YOUR SHORT TERM DISABILITY INCOME INSURANCE PLAN

ODP International, LLC

GROUP SHORT TERM DISABILITY INCOME INSURANCE
CERTIFICATE OF COVERAGE

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

To present inquires, obtain information about coverage, or get assistance to resolve a complaint, please call us at 866-228-8742. To receive claims assistance, please call us at 800-955-7736.

POLICYHOLDER: ODP International, LLC

GROUP POLICY NUMBER: 74634-7STD2

POLICY EFFECTIVE DATE: January 1, 2025

POLICY ANNIVERSARY DATE: January 1

GOVERNING JURISDICTION: **Florida**

ReliaStar Life Insurance Company certifies that we have issued the group Policy listed above to the Policyholder. The Policy is available for you to review if you contact the Policyholder for more information. Subject to the provisions of this Certificate, we certify that eligible Employees are insured for the benefits described in this Certificate. **This is your Certificate as long as you are eligible for coverage and you become insured. Please read it carefully and keep it in a safe place.**

This Certificate summarizes and explains the parts of the Policy which apply to you, if you are an eligible Employee as defined. The Certificate is part of the group Policy but by itself is not a Policy. This Certificate replaces any other Certificates we may have given you under the Policy. Your coverage may be changed under the terms and conditions of the Policy. The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. Your rights and benefits under the Policy will not be less than those stated in your Certificate.

For purposes of effective dates and ending dates under the Policy, all days begin at 12:01 a.m. standard time at the Policyholder's address and end at 12:00 midnight standard time at the Policyholder's address.

In this Certificate, “you” and “your” refer to an Employee who is eligible for coverage under the Policy; “we”, “us” and “our” refer to ReliaStar Life Insurance Company.

READ THIS CERTIFICATE CAREFULLY! Insurance benefits may be subject to certain requirements, reductions, limitations and exclusions.

GROUP DISABILITY INCOME INSURANCE

Group disability income insurance provides benefits to replace a portion of your income while you are Disabled. The amount you receive is based on the amount you earned before your Disability began, subject to all policy provisions. Group insurance covers a group of persons under a single policy issued to a group policyholder.

Premiums for disability income insurance are Contributory by Insured Persons.

Signed for ReliaStar Life Insurance Company at its home office in Minneapolis, Minnesota on the Policy Effective Date.

Robert L. Grubka
President

Melissa A. O'Donnell
Secretary

TABLE OF CONTENTS

Section	page
Cover Page	1
Table of Contents	2
Schedule of Benefits	3
Definitions	5
General Provisions	9
Disability Benefits	14
Exclusions and Limitations	17
Claims	18

Policyholder's Contact Information:
ODP International, LLC, 6600 North Military Trail, Boca Raton, FL 33496

Florida Insurance Department Phone Number: 1-877-693-5236

California residents:
If you are age 65 or older on the effective date of any coverage under the Policy for which you are required to pay all or part of the premium, then you have 30 days from the date you receive your initial Certificate to cancel your coverage and have your full premium contribution and any policy or membership fee paid refunded, by returning the Certificate to the Policyholder by mail or other delivery method for cancellation without claim.

Arizona residents:
Notice: This Certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this Certificate carefully.

Maryland residents:
Notice: This Certificate of insurance may not provide all benefits required for a policy issued and delivered in Maryland.

West Virginia residents:
Please read this Certificate carefully. If you are not satisfied with it for any reason, you may return it within 10 days after receipt for a refund of any premium you paid.

SCHEDULE OF BENEFITS

EMPLOYER: ODP International, LLC

GROUP POLICY NUMBER: 74634-7STD2

ELIGIBLE CLASS(ES)

All eligible Associates, excluding Associates working in Puerto Rico, that are Employees in Active Employment with the Employer in the United States.

You must be an Employee of the Employer and in an eligible class.

Temporary workers are excluded from coverage.
Seasonal workers are excluded from coverage.

MINIMUM HOURS REQUIREMENT

Classified as a regular full-time associate scheduled to work at least 30-hours per week

ELIGIBILITY WAITING PERIOD

For persons in an eligible class on or before the Policy Effective Date: End of month in which you complete a continuous period of 30 days of Active Employment.

For persons entering an eligible class after the Policy Effective Date: End of month in which you complete a continuous period of 30 days of Active Employment.

WHO PAYS FOR THE COVERAGE

You pay the cost of your coverage.

ELIMINATION PERIOD

7 consecutive days.

The elimination period begins on the first day of your Disability.

Benefits for a Payable Claim begin the day after the elimination period is completed.

MAXIMUM BENEFIT

The Maximum Benefit is: $1,154 per week.

WEEKLY BENEFIT FOR ASSOCIATES ELECTING THE 10% BENEFIT

10% of Weekly Earnings to a Maximum Benefit of $1,154 per week.

Your benefit may be reduced by Disability Earnings. Some Disabilities may not be covered or may have limited coverage under the Policy.

WEEKLY BENEFIT FOR ASSOCIATES ELECTING THE 15% BENEFIT

15% of Weekly Earnings to a Maximum Benefit of $1,154 per week.

Your benefit may be reduced by Disability Earnings. Some Disabilities may not be covered or may have limited coverage under the Policy.

WEEKLY BENEFIT FOR ASSOCIATES ELECTING THE 20% BENEFIT

20% of Weekly Earnings to a Maximum Benefit of $1,154 per week.

Your benefit may be reduced by Disability Earnings. Some Disabilities may not be covered or may have limited coverage under the Policy.

WEEKLY EARNINGS

Weekly Earnings means your gross weekly income from your Employer in effect just prior to your date of Disability. It includes your total income before taxes and any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, flexible spending account or health savings account. It includes income received from commissions averaged over the 12 months just prior to your date of Disability. It does not include income received from bonuses, overtime pay, any other extra compensation, or income received from sources other than your Employer.

Earnings, whether for a full year or partial year, will be converted to a weekly amount for the purpose of calculating the Weekly Payment.

MAXIMUM PERIOD OF PAYMENT

25 weeks

SUPPORT SERVICES

In conjunction with insurance coverage under the Policy enrollment, risk management and other support services may be offered.

DEFINITIONS

Accident means an unforeseen event that results in a bodily Injury.

Active Employment means you are working for the Employer for earnings that are paid regularly and you are performing the Material and Substantial Duties of your Regular Occupation. You must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT shown in the SCHEDULE OF BENEFITS.

To be in active employment your work site must be:
- The Employer's usual place of business;
- An alternative work site at the direction of the Employer, including your home; or
- A location to which your job requires you to travel.

We will consider you to be in active employment on personal holidays, weekends, holidays, planned vacations that your Employer has approved in advance and during a temporary business closure not to exceed 15 day(s) if you were in active employment on the last scheduled work day immediately prior to such time off. A temporary business closure includes a closure due to inclement weather, power outage or public health agency orders.

Temporary workers are excluded from coverage.
Seasonal workers are excluded from coverage.

Open Enrollment Period means a period of time before the beginning of the Policy Anniversary Date.

