
- any person to or for whom payment was made.

Clerical Error

No clerical error on the part of ODP, the Plan, or the Claims Administrator shall operate to defeat any of the rights, privileges, services, or benefits of any associate hereunder, nor create or continue coverage which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or benefits will be made when the error or delay is discovered.

Confidentiality Notice

The Claims Administrator considers Personal Information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. Personal Information includes information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of the disability options, or other related activities, the Claims Administrator will use personal information internally, share it with affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, claims and/or third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law.

Some of the ways in which personal information is used include claim payment; utilization review and management; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; disability claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and claims and/or third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. MetLife considers these activities key for the operation of our disability programs.

Right of Reimbursement and Subrogation

If you suffer from a Disability caused by the actions or omissions of a third party, MetLife has the right to recover from the third party the Disability payments that it made to you. For this purpose, a “party” means any individual, entity, person or other party responsible for causing your Disability or responsible for making any payment to you due to your Disability, including uninsured motorist coverage, underinsured motorist coverage, traditional fault-based automobile insurance coverage, no-fault automobile insurance coverage, homeowner’s/renter’s insurance, personal umbrella coverage, workers’ compensation coverage and any first-party insurance coverage. For example, if you are injured in a car accident, the person who caused the accident (and the person’s insurer) are the “third parties.”

MetLife also has the same “right of subrogation” rights that you have against the party, e.g., MetLife can bring a lawsuit against the party to recover disability benefits paid to you if you choose not to do so.

The specific terms, conditions and rights of reimbursement and subrogation that apply to MetLife are explained in the individual disability insurance certificate and the group insurance certificate. If you do not have a copy of these certificates, please contact the Benefits Department or the Claims Administrator.

Executive LTD Coverage - Special Services

Social Security Assistance Program

If you become disabled, MetLife provides you with assistance in applying for Social Security disability benefits. Before outlining the details of this assistance, you should understand why applying for Social Security disability benefits is important.

Why You Should Apply for Social Security Disability Benefits

Both you and ODP contribute payroll taxes to Social Security. A portion of those tax dollars are used to finance Social Security’s program of disability protection. Your spouse and children may also be eligible to receive Social Security disability benefits due to your disability.

There are several reasons why it may be to your financial advantage to receive Social Security disability benefits. Some of them are:

- **Avoids Reduced Retirement Benefits**

Should you become disabled and approved for Social Security disability benefits, Social Security will freeze your earnings record as of the date Social Security determines that your disability has begun. This means that the months/years that you are unable to work because of your disability will not be counted against you in figuring your average earnings for retirement and survivor’s benefit.

- **Medicare Protection**

Once you have received 24 months of Social Security disability benefits, you will have Medicare protection for hospital expenses. You will also be eligible to apply for the medical insurance portion of Medicare.

- **Trial Work Period**

Social Security provides a trial work period for the rehabilitation efforts of disabled workers who return to work while still disabled. Full benefit checks can continue for up to 9 months during the trial work period.

- **Cost-of-Living Increases Awarded by Social Security Will Not Reduce Your Disability Benefits**

MetLife will not decrease your disability benefit by the periodic cost-of-living increases awarded by Social Security. This is also true for any cost-of-living increases awarded by Social Security to your spouse and children.

This is called a Social Security “freeze.” It means that only the Social Security benefit awarded to you and your dependents will be used by MetLife to reduce your disability benefit, with the following exceptions:

- an error by Social Security in computing the initial amount.
- a change in dependent status; or
- your Employer submitting updated earnings records to Social Security for earnings received prior to your Disability.

Over a period of years, the net effect of these cost-of-living increases can be substantial.

How MetLife Assists You in the Social Security Approval Process

As soon as you apply for disability benefits, MetLife will assist with the Social Security approval process.

- **Assistance Throughout the Application Process**

MetLife has a dedicated team of Social Security Specialists. These Specialists, many of whom have worked for the Social Security Administration, are also located within our Claim Department. They provide expert assistance up front, offer support while you are completing the Social Security forms, and help guide you through the application process.