Appropriate Care means that all of the following are true:
- You visit a Treatment Provider as frequently as medically required according to standard medical practice to effectively treat and manage your disabling condition(s).
- You receive care or treatment appropriate for the disabling condition(s), conforming with standard medical practice, by a Treatment Provider whose specialty or experience is appropriate for the disabling condition(s) according to standard medical practice.
- You have the obligation to minimize your disabling condition including having corrective treatment or minor surgery.

Certificate means the document that explains the parts of the Policy which apply to eligible Insured Persons. It may include riders, endorsements or amendments.

Child means your biological children, adopted children, stepchildren, children who are dependent on you for financial support and living with you in a regular parent-child relationship, and any other children required to be covered under the civil union, domestic partnership, marriage, or other family or domestic relations law of the governing jurisdiction. A child will be considered adopted on the date of placement in your home.

If the Certificate is delivered in a state different from the governing jurisdiction of the Policy, the Certificate shall, if required, comply with the applicable civil union, domestic partnership, marriage or other family or domestic relations law of the state in which the Certificate is delivered.

Contributory means insurance for which the Policyholder requires you to pay all or a portion of the Premium.

Disability or Disabled means Total Disability or Totally Disabled and Partial Disability or Partially Disabled, as individually defined in alphabetical order within this DEFINITIONS section.

Disability Earnings means the earnings which you receive while you are Disabled and working, plus the earnings you could receive if you were working to your Maximum Capacity.

Disability earnings do not include earnings from secondary employment if such employment began prior to your date of Disability; however, it does include any increase in earnings from the secondary employment occurring after your date of Disability.

Treatment Provider means a person performing tasks that are within the limits of his or her medical license, and also meets one of the following requirements:

- Is licensed to practice medicine and prescribe and administer drugs or to perform surgery.
- Has a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients.
- Is a legally qualified medical practitioner according to the laws and regulations of the jurisdiction where treatment occurred.

We will not recognize you or your family members including, but not limited to: Spouse, children, parents, including in-laws, or siblings, including in-laws, or a business or professional partner, or any person who has a financial affiliation or business interest with you as a doctor for a claim that you send to us.

Eligible Survivor means your Spouse, if living; otherwise, your child(ren).

Eligibility Waiting Period means the continuous period of time (shown in the SCHEDULE OF BENEFITS) that you must be in Active Employment in an eligible class before you are eligible for coverage under the Policy.

Employee means a person who is a citizen or legal resident of the United States in Active Employment with the Employer in the United States.

Employer means the Policyholder and includes any division, subsidiary or affiliated company named in the Policy.

Evidence of Insurability means your affirmation, on a form acceptable to us, of various factors that we will use to determine if you are approved for coverage. Those factors may include, but are not limited to, your medical history and treatment, driving record, and/or family medical history. We may also, at our expense, request additional information to determine your eligibility for coverage.

Family and Medical Leave means the Family and Medical Leave Act of 1993 and any amendments ("FMLA"), or any other applicable state (including the District of Columbia), or local paid family and medical leave (“State FML”).

Gross Weekly Payment means your benefit before any reduction for Disability Earnings.

Hospital, Health Facility or Institution means an accredited facility licensed according to state and local laws to provide care and treatment for the condition causing your Disability. The facility must be supervised by one or more Treatment Providers with 24 hour registered graduate nursing staff. The facility may specialize in treating alcoholism, drug addiction, chemical dependency or Mental Illness. A facility specializing in treating alcoholism, drug addiction, chemical dependency or Mental Illness does not include a rest home, convalescent home, and home for the aged or a facility primarily for custodial or educational care.

Injury means a bodily injury that is the direct result of an Accident and not related to, contributed to by, or resulting from any other cause. The injury must occur, and Disability resulting from the injury must begin, while you are covered under the Policy. Injury that occurs before you are covered under the Policy will be treated as a Sickness.

Insured Person means an Employee who is eligible for coverage under the Policy, becomes covered according to the terms of the Policy, and whose coverage remains in effect according to the terms of the Policy.

Material and Substantial Duties means essential duties tasks, functions and operations that are normally required for the performance of your Regular Occupation.

Maximum Benefit means the total weekly benefit amount for which you are insured under the Policy subject to all Policy provisions.

Maximum Capacity means, based on your restrictions and limitations, the greatest extent of work you are able to do in your Regular Occupation.

Maximum Period of Payment means the longest period of time we will make payments to you for any one period of Disability.

Mental Illness means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a Disability. Such disorders include, but are not limited to: psychotic, emotional or behavioral disorders, or disorders related to stress or to substance abuse or dependency. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a Disability.

Non-Contributory means insurance for which the Policyholder does not require you to pay any part of the Premium. The Certificate specifies who pays the cost of the coverage.

Occupational Sickness or Injury means a Sickness or Injury that was caused by or aggravated by any employment for pay or profit.

Partial Disability or Partially Disabled means that, due to your Sickness or Injury, one of the following is true:

- You are able to perform the Material and Substantial Duties of your Regular Occupation or another occupation on a less than full-time basis and as a result your Disability Earnings are less than 80% of your Weekly Earnings.
- You are able to perform one or more, but not all, of the Material and Substantial Duties of your Regular Occupation or another occupation on a full-time or Part-time Basis and as a result your Disability Earnings are less than 80% of your Weekly Earnings.

This definition does not apply if you are Totally Disabled. This definition is used to determine the amount of your Weekly Payment under the Policy.

The elimination period may be satisfied by combining days of Total Disability and Partial Disability. You do not need to be Totally Disabled before being considered Partially Disabled.

The loss of a professional or an occupational license or certification does not, in itself, constitute Partial Disability.

Part-time Basis means the ability to work and earn from 20% through 80% of your Weekly Earnings. Ability is based on capacity and not market availability.

Payable Claim means a claim for which we are liable under the terms of the Policy.

Policy means the Written group insurance contract between us and the Policyholder.

Policyholder means the Employer to whom the Policy is issued and who sponsors and administers the coverage for its Employees.

Pre-Existing Condition means any condition for which you have done any of the following at any time during the 3 months just prior to your effective date of coverage:

- Received medical treatment or consultation.
- Taken or were prescribed drugs or medicine.
- Received care or services, including diagnostic measures.

Routine follow-up care to determine the recurrence of breast cancer does not constitute medical advice, diagnosis, care or treatment unless evidence of breast cancer is found during or as a result of the follow-up care.

Premium means the amount the Policyholder will pay to us for the insurance provided under the Policy.

Prior Policy means the Policyholder's short term disability income insurance policy for which you were insured on the day prior to the effective date of our Policy.

Recurrent Disability means a Disability for which both of the following are true:

- It is caused by a worsening in your condition.
- It is due to the same cause(s) as your prior Disability for which we made a Weekly Payment.

Regular Occupation means the occupation you are routinely performing when your Disability begins.

Retirement Plan means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions. Retirement plan includes but is not limited to any plan which is part of any federal, state, county, municipal or association retirement system.

Sickness means illness, disease, pregnancy or complications due to pregnancy. Disability resulting from sickness must begin while you are covered under the Policy.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

Spouse means your lawful spouse or any other person recognized as your spouse under the civil union, domestic partnership, marriage or other family or domestic relations law of the governing jurisdiction.

If you reside in a State different from the governing jurisdiction of the Policy, the Certificate shall, if required, comply with the applicable civil union, domestic partnership, marriage or other family or domestic relations law of the State in which you reside.