- **Guidance Through Appeal Process by Social Security Specialists**

Social Security disability benefits may be initially denied but are often approved following an appeal. If your benefits are denied, our dedicated team of Social Security Specialists provides expert assistance on an appeal if your situation warrants continuing the appeal process. They guide you through each stage of the appeal process. These stages may include:

- Reconsideration by the Social Security Administration
- Hearing before an Administrative Law Judge
- Review by Appeals Council within the Social Security Administration in Washington, D.C.
- A civil suit in Federal Court

- **Social Security Attorneys**

Depending on your individual needs, MetLife may provide a referral to an attorney who specializes in Social Security law. The Social Security approved attorney's fee is credited to the Long-Term Disability overpayment, which results upon your receipt of the retroactive Social Security benefits. The attorney's fee, which is capped by Social Security law, will be deducted from the lump sum Social Security Disability benefits award, and will not be used to further reduce your Long-Term Disability benefit.

Early Intervention Program

The MetLife Early Intervention Program is offered to all covered associates, and your participation is voluntary*. The program helps identify early those associates who might benefit from vocational analyses

and rehabilitation services before they are eligible for Long Term Disability benefits. Early rehabilitation efforts are more likely to reduce the length of your Long-Term Disability and help you return to work sooner than expected.

If you cannot work, or can only work part-time due to a disability, ODP will notify MetLife. MetLife's Clinical Specialists may be able to assist you by:

- Reviewing and evaluating your disabling condition, even before a claim for Long Term Disability benefits is submitted (with your consent).
- Designing individualized return to work plans that focus on your abilities, with the goal of return to work.
- Identifying local community resources.
- Coordinating services with other benefit providers, including medical carrier, short-term disability carrier, * Workers' Compensation carrier, and state disability plans.
- Monitoring return to work plans in progress and modifying them as recommended by the attending physician (with your consent).

Assistance is offered at no cost to either you or ODP.

Return to Work Program

Goal of Rehabilitation

The goal of MetLife is to focus on your abilities, instead of disabilities. This "abilities" philosophy is the foundation of MetLife's Return to Work Program. By focusing on what you can do versus what you can't, MetLife can assist you in returning to work sooner than expected.

Incentives for Returning to Work

Your disability plan is designed to provide clear advantages and financial incentives for returning to work either full-time or part-time, while still receiving a disability benefit. In addition to financial incentives, there may be personal benefits resulting from returning to work. Many associates experience higher self-esteem and the personal satisfaction of being self-sufficient and productive once again. If it is determined that you are capable, but you do not participate in the Return-to-Work Program, your disability benefits may cease.

Return-to-Work Services

As a covered associate, you are automatically eligible to participate in our Return-to-Work Program. The program aims to identify the necessary training and therapy that can help you return to work. In many cases, this means helping you return to your former occupation, although rehabilitation can also lead to a new occupation which is better suited to your condition and makes the most of your abilities.

There is no additional cost to you for the services that MetLife provides, and they are tailored to meet your individual needs. These services include, but are not limited to, the following:

- **Vocational Analyses**
 - Assessment and counseling to help determine how your skills and abilities can be applied to a new or a modified job.
- **Labor Market Surveys**
 - Studies to find jobs available in your locale that would utilize your abilities and skills. Also identify one's earning potential for a specific occupation.
- **Retraining Programs**
 - Programs to facilitate return to your previous job, or to train you for a new job.
- **Job Modifications/Accommodations**
 - Analyses of job demands and functions to determine what modifications may be made to maximize your employment opportunities. This also includes changes in your job or accommodations to help

you perform the previous job or a similar vocation, as required of your employer under the Americans with Disabilities Act (ADA).

- **Job Seeking Skills and Job Placement Assistance**

- Special training to identify abilities, set goals, develop resumes, polish interviewing techniques, and provide other career search assistance.

Return-to-Work Program Staff

The Case Manager handling your claim will coordinate return-to-work services. You may be referred to a clinical specialist, such as a Nurse Consultant, Psychiatric Clinical Specialist, or Vocational Rehabilitation Consultant, who has advanced training and education to help people with disabilities return to work. One of the clinical specialists will work with you directly, as well as with local support services and resources.

Rehabilitation Vendor Specialists

In many situations, the services of independent vocational rehabilitation specialists may be utilized. Services are obtained at no additional cost to you; MetLife pays for all vendor services. Selecting a rehabilitation vendor is based on:

- attending physician's evaluation and recommendations.
- your individual vocational needs; and
- vendor's credentials, specialty, reputation, and experience.

When working with vendors, MetLife continues to collaborate with you and your doctor to develop an appropriate return-to-work plan.

Employee Assistance Plan (EAP)

The ODP Employee Assistance Program (EAP) provides a highly confidential and an experienced source of help for associates and their household family members who are experiencing personal problems, need referrals for child/elder care, or want to address legal and financial concerns.

You and your household family members have up to five (5) face-to-face counseling sessions (per incident) with an in-network counseling professional at no cost to you. Additional counseling sessions are not covered by the EAP; however, if you are enrolled in an ODP medical option, you may utilize that option's mental health services. You are not required to use the EAP first. If you are eligible, you may utilize the ODP medical option for any mental health services. Refer to the Benefit Summaries for the medical options for additional information.

When faced with a crisis, you may call the EAP at (800) 789-2273. The EAP provides you with immediate telephone-based crisis intervention and stabilization services 24 hours a day, 365 days a year. The EAP also offers information, resources, and self-help tools on a wide range of issues online through the website at www.member.magellanhealthcare.com including:

- **Work-Life Services:** Specialist provide expert guidance and personalized referrals to service providers including childcare, adult care, education, home improvement, consumer information, emergency preparedness and more.
- **Legal Assistance, Financial Coaching & Identity Theft Resolution:** Expert consultation to help with your legal, financial and identity theft needs. Access a free online library with resources for identity theft resolution, budgeting, debt management, family law, wills and more.
- **Counseling, Coaching & Online programs:** Resources to help with challenges such as anxiety, grief, depression, relationships and more. Meet with a counselor in-person, via text message, live chat, phone, or video.

How to Access the EAP Website

- Log on to www.member.magellanhealthcare.com
- If you are already registered, click **Sign in** and enter your email and password.
- To register, go to **Sign Up** and under **Find my Company**, search for The ODP Corporation. Follow the remaining prompts to set up your account.
- Note: you may enter as a "guest" however, you will have limited access.

How to Receive Benefits

The EAP is available 24 hours a day, seven days a week at (800) 789-2273. When you call, an EAP representative will ask some initial information and assist you with locating a counselor convenient to your location. You may also access information about the EAP online at www.member.magellanhealthcare.com.

If at any time during your treatment the counselor determines that your issue cannot be resolved within five (5) face-to-face sessions, the counselor will refer you to another provider whose services will not be covered under the EAP. Those services might be covered by your medical plan, if applicable, but they will not be covered by the EAP. You decide whether to use the other provider's services.

Confidentiality

Qualified counselors provide services with full confidentiality. Magellan will put you in touch with highly trained counselors carefully selected for their professional experience, reputation, and expertise. These specialists include licensed psychologists, clinical social workers, marriage and family therapists, certified alcohol and drug counselors, and attorneys, as well as financial, childcare, adult care, academic, adoption and personal care consultants.

Your concerns, their source, your treatment, and the resolution will always be afforded the maximum confidentiality required by law.

Filing a Claim

There are no claim forms required for services provided under the EAP. All services must be accessed by dialing (800) 789-2273 or making an online request for services at www.member.magellanhealthcare.com.

Disciplinary Action

Participation in the EAP is voluntary, is not reported to ODP and does not affect ODP's right to take disciplinary action in the event of unsatisfactory performance, attendance, or conduct before, during, or after participation in the EAP. Your participation in the EAP does not affect employment decisions made by ODP.