Third Party means any person or entity whose act or omission, in full or in part, caused you to suffer a Disability for which benefits are paid or payable under the Policy. Third party also includes your homeowners, automobile or other insurance company if they make payment to you because of the acts or omissions of another person or entity.

Total Disability or Totally Disabled means that due to your Sickness or Injury you are unable to perform the Material and Substantial Duties of your Regular Occupation, and you are not working in any occupation.

The loss of a professional or an occupational license or certification does not, in itself, constitute Total Disability.

Vocational Rehabilitation Plan means a Written plan that a vocational rehabilitation professional, designated by us, prepares in accordance with the Vocational Rehabilitation Services provision of the Policy.

Weekly Earnings means your gross weekly income from your Employer as stated in the SCHEDULE OF BENEFITS.

Weekly Payment means the weekly benefit amount.

Written or Writing means a record which is on or transmitted by paper, electronic or telephonic media and which is consistent with applicable law.

GENERAL PROVISIONS

ELIGIBILITY

If you are working for the Employer in an eligible class (shown in the SCHEDULE OF BENEFITS), the date you are eligible for coverage is the later of the following:

- The Policy Effective Date.
- The day after you complete your Eligibility Waiting Period.

ENROLLMENT

If you are eligible for Contributory coverage, you must enroll for any Contributory coverage before it will become effective. We or the Employer will provide you with the forms or information needed to complete your enrollment.

No enrollment is required if the Policy replaces a group policy issued by us or by another insurance company, and you were covered under the Prior Policy on the day before that policy was replaced by our Policy. The amount of Contributory coverage that becomes effective on our Policy Effective Date will be at the same level as under the Prior Policy, subject to the terms of our Policy including any maximum coverage amounts under our Policy.

EFFECTIVE DATE OF COVERAGE

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date you are eligible for coverage, if you apply for coverage on or before that date.
- The first day of the month following the date you apply for coverage.
- The Policy Anniversary Date following the Open Enrollment Period.
- The first day of the month following the date you return to Active Employment, if you are not in Active Employment when your coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: planned vacations that your Employer has approved, personal holidays, weekends and holidays, approved non-medical leave of absence and paid time off for non-medical-related absences.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your coverage begins, any increased or additional coverage will take effect on the latest of the following:

- The date of the increased or additional coverage, if you are in Active Employment.
- The date you return to Active Employment, if you are not in Active Employment due to Injury or Sickness.
- The Policy Anniversary Date following the Open Enrollment Period.

As it applies to this provision, additional coverage includes increases in your weekly benefit and other changes that may impact when or for how long benefits are payable. Additional coverage is subject to the PRE-EXISTING CONDITION EXCLUSION provision.

Any decrease in coverage will take effect immediately but will not affect a Payable Claim that occurs prior to the decrease.

CHANGE OF INSURANCE CARRIERS

If you are in Active Employment in an eligible class on the date your Employer changes insurance carriers to our Policy, and you were covered under the Prior Policy on the day before your Employer's coverage under our Policy became effective, we will provide continuity of coverage under our Policy. In order for this provision to apply, the Prior Policy's coverage must be similar to our Policy.

If you are not in Active Employment due to Injury or Sickness on the effective date of the Employer's coverage under our Policy, and you were covered under the Employer's prior group policy of disability income insurance at the time the Employer's coverage under our Policy became effective, we will provide continuity of coverage under our Policy. In order for this provision to apply, the Policy's coverage must be similar to our Policy.

If you are not in Active Employment due to Injury or Sickness on the effective date of our Policy, and you would otherwise be eligible to become insured under our Policy, we will provide limited coverage under our Policy. Coverage under this provision will begin on our Policy Effective Date and will continue until the earliest of the following:

- The date you return to Active Employment.
- The end of any period of continuance or extension provided under the Prior Policy.

If you are not in Active Employment due to Employer approved non-medical leave of absence on the effective date of the Employer's coverage under our Policy, and you were covered under the Employer's prior group policy of disability income insurance at the time the Employer's coverage under our Policy became effective, we will provide continuity of coverage under our Policy. In order for this provision to apply, the Prior Policy's coverage must be similar to our Policy.

If you are not in Active Employment due to an Employer approved non-medical leave of absence on the Policy Effective Date, and you would otherwise be eligible to become insured under our Policy, we will provide limited coverage under our Policy. Coverage under this provision will begin on our Policy Effective Date and will continue until the earliest of the following:

- The date you return to Active Employment.
- The end of any period of continuance or extension provided under the Prior Policy.
- The date coverage would otherwise end, according to the provisions of our Policy.

Your coverage under this provision is subject to payment of Premiums.

Any benefits payable under this provision will be paid as if the Prior Policy had remained in force. We will reduce our payment by any amount for which the prior carrier is liable.

If your coverage ends under this provision, or if you were not covered under the Employer's Prior Policy on the date that policy terminated, the EFFECTIVE DATE OF COVERAGE provision under our Policy will apply.

CREDIT FOR PRE-EXISTING CONDITIONS

We may pay benefits if your Disability results from a Pre-Existing Condition if both of the following are true:

- You were insured for disability income insurance under the Employer's Prior Policy at the time the Employer changed insurance carriers to our Policy.
- You have been continuously covered under our Policy from our Policy Effective Date through the date the Disability occurs.

In order to receive benefits, you must satisfy THE PRE-EXISTING CONDITION EXCLUSION provision under either our Policy or under the Prior Policy, if benefits would have been paid had that Prior Policy remained in force.

If you satisfy the PRE-EXISTING CONDITION EXCLUSION provision of our Policy, we will determine your benefits according to our Policy's provisions.

If you do not satisfy the PRE-EXISTING CONDITION EXCLUSION provision of our Policy, but you do satisfy the Prior Policy's Pre-Existing Condition provision, then both of the following apply:

- The benefit will be the lesser of:
  - the benefit that would have been payable under the terms of the Prior Policy had it remained in force.
  - the benefit under our Policy.
- Benefits will end on the earlier of:
  - the date benefits end under our Policy, as described under the WHEN PAYMENTS END provision.
  - the date benefits would have ended under the Prior Policy if it had remained in force.

If you do not satisfy either our Policy's PRE-EXISTING CONDITION EXCLUSION provision or the Prior Policy's Pre-Existing Condition provision, we will not make any payments.

We will require proof that you were insured under the Prior Policy. All other provisions of our Policy will apply.

TERMINATION OF COVERAGE

Your coverage under the Policy ends on the earliest of the following dates:

- The date the Policy terminates.
- The date you are no longer in an eligible class.
- The date your eligible class is no longer covered.
- The date you voluntarily cancel your coverage.
- The end of the period for which you paid Premiums, if you stop making a required premium contribution, subject to the grace period.
- The end of the Policyholder's grace period, if the Policyholder does not remit Premium to us by the end of such period.
- The last day you are in Active Employment.

If a disability for which benefits are payable begins while your coverage under the policy is in force, benefits will be payable after the termination of your coverage to the same extent as if the coverage had not terminated.

Upon your return to Active Employment following active military service, and while coverage is in force for Employees under the Policy, we will reinstate your coverage in accordance with the requirements of the federal Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended.