What's Not Covered

The following services are not covered by the EAP coverage under the Plan:

- Services not authorized by Magellan.
- Inpatient behavioral healthcare treatment.
- Healthcare services of any kind including prescription drugs.
- Testing, screening, or treatment of learning disabilities.
- Missed appointments.
- Court ordered testing and treatment.
- Any treatment provided through Workers' Compensation or for which the recipient was not legally obliged to pay.
- Professional services received from a household member or relative.
- Services rendered before coverage was effective or after coverage terminates.

Special Rule for COBRA Continuation Coverage

COBRA qualified beneficiaries who are eligible for EAP coverage upon the occurrence of a qualifying event will be eligible to continue EAP coverage after the qualifying event for a period of time equal to the applicable COBRA continuation coverage period. (Disability extensions and second qualifying event extensions will be automatically approved.) For example, if you are eligible for the EAP and you terminate employment, you and your applicable family members will be able to continue EAP coverage for up to 18 months after your termination, subject to extension as noted above. In no event will EAP coverage be continued longer than 36 months after the qualifying event for any applicable qualified beneficiary. This limited continuation of EAP coverage shall be your COBRA continuation coverage for EAP. COBRA continuation coverage for the EAP is automatic – no election or payment of premiums is necessary to obtain this continuation of EAP coverage. COBRA qualified beneficiaries should directly contact the EAP provider listed in this EAP section to obtain EAP services during the applicable COBRA continuation coverage period.

COBRA

You and your dependents may extend your medical, dental, vision, EAP and Health Care Flexible Saving Account (“FSA”) coverage in certain instances when coverage would otherwise end.

General eligibility requirements are described in the *Benefits Basics* section of this booklet. COBRA-specific eligibility requirements are described within this section.

This section of the Flex SPD is intended to provide a summary of the major provisions of a plan in which you may be eligible to participate in COBRA. Your benefits are described as clearly as possible, with minimal use of the technical words and phrases appearing in the official plan documents. However, this description is not intended to augment rights provided under the terms of the official plan documents.

Your COBRA Rights

The health care program gives you and your dependents the option to extend your health care coverage through COBRA in certain instances when coverage under the program would otherwise end. COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. The following sections set forth in general terms your rights and obligations under COBRA. A copy of your initial notice of COBRA rights and obligations as required by COBRA, which you may have received separately, also follows this general description.

Domestic partners and their eligible dependent children are not eligible for COBRA coverage unless they qualify as the associate’s tax dependents. However, ODP does provide continuation coverage to domestic partners and their children. This coverage (referred to throughout this Flex SPD as “continuation coverage” will generally be administered in the same manner as COBRA coverage unless specifically noted otherwise. Domestic partner continuation coverage is not COBRA coverage and is not required by law. ODP reserves the right to amend, modify, reduce, discontinue, or terminate continuation coverage at any time.

COBRA Participation

If one of the circumstances listed in the COBRA Continuation Coverage Period chart below causes you or a dependent to lose health coverage, you may continue coverage in the medical, dental, and vision plans, as well as the Health Care FSA for yourself and your dependents - if you pay the entire cost of coverage, plus two percent (2%) to cover administrative expenses. The Health Care FSA continues only through the end of the current plan year, at which point you may no longer contribute. Domestic partners and their eligible dependents cannot continue Health Care FSA coverage unless they are considered your tax dependents.

COBRA/continuation coverage is available for a maximum of 18, 29 or 36 months, depending on the circumstances outlined in the COBRA/Continuation Coverage Period chart. The maximum continuation period if multiple circumstances should occur is a total of 36 months. For example, if you terminate and then die while on COBRA/continuation coverage, your covered dependents’ coverage may continue for a total of 36 months if COBRA/continuation coverage was in effect at your death.

It is the responsibility of you or your spouse, domestic partner, dependent child or dependent child of domestic partner (each a “covered dependent”) who would lose coverage to contact the Benefits Department at BenefitsTeam@theodpcorp.com, within 60 days of the event to request an application to continue participation due to a qualifying event such as divorce, legal separation, termination of domestic partnership, or your child or your domestic partner’s child losing eligibility for coverage. While you are receiving COBRA continuation coverage benefits, it is the responsibility of you and your covered dependents to contact the bswift COBRA Service Center if you or a covered dependent have a second qualifying event or are determined to be disabled by the Social Security Administration.

To extend COBRA continuation coverage beyond 18 months because of disability, you or your covered dependent must be deemed disabled by the Social Security Administration (SSA) within sixty (60) days of your qualifying event. Notice of the SSA's determination must be provided to the Plan Administrator during the initial 18-month coverage period and within 60 days of the date on the notification letter.

ODP is responsible for notifying the COBRA Administrator of certain qualifying events that result in your loss of coverage such as reduction of your work hours, your termination of employment, retirement, Medicare eligibility or death.

You or your covered dependents must pay the full group rate for continued coverage, plus two percent for administrative expenses. In addition, if you or a covered dependent are disabled and coverage continues for 29 months, during the 19th through 29th month of COBRA/continuation coverage participation, the cost for coverage will be greater than that charged for the first 18 months of coverage (up to 150 percent).

You or your covered dependents have 60 days from the COBRA/continuation coverage election notice date to elect continued participation under COBRA/continuation coverage. Once you make your election, you will have 45 days to pay the initial premium payment. COBRA/continuation coverage will be effective the day after the qualifying event.

COBRA/Continuation Coverage Continuation Period			
Circumstances	Maximum Continuation Period		
	Associate	Spouse/ Partner	Child
Associate loses coverage because of reduced work hours	18 months	18 months	18 months
Associate retires, goes on strike, is laid off or terminates for any reason (except gross misconduct)	18 months	18 months	18 months
Associate or covered dependent is disabled (as defined by Title II or XVI of the Social Security Act) during the first 60 days of COBRA coverage, and provides notice within initial 18-month period and within 60 days of receiving the Social Security determination	29 months	29 months	29 months
Associate dies	N/A	36 months*	36 months*
Associate and spouse legally separate or divorce, or associate and domestic partner terminate their domestic partnership	N/A	36 months	36 months
Associate or covered dependent becomes entitled to Medicare	N/A	36 months	36 months
Child no longer qualifies as dependent	N/A	N/A	36 months
* If your covered dependent is eligible for six months of extended coverage under the Medical, Dental, and Vision Options, then the maximum COBRA/continuation coverage period for medical, dental, and vision will be 30 months.			

Health Insurance Marketplace

The Marketplace offers “one-stop shopping” to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and

copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you decide to enroll. Through the Marketplace, you will also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.healthcare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage will not limit your eligibility for coverage or for a tax credit through the Marketplace.

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days, your special enrollment period will end and you may not be able to enroll until annual enrollment, so you should act right away if you think that you may want Marketplace coverage. In addition, you may also enroll in Marketplace coverage annually during what is called an "open enrollment" period. The open enrollment period is the time during which anyone can purchase coverage through the Marketplace. To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.healthcare.gov.

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also choose to end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." If, however, you terminate your COBRA continuation coverage early without another qualifying event, you will have to wait to enroll in Marketplace coverage until the next open enrollment period and could end up without any health coverage in the interim.

Once you have exhausted your COBRA continuation coverage and the coverage expires, you will be eligible to enroll in Marketplace coverage through a special enrollment period, even if you enroll outside of the Marketplace open enrollment.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 31 days of the loss of coverage. If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you are eligible, you will have another opportunity to enroll in the other group health plan within 31 days of losing your COBRA continuation coverage.

Before making your health coverage decision, consider the following:

- **Premiums:** You can be charged up to 102% of total plan premiums for COBRA coverage (more if you qualify for an extension of coverage on account of a disability). Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- **Provider Networks:** If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- **Drug Formularies:** If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- **Service Areas:** Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.

- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

If you have questions about your right to coverage, contact the COBRA Administrator.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-(866) 444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assistant in your area who you can talk to about the different options, visit www.HealthCare.gov.