POLICY TERMINATION

The Policy can be terminated either by us or by the Policyholder.

We may terminate the Policy for any of the following reasons:

- There is less than 5% participation of those eligible persons who pay all or part of their Premium for the Policy.
- The Policyholder does not within 90 days provide us with information that is reasonably required, or fails to perform any obligation required by the Policy and applicable law.
- Fewer than 51 persons are insured under the Policy.
- The Premium is not paid in accordance with the provisions of the Policy.
- We determine that there is a 15% change in the number of lives, or a significant change in the occupation or age of the eligible class(es) as a result of a corporate transaction such as a merger, divestiture, acquisition, sale or reorganization of the Policyholder and/or its persons.
- We stop providing the type of coverage under this Policy to all groups in the Policy issue state.

If the Policyholder fails to pay the full Premium due by the end of the grace period, the Policy will terminate according to the GRACE PERIOD provision.

If we terminate the Policy for reasons other than the Policyholder's failure to pay Premiums, Written notice will be mailed to the Policyholder at least 90 days prior to the termination date.

The Policyholder may terminate the Policy by Written notice delivered to us at our home office. The Policy will terminate on the later of the date stated in the Written notice or the date we receive the notice. When both the Policyholder and we agree, the Policy can be terminated on an earlier date.

If the Policyholder or we terminate the Policy, coverage will end at 12:00 midnight standard time at the Policyholder's address on the termination date.

If the Policy is terminated, the cancellation will not affect a Payable Claim.

GRACE PERIOD

The Policyholder has a grace period of 90 days for the payment of any Premium due except the first. During the grace period the Policy will remain in force. If full payment is not received by us by the end of the grace period, the Policy will automatically terminate at the end of the grace period. The Policyholder is required to pay a pro rata Premium for any period the Policy was in force during the grace period. There is no grace period if the Policyholder gives us advance Written notice of termination, or if we have given the Policyholder advance Written notice of termination as described under the POLICY TERMINATION provision.

INCONTESTABILITY

Any statement made by you is considered a representation and not a warranty. We will not use such statement to avoid insurance, reduce benefits or defend a claim unless the statement is included in a Written statement of insurability which has been Signed by you and a copy of such statement has been given to you or your personal representative.

Except in the case of fraud, no statement made by you in a statement of insurability will be used to contest the insurance or an increase in insurance for which the statement was made after the coverage has been in force for two years during your lifetime. Fraud in the procurement of coverage under the Policy may be contestable when permitted by applicable law in the governing jurisdiction. The statement on which any contest is based must be material to the risk accepted or the hazard assumed by us.

CLERICAL ERROR

Clerical error or omission by us or by the Policyholder will not:

- Prevent you from receiving benefits or coverage, if you are entitled to benefits or coverage under the terms of the Policy.
- Cause benefits or coverage to begin or continue for you when the benefits or coverage would not otherwise be due or effective.

If the Policyholder gives us information about you that is incorrect, we will do both of the following:

- Use the facts to decide whether you are entitled to benefits or eligible for coverage under the Policy and in what amounts.
- Make a fair adjustment of the Premium.

MISSTATEMENT OF AGE

If Premiums are based on your age and you have misstated your age, we will make a fair adjustment of benefits to reflect the amount of coverage that the Premium paid would have purchased at your true age. If the benefits applicable to you are based on age and you have misstated your age, we will make a fair adjustment of benefits based on your true age. We may require satisfactory proof of your age before paying any claim.

AGENCY

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

ENTIRE CONTRACT

The entire contract consists of all of the following:

- The Policy issued to the Policyholder including Part A and Part B.
- This Certificate(s) which is (are) made part of Part B under the Policy.
- Any amendments and/or riders issued.
- The Policyholder's Signed application, a copy of which is attached to the Policy when issued and
- The Insured Person’s Signed Statement of Insurability form.

CHANGES TO POLICY OR CERTIFICATE

The terms and provisions of the Policy, Certificate or any rider, endorsement or amendment issued under it, may be changed at any time without the consent of Insured Persons or anyone else with a beneficial interest in the Policy. We will issue riders, endorsements or amendments to effect such changes, and only those forms Signed by one of our executive officers will be valid. Any rider, endorsement or amendment added to the Policy after the date of issue that eliminates or reduces benefits or rights under the Policy shall require signed acceptance by the Policyholder. We will provide a copy of the rider, endorsement or amendment to the Policyholder for attachment to the Policy, and also for the Employees if the change affects the Certificate(s).

Riders, endorsements and amendments are subject to prior approval by the appropriate regulatory body. A rider, endorsement or amendment will not affect the insurance provided under the Certificate(s) until the effective date of the change, unless retroactivity is required by the applicable regulatory body.

No agent, representative or employee of ours or of any other entity may change or waive the terms of the Policy, or of any Certificate, rider, endorsement or amendment issued under it, except in a Writing, Signed by one of our executive officers and endorsed or attached to the Policy.

If there is a conflict between the terms of this Certificate or any attached rider, endorsement or amendment and the Policy, the Policy controls.

DISABILITY BENEFITS

We will pay a benefit as shown on the SCHEDULE OF BENEFITS if you become Disabled and qualify to receive benefits. The benefit payable is based on the SCHEDULE OF BENEFITS in effect on the day you become Disabled.

ELIMINATION PERIOD

You must be continuously Disabled through your elimination period. Your elimination period is as stated in the SCHEDULE OF BENEFITS and is the period of continuous Disability you must satisfy before you are eligible to receive benefits under the Policy.

We will consider your Disability to be continuous if your Disability stops during the elimination period for 5 days or less. The days that you are not Disabled will not count toward your elimination period.

The elimination period begins on the first day of your Disability.

Benefits for a Payable Claim begin the day after the elimination period is completed.

SATISFYING YOUR ELIMINATION PERIOD IF YOU ARE WORKING

If you are working while you are Disabled, the days you are Disabled will count toward your elimination period.

WHEN YOU RECEIVE PAYMENTS

You will begin to receive payments when we approve your claim, provided the elimination period has been met and you are Disabled. We will send you a Weekly Payment at the end of each week for any period for which we are liable.

After the elimination period, if you are Disabled for less than one week, we will send you 1/7th of your Weekly Payment for each day of your Disability.

AMOUNT OF PAYMENT

A. IF YOU ARE TOTALLY DISABLED OR YOU ARE PARTIALLY DISABLED AND YOUR DISABILITY EARNINGS ARE LESS THAN 20% OF YOUR WEEKLY EARNINGS

We will follow this process to figure your payment:

1. Multiply your Weekly Earnings by your elected and approved weekly benefit percentage.
2. The Maximum Benefit as shown in the SCHEDULE OF BENEFITS.
3. Compare the answers from Step 1 and Step 2. The lesser of these two amounts is your Gross Weekly Payment.

The amount figured in Step 3 is your Weekly Payment. If this amount is less than the Minimum Payment amount under the Policy, your payment will be subject to the MINIMUM PAYMENT provision.

Your Weekly Payment will be the weekly benefit amount for which Premium is being paid.

B. IF YOU ARE PARTIALLY DISABLED AND YOUR DISABILITY EARNINGS ARE AT LEAST 20% BUT LESS THAN OR EQUAL TO 80% OF YOUR WEEKLY EARNINGS

You will receive payments based on the percentage of income you are losing due to your Disability. We will follow this process to determine your Weekly Payment:

1. Subtract your Disability Earnings from your Weekly Earnings.
2. Divide the answer in Step 1 by your Weekly Earnings. The result is your percentage of lost earnings.

The answer in Step 2 is your Weekly Payment. If this amount is less than the Minimum Payment amount under the Policy, your payment will be subject to the MINIMUM PAYMENT provision.

C. IF YOU'RE DISABLED AND WORKING, AND YOUR DISABILITY EARNINGS ARE MORE THAN 80% OF YOUR WEEKLY EARNINGS

If you are working and your Disability Earnings are more than 80% of your Weekly Earnings, no benefit will be payable.

We may require you to send proof of your weekly Disability Earnings each week. We will adjust your payment based on your weekly Disability Earnings. As part of your proof of Disability Earnings, we can require that you send us appropriate financial records that we believe are necessary to substantiate your income.

IF YOUR DISABILITY EARNINGS FLUCTUATE

If your Disability Earnings routinely fluctuate from week to week, we may average your Disability Earnings over the most recent twelve weeks to determine if your claim should continue.

If we average your Disability Earnings, we will not terminate your claim unless the average of your Disability Earnings from the last twelve weeks exceeds 80% of your Weekly Earnings.

We will not pay you for any week during which your Disability Earnings exceed the amount allowable under the Policy. In no event will benefits be paid beyond the Maximum Period of Payment.

TOTAL BENEFIT CAP

If you are eligible to receive benefits under the Policy in addition to the Weekly Payment, the total benefit payable to you on a weekly basis (including all benefits provided under the Policy) will not exceed 100% of your Weekly Earnings. However, if you are participating in a Vocational Rehabilitation Plan, the total benefit payable to you on a weekly basis (including all benefits provided under the Policy) will not exceed 110% of your Weekly Earnings.

MINIMUM PAYMENT

The Minimum Payment each week for a Payable Claim is $100.

We may apply this amount to recover any outstanding overpayment.

DURATION OF PAYMENTS

We will send you a payment each week up to the Maximum Period of Payment. Your Maximum Period of Payment is stated in the SCHEDULE OF BENEFITS and will be paid during a continuous period of Disability.

WHEN PAYMENTS END

We will stop sending you payments and your claim will end on the earliest of the following:

- The end of the Maximum Period of Payment.
- The date you are no longer Disabled under the terms of the Policy.
- The date you fail to submit proof of continuing Disability.
- The date you die.
- The date your Disability Earnings exceed 80% of your Weekly Earnings.

We will not pay a benefit for any period of Disability during which you are incarcerated.

RECURRENT DISABILITY

If you have a Recurrent Disability, and after your prior Disability ended, you returned to work for your Employer for 15 consecutive days or less, we will treat your Disability as part of your prior claim and you do not have to complete another elimination period.

Your Weekly Payment will be based on your Weekly Earnings as of the date of your initial claim.

Your Disability, as outlined above, will be subject to the same terms of this Policy as your prior claim.

Your Disability will be treated as a new claim if your current Disability:

- Is unrelated to your prior Disability; or
- After your prior Disability ended, you returned to work for your Employer for more than 15 consecutive days.

The new claim will be subject to all of the provisions of the Policy and you will be required to satisfy a new elimination period.

If the Policy terminates, you will no longer be eligible for coverage under the Policy.

VOCATIONAL REHABILITATION SERVICES

We have vocational rehabilitation services available to assist you in returning to work to the extent of your ability. We will review your disability claim to determine whether you are eligible for these services. In order to be eligible for vocational rehabilitation services, you must be medically able to participate in a return to work plan.

Your participation in a Vocational Rehabilitation Plan is voluntary. If you elect not to participate it will not affect our determination of whether you are Disabled under the Policy. Your claim file will be reviewed by a vocational rehabilitation professional to determine if rehabilitation services might help you return to gainful employment. As your file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work plan.

We will make the final determination of your eligibility for these services.

If we determine that vocational rehabilitation services are appropriate, we will provide you with a Written Vocational Rehabilitation Plan developed specifically for you.

The Vocational Rehabilitation Plan may include at our sole discretion, but is not limited to, the following services:

- Coordination with your Employer to assist you to return to work;
- Evaluation of adaptive equipment or job accommodations to allow you to work;
- Evaluation of possible workplace modifications which might allow you to return to work in your Regular Occupation or another job or occupation;
- Vocational evaluation to determine how your Disability may impact your employment options;
- Job placement services, including resume preparation services and training in job-seeking skills; alternative treatment plans such as recommendations for support groups, physical therapy, occupational therapy, or other treatment designed to enhance your ability to work.

EXCLUSIONS AND LIMITATIONS

EXCLUSIONS

The Policy does not cover any Disability caused by, contributed to by, or resulting from:

- Commission or attempt to commit a felony or illegal activity.
- Engaging in any illegal occupation, work or employment.
- Operating a motorized vehicle while under the influence of alcohol as evidenced by a blood alcohol level at or in excess of the state legal intoxication limit.
- Intentionally self-inflicted harm.
- Attempted suicide, regardless of mental capacity.
- Participation in a war, declared or undeclared, or any act of war. An act of war is military activity by one or more national governments and does not include terrorist acts, other random acts of violence not perpetrated by you, or civil war or community faction.
- Active duty as a member of the armed forces of any nation. However, we will refund, upon Written notice of such service, any Premium which has been accepted for any period not covered as a results of this exclusion.
- Active participation in a riot, insurrection or terrorist activity, but not including civil commotion, disorder, Injury as an innocent bystander, or Injury because of self-defense.
- Voluntary intake of any narcotic or other controlled substance, unless the narcotic or controlled substance is taken under the direction of and as directed by a Treatment Provider.
- Cosmetic surgery except when required for your Appropriate Care as a result of your Injury or Sickness; cosmetic surgery shall not include (1) reconstructive surgery when the surgery is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and (2) reconstructive surgery because of congenital disease or anomaly resulting in a functional defect and (3) surgery necessitated by gender dysphoria.
- Occupational Sickness or Injury.

We will not pay a benefit for any period of Disability during which you are incarcerated.

PRE-EXISTING CONDITION EXCLUSION

Benefits will not be paid if your Disability begins in the first 12 months following the effective date of your coverage; and your Disability is caused by, contributed to by, or the result of a Pre-Existing Condition.

Routine follow-up care to determine the recurrence of breast cancer does not constitute medical advice, diagnosis, care or treatment unless evidence of breast cancer is found during or as a result of the follow-up care.

Additional coverage as described under the EFFECTIVE DATE OF CHANGES TO COVERAGE provision, is subject to this PRE-EXISTING CONDITION EXCLUSION provision, as of the date the additional coverage became effective for you.

CLAIMS

NOTICE OF CLAIM

Written notice of your claim should be given to us within 20 days after the date your Disability begins. The notice may be given to us at our home office or to our authorized agent or administrator. Failure to give notice within this timeframe will not invalidate or reduce any Payable Claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible after the date your Disability begins.

CLAIM FORM

The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us Written proof of claim without waiting for the form. If such Written proof covers the requirements described below for proof of claim, within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM

The claim form(s) requires completion by you and the Employer and your attending Treatment Provider. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM

You must send us Written proof of your claim within 90 days after your elimination period ends. Failure to give such proof within this timeframe will not invalidate or reduce any Payable Claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

Your proof of claim, provided at your expense, must show all of the following:

- That you are under the Appropriate Care of a Treatment Provider.
- The date your Disability began.
- The cause of your Disability.
- The appropriate documentation of your earnings and your activities.
- The extent of your Disability, including restrictions and limitations preventing you from performing your Regular Occupation.
- The names and addresses of all Hospitals, Health Facilities and Institutions where you received treatment or consultation.
- The names and addresses of all Treatment Providers with whom you treated or consulted.
- Documentation of prior disability coverage, if applicable.

CONTINUING PROOF OF CLAIM

We may require you to provide continuing proof of your claim as often as it is reasonable to do so during the pendency of your next benefit payment. You will have 60 days from the date of our request to provide us with continuing proof of your claim. As part of this process, we may require you to provide us with a signed authorization to allow us to obtain information as part of your continuing proof of claim. Failure to provide continuing proof of your claim or a signed authorization in 60 days may delay your payments until the required proof of continuing claim is received.

You must notify us immediately when you return to work in any capacity.

PAYMENT OF CLAIMS

Once your claim has been approved, we will send you a payment at the end of each week for any period for which we are liable. Any balance remaining unpaid by us upon termination of such period will be paid upon receipt of proof of your claim.

If any amount for which we are liable remains unpaid when you die, we will pay that amount to your Eligible Survivor. If, however, it is necessary for the establishment of a guardianship or conservatorship, or appointment of a trustee, executor or administrator, we may withhold further benefits until sufficient evidence is provided to us that any such establishment or appointment has been finalized. If the Eligible Survivor has a special needs trust, we will pay that person's trust upon receipt of trust documents. We will pay benefits upon receiving sufficient evidence of guardianship, conservatorship or trust. . If you have no Eligible Survivors, payment will be made to your estate, unless there is none. In this case, no payment will be made.

PHYSICAL EXAMINATION

We may require you to be examined by one or more Treatment Providers or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while your claim is pending. We may also require you to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

REVIEW OF DENIAL OF CLAIMS

If your claim is denied, you have the right to notify us in Writing within 180 days of receiving notice of the denial that you would like us to review the denial.

Upon request, you have the right to review copies of all documents, records, and other information relevant to your claim free of charge. You may submit Written comments, documents, records and other information relating to your claim that you would like us to consider in reviewing your denial.

We will review the denial of your claim and send you notice of our decision within 45 days of receiving your request. If we require an extension of the deadline to obtain more information, we will give you notice of our decision within 45 days after the end of the extension period. Our decision will state the reasons for our decision, refer to the relevant portions of your Certificate and advise you of any further appeal rights.

AUTHORITY

The Policyholder has delegated to the insurance company or its designee certain rights and discretion. These include the right and discretion to make determinations regarding the eligibility for participation or benefits and to interpret the terms of the Policy and Certificate. This delegation is made for the purpose of administering the terms of the Policy and Certificate.

TIME LIMITS FOR LEGAL PROCEEDINGS

You can start legal action regarding a claim no earlier than 60 days after initial Written proof of claim has been given to us. You may not start legal action after the date the applicable statute of limitations has expired. However, for new claims, in no case may you start legal action more than 5 years after initial proof of claim was required; and for claims where benefit payments have been paid, in no case may you start legal action more than 5 years after continuing proof of claim was required.

RIGHT TO REIMBURSEMENT

We have the right to recover any overpayments due to any of the following:

- Fraud.
- Any administrative error we make in processing a claim.

You must reimburse us in full. If we find that we should have paid a benefit amount different from the amount actually paid, we will adjust the benefit accordingly. If we underpaid your benefit, we will adjust the benefit to make up the underpayment. If we overpaid your benefit, you shall reimburse us. Any future benefits that are determined to be due, including any applicable Minimum Payment, will be applied to the overpayment until we are reimbursed in full. If future benefits are not due, we will determine the method by which the repayment is to be made.

You shall not act or fail to act in any manner that will prejudice our right to reimbursement without our prior Written agreement. If you prejudice our right to reimbursement, fail to cooperate with us or fail to comply with this provision, we may withhold any and all benefits in addition to pursuing all remedies available to us under applicable law.

If we pursue legal action against you to obtain reimbursement, you will be required to pay our costs and attorney's fees as permitted by applicable law. We reserve the right to recover any prior or current overpayment not only from the amounts you receive as Benefit Deductible Sources of Income (to the extent permitted by applicable law) but also from any benefits from any past, current or new disability claim payable under the Policy as well as from any other funds You may have.

You must notify us if you make a claim against any Third Party. Neither you nor anyone acting on your behalf may settle your claim against the Third Party without our prior Written consent. If you recover amounts from a Third Party by award, judgment, settlement or otherwise, you must reimburse us for lost income due to a Disability because of an act or omission of the Third Party. You must reimburse us regardless of whether you have been made whole by the recovery, subject to limitations under applicable law where the Policy is delivered or issued for delivery. If the award, judgment or settlement does not specify the lost income amount, we will estimate the amount using a percentage of the total amount received based on your Weekly Earnings, prorated to cover the period for which the award, judgment or settlement was made. We shall have first right to reimbursement. The amount you reimburse us will be reduced by our pro rata share of your attorney's fees and costs. If another entity is also entitled to reimbursement but does not reduce its reimbursement by its pro rata share of such fees and costs, our pro rata share will be calculated as if that entity did make such reductions.

RIGHT TO SUBROGATION

If we have paid or will pay benefits in connection with a Disability which you suffered because of an act or omission of a Third Party, we reserve any and all rights of recovery available to us under applicable law in the state where the Policy is delivered or issued for delivery that you have against the Third Party to the extent necessary to protect our interests. We have the right to bring legal action against the Third Party on your behalf to recover the payments made by us if you do not initiate legal action for the recovery of such payments from the Third Party in a reasonable period of time. You must agree to furnish all information and documents that are necessary to secure our rights. We will pay for any expenses connected with our pursuit of subrogation or recovery. You shall not act or fail to act in any manner that will prejudice our right to subrogation without our prior Written agreement. If you prejudice our right to subrogation, fail to cooperate with us or fail to comply with this provision, we may pursue all remedies available to us under applicable law.

If we bring a legal action against the Third Party on your behalf, we will not reduce your disability benefits by any other amounts you receive from the Third Party. If we elect to reduce your disability benefits for lost income because of an award, judgment or settlement (minus attorney's fees) due to an act of omission of a Third Party, we will not pursue subrogation for your claim.

CONTINUATION OF INSURANCE RIDER

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: ODP International, LLC

GROUP POLICY NUMBER: 74634-7STD2

This rider is made a part of the Group Short Term Disability Income Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

CONTENTS

Section	Page
Definitions	1
General Provisions	1
Continuation of Insurance	2

DEFINITIONS

Leave of Absence means you are absent from Active Employment for a period of time under a leave granted in advance in writing by the Employer that is in accordance with the Employer's formal leave policies. Your normal vacation time is not considered a Leave of Absence.

GENERAL PROVISIONS

ELIGIBILITY

If you are covered under the Policy, then you are eligible for this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your disability income insurance coverage effective date.

EFFECTIVE DATE

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for this rider.

CHANGE OF INSURANCE CARRIERS

The CHANGE OF INSURANCE CARRIERS provision in the Certificate is revised to include an Employee whose coverage was being continued under a similar continuation provision in the Employer's Prior Policy on the date the Employer changes insurance carriers to our Policy.

TERMINATION

This rider terminates on the earliest of the following:

- The date your disability income insurance terminates, as outlined under the TERMINATION OF COVERAGE provision in your Certificate.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.

CONTINUATION OF INSURANCE

If you stop Active Employment due to:

- Employer-approved Leave of Absence

then insurance coverage may be continued under the Policy beyond the date you are no longer in Active Employment, limited to the time period(s) described below.

During this continued coverage period, the amount of continued insurance equals the amount in effect the day prior to the continuation period. That amount will reduce or stop according to the Certificate and riders in effect the day prior to the continuation period.

Premiums are due during the continuation period on the same basis as on the day prior to the continuation period. Contact the Employer for more information.

If an eligible claim occurs while coverage is being continued under this rider, then benefits will be paid as described in the Certificate and riders.

EMPLOYER-APPROVED LEAVE(S) OF ABSENCE

Family and Medical Leave

If you are on a Leave of Absence as described under the Family and Medical Leave Act of 1993 and any amendments ("FMLA") or any applicable state (including the District of Columbia), or local paid family and medical leave law, ("State FML"), and the Employer's human resource policy provides for continuation of insurance during an FMLA or State FML Leave of Absence, then your insurance coverage may be continued until the end of the later of:

- The leave period permitted by FMLA.
- The leave period permitted by State FML.

This continuation of coverage includes all riders that were in effect on the date before the FMLA or State FML Leave of Absence began.

Military Leave

If you are on a Leave of Absence for active military service as described under the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) and any applicable state law, then your insurance coverage may be continued until the date which is 12 weeks after the date you stopped Active Employment.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

Other Leave of Absence

If you are on a Leave of Absence other than a Family and Medical Leave, military leave or sabbatical, then your insurance coverage may be continued until the last day of the month which next follows the date which is 6 months after the date you stopped Active Employment.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

CONCURRENT LEAVES OF ABSENCE

If you would be eligible for more than one type of continuation under this rider during any one period that you are not in Active Employment, we will consider such periods to be concurrent for the purpose of determining how long your coverage may continue under the Policy.

TERMINATION OF CONTINUATION

Coverage continued under this rider will end on the earliest of the following:

- The end of the continuation period as indicated above.
- The end of the period for which Premiums are paid if the next Premium is not paid by its due date, subject to the grace period.
- The date you are eligible under the Policy due to Active Employment.
- The date of your death.
- The date you become covered under another group disability income insurance policy as an employee or member.
- The date the Policy terminates.
- The date coverage for all Employees under the Policy terminates.

In no event will coverage for you be continued beyond the date coverage would otherwise end according to the termination provision(s) of the Certificate and riders.

When this continuation ends, your insurance under the Policy will stay in force only if all of the following conditions are met:

- Disability income insurance is in force for Employees under the Policy; and
- You are in an eligible class for coverage under the Policy; and
- Your premium payments continue to be submitted.

The amount of insurance will be subject to the Certificate and riders in effect on the date you return to Active Employment and continued premium payments.

RETURN TO ACTIVE EMPLOYMENT

If coverage is not continued during any period that is eligible for continuation under the Policy, and you return to Active Employment in an eligible class while coverage is in force for Employees under the Policy, then the terms of the Certificate and riders in effect on the date of your return to Active Employment will apply.

To present inquiries, obtain information about coverage, or get assistance to resolve a complaint, please call us at 866-228-8742. To receive claims assistance, please call us at 800-955-7736.

Executed at our Home Office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401

Robert L. Grubka
President

Melissa A. O'Donnell
Secretary

Consumer Notice for Arkansas Residents

The nearest servicing office is the Minneapolis, Minnesota office of Voya Employee Benefits, a division of ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York.
The mailing address is:

PO Box 20
Minneapolis, Minnesota 55440-0122
Telephone: (800) 537-5024

You have the right to file a complaint with the Arkansas Insurance Department (AID). A complaint can be filed online at the AID website https://insurance.arkansas.gov.

You may also contact AID to request a complaint form be mailed to you by calling AID at (800) 852-5494 or (501) 371-2640.

You may also request in writing for a complaint form to be mailed to you. Mail your request to:

Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, AR 72202

This consumer notice is for information only and does not become a part or condition of this certificate or policy. Please insert this notice in your certificate or policy.

ReliaStar Life Insurance Company
250 Marquette Avenue, Suite 900, Minneapolis, MN 55401

NOTICE TO CALIFORNIA POLICYHOLDERS/CERTIFICATEHOLDERS
KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

If you have a question about your policy, if you need assistance with a problem, or if you have questions about a claim, you may write to us at the above address or call 1-800-955-7736.

You will need to provide your policy number with any communication.

If you do not reach a satisfactory resolution after having discussions with us, or our agent or representative, or both, you may contact the following unit within the Department of Insurance that deals with consumer affairs:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, California 90013

Outside Los Angeles: 1-800-927-HELP (1-800-927-4357)
Los Angeles: (213) 897-8921

Web Site: www.insurance.ca.gov/01-consumers/101-help

NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities
  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O. Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

RELIASTAR LIFE INSURANCE COMPANY

Minneapolis, Minnesota

CERTIFICATE ENDORSEMENT

Group Short Term Disability Income Insurance

Applicable to District of Columbia Residents

Your Certificate has been changed as follows. Please insert this endorsement in your Certificate. This endorsement is subject to all of the terms of the Policy.

All other provisions of the Certificate apply and remain unchanged.

I. DISABILITY BENEFITS

The **DEDUCTIBLE SOURCES OF INCOME** provision is changed as follows:

If your Certificate lists as a Deductible Source of Income the amount that you receive, or are eligible to receive, as disability income payments under any:

- Federal, state or local (including the District of Columbia) compulsory benefit act or law

it is changed to read as follows:

- Federal, state or local compulsory benefit act or law. **Exception:** This does not include benefits payable under the District of Columbia Universal Paid Leave Amendment Act of 2021.

II. EFFECTIVE DATE

This endorsement is effective for you on the latest of the following dates:

- December 13, 2022.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota 55401

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE HAWAII LIFE AND DISABILITY INSURANCE GUARANTY ASSOCIATION ACT

Residents of Hawaii who purchase life insurance, annuities, or disability insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Hawaii Life and Disability Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumer's care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Hawaii Life and Disability Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Hawaii. You should not rely on coverage by the Hawaii Life and Disability Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is *NOT* provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. *However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.*

The Hawaii Life and Disability Insurance Guaranty Association
1132 Bishop Street, Suite 1590
Honolulu, Hawaii 96813

Department of Commerce and Consumer Affairs
Insurance Division
P.O. Box 3614
Honolulu, Hawaii 96811

The state law that provides for this safety-net coverage is called the Hawaii Life and Disability Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

(please turn to back of page)

COVERAGE

Generally, individuals will be protected by the Hawaii Life and Disability Insurance Guaranty Association if they live in this state and hold a life or disability insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by the Guaranty Association if –

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state); or
- the insurer was not a member insurer of the Guaranty Association. A nonprofit hospital or medical service organization (the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or an insurance exchange are examples of nonmember insurers.

The Guaranty Association also does **not** provide coverage for –

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employer's plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contract holders, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to pay out. The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits and with regard to one owner of multiple non-group policies of life insurance.

RELIASTAR LIFE INSURANCE COMPANY

Minneapolis, Minnesota

CERTIFICATE BOOKLET RIDER

Group Short Term Disability Income Insurance

Applicable to Idaho Residents

Your Certificate has been changed as follows. Please insert this rider in your Certificate. This rider is subject to all of the terms of the Policy.

All other provisions of the Certificate apply and remain unchanged.

I. CERTIFICATE COVER PAGE

The following provisions are added:

RENEWABILITY
The Policy is conditionally renewable on each Policy Anniversary.

Notice to Buyer: This is a disability income protection Certificate. You have the right to return this Certificate of Coverage within 10 days of its delivery and have premium you contributed (if any) refunded if, after examination of this Certificate of Coverage you are not satisfied for any reason.

II. SCHEDULE OF BENEFITS

If your Certificate contains an **Elimination Period** provision, the elimination period will be no more than 180 days.

III. EXCLUSIONS AND LIMITATIONS

i. The **EXCLUSIONS** provision is changed as follows:

The following exclusion is added –
Professional aviation for wage or profit.

If your Certificate contains an exclusion for engaging in any illegal occupation, work or employment, that exclusion does not apply.

If your Certificate contains an exclusion for operating a motorized vehicle while under the influence of alcohol, that exclusion does not apply.

If your Certificate contains an exclusion for voluntary intake of any narcotic or other controlled substance, that exclusion does not apply.

If your Certificate contains an exclusion for voluntary intake of any poison, drugs or fumes, that exclusion does not apply.

If your Certificate contains an exclusion related to traveling in an aircraft, that exclusion does not apply.

If your Certificate contains an exclusion for hang-gliding, skydiving, parachuting, ultralight, soaring, ballooning and parasailing, that exclusion does not apply.

If your Certificate contains an exclusion for participating in recreational motor sports events, racing, speed or endurance, rock or mountain climbing, skin or scuba diving, or bungee jumping, that exclusion does not apply.

If your Certificate contains an exclusion for participating in any sport for wage, compensation or profit, that exclusion does not apply.

If your Certificate contains an exclusion for occupational Sickness or Injury, that exclusion does not apply.

ii. If your Certificate contains a **PRE-EXISTING CONDITION EXCLUSION** provision, the exclusion will be no longer than 6 months following the effective date of your coverage.

iii. If your Certificate contains a **PRE-EXISTING CONDITION LIMITED BENEFIT** provision, the limited benefit is payable according to the SHEDULE OF BENEFITS if your Disability begins no longer than 12 months following the effective date of your coverage.

V. EFFECTIVE DATE

This rider is effective for you on the latest of the following dates:

- March 20, 2020.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

RELIASTAR LIFE INSURANCE COMPANY

Minneapolis, Minnesota

CERTIFICATE BOOKLET RIDER

Group Short Term Disability Income Insurance

Applicable to Illinois Residents

Your Certificate has been changed as follows. Please insert this rider in your Certificate. This rider is subject to all of the terms of the group Policy.

All other provisions of the Certificate apply and remain unchanged.

I. CLAIMS

The **AUTHORITY** provision does not apply.

II. EFFECTIVE DATE

This rider is effective for you on the latest of the following dates:

- September 17, 2021.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

ReliaStar Life Insurance Company
250 Marquette Avenue, Suite 900
Minneapolis, Minnesota 55401
(612) 372-5432

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer or health maintenance organization that issued your life, annuity or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy or contract from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer or the health maintenance organization.

In addition, residents of Minnesota who purchase life insurance, annuities, health insurance, or health maintenance coverage from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer or health maintenance organization becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

For purposes of this notice, the terms “insurance company” and “insurer” include health maintenance organizations.

Minnesota Life and Health Insurance Guaranty Association
3300 Wells Fargo Center
90 South Seventh Street
Minneapolis, Minnesota 55402
Telephone: (612) 322-8713

The maximum amount the Guaranty Association will pay for all policies or contracts issued on one life by the same insurer or health maintenance organization is limited to $500,000. Subject to this $500,000 limit, the Guaranty Association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance, health maintenance organization, and long-term care benefits, including any net cash surrender and net cash withdrawal values, $500,000 in disability income insurance, $250,000 in annuity net cash surrender and net cash withdrawal values, $410,000 in the present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant’s lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue code of 1986, as amended through December 31, 1992, are covered up to $250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the Guaranty Association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the Guaranty Association’s limits you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The Guaranty Association assesses insurers and health maintenance organizations licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY CONTRACT OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, HEALTH INSURANCE, OR HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY IMPAIRED OR INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, HEALTH INSURANCE, AND HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS ARE REQUIRED TO PROVIDE THIS NOTICE.

RELIASTAR LIFE INSURANCE COMPANY

Minneapolis, Minnesota

CERTIFICATE BOOKLET RIDER

Group Short Term Disability Income Insurance

Applicable to New Hampshire Residents

Your Certificate has been changed as follows. Please insert this rider in your Certificate. This rider is subject to all of the terms of the Group Policy.

All other provisions of the Certificate apply and remain unchanged.

I. CERTIFICATE COVER PAGE

The following notices are added –

Right to Examine Certificate

If you contribute to the cost of your insurance, you may cancel your insurance within 30 days after your receipt of the initial certificate under the Group Policy, provided no benefits have been paid. Contact the Policyholder to cancel your insurance and receive any premium refund.

Notice to Buyer: This is an ancillary health certificate. This certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

This is a Limited Benefit Certificate-Read it Carefully

II. DISABILITY BENEFITS

DEDUCTIBLE SOURCES OF INCOME

If included, reference to Military Disability Benefit plan is deleted and replaced with:

- Disability benefits received from the Department of Veterans Affairs.

IF YOU QUALIFY FOR DEDUCTIBLE SOURCES OF INCOME

If included, the following language is added:

Exception: we will NOT estimate benefits or income from a retirement plan, and lost income benefits from no-fault vehicle insurance or third -party settlements.

III. EXCLUSIONS AND LIMITATIONS

PRE-EXISTING CONDITION EXCLUSION

If included, the time period for the pre-existing condition exclusion is changed to 9 months.

IV. OUTLINE OF COVERAGE FOR NEW HAMPSHIRE RESIDENTS

See the next page for the Outline of Coverage for New Hampshire residents.

V. EFFECTIVE DATE

This rider is effective for you on or after the later of the following dates:

- The Group Policy effective date.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

SHORT TERM DISABILITY INCOME PROTECTION COVERAGE

OUTLINE OF COVERAGE

Read Your Policy Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Short term disability income protection coverage is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

Your short term group disability income plan provides Weekly Income Benefits to replace a portion