USERRA Continuation Coverage

If you, your spouse or your dependent children lose coverage under the Plan as a result of your qualifying service in the uniformed services, you have the right to elect to continue such coverage under Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). To be entitled to USERRA rights, you must give advance notice of your service unless it is impossible or unreasonable under the circumstances to give such notice or giving such notice is precluded by military necessity. Service in the uniformed services includes performance of duty on a voluntary or involuntary basis in the Armed Forces (including the Coast Guard and the Reserves), the Army National Guard, the Air National Guard, and the commissioned corps of the Public Health Service.

Your right to continued health coverage under USERRA is very similar, but not identical, to your right to continued health coverage under COBRA. In those instances where your rights under COBRA and USERRA are not the same, whichever law gives you the greater benefit will apply. The administrative policies and procedures, which govern your right to COBRA continuation coverage, also apply to your right to USERRA continuation coverage, with a few limited exceptions.

Any election that you make under COBRA will also be an election to continue your health coverage under USERRA. If, however, you are unable to elect COBRA within the required period because of military necessity or because it is impossible or unreasonable for you to do so, the period for electing USERRA coverage will be tolled until the military necessity is abated or it is no longer impossible or unreasonable for you to make the required election. The period for electing COBRA coverage, however, will not be tolled in this situation.

You are the only one that has the right to make an election under USERRA to continue health coverage for yourself and any covered dependents. Your covered Dependents do not have an independent right to make an election for USERRA continuation coverage. As a result, if you do not elect USERRA / COBRA coverage on behalf of your covered dependents, your covered dependents will still have a right to elect to continue their health coverage under COBRA, but they will not be entitled to receive any additional benefits provided under USERRA.

If you elect to continue health coverage for yourself (or your covered dependents) under USERRA, you must pay 102% of the full premium elected (the same rate as COBRA) at the same time as the premium for COBRA coverage is due. However, if your uniformed service period is less than 31 days, you are not required to pay more for health coverage than you would be required to pay as an active associate.

USERRA continuation coverage will generally continue for up to 24 months following the date your leave of absence begins. However, this coverage will terminate earlier if any one of the following events occurs:

- A premium payment is not made within the required time.

- You fail to return to work within the time required under USERRA following the completion of your service in the uniformed services; or
- You lose your rights under USERRA because of a dishonorable discharge or other conduct specified in USERRA.

Although COBRA coverage and USERRA coverage begin at the same time, they do not end at the same time. COBRA coverage continues for up to 18 months (although, if certain events occur, it can be extended), while USERRA coverage continues for to 24 months as described above. On the other hand, there are certain events, like your failure to return to work at the end of your service or a dishonorable discharge, which cause your USERRA coverage to terminate early, but which do not cause COBRA coverage to terminate. In that situation, even if your USERRA coverage terminates, you may still be entitled to continued health coverage under COBRA.

Special Rule for Health Care FSA

For those qualified beneficiaries who are enrolled in the Health Care FSA upon the occurrence of a qualifying event, COBRA coverage under the Health Care FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered associate, reduced by reimbursements up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health Care FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the Health Care FSA coverage in effect at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The “use or lose” rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year (which is December 31). Further, COBRA coverage will terminate at the end of the plan year and cannot be extended beyond the plan year in which the qualifying event occurs. Domestic partners and their eligible dependents cannot continue Health Care FSA coverage unless they are considered your tax dependents.

Special Rule for the Employee Assistance Program

Qualified beneficiaries who are eligible for EAP coverage upon the occurrence of a qualifying event will be eligible to continue EAP coverage after the qualifying event for a period equal to the applicable COBRA/continuation coverage period. (Disability extensions and second qualifying event extensions will be automatically approved.) For example, if you are eligible for the EAP and you terminate employment with ODP, you and your applicable family members will be able to continue EAP coverage for up to 18 months after your termination, subject to extension as noted above. In no event will EAP coverage be continued longer than 36 months after the qualifying event for any applicable qualified beneficiary. This limited continuation of EAP coverage shall be your COBRA/continuation coverage for EAP. COBRA continuation coverage for the EAP is automatic – no election or payment of premiums is necessary to obtain this continuation of EAP coverage. Qualified beneficiaries should directly contact the EAP provider listed in the EAP section to obtain EAP services during the applicable COBRA/continuation coverage period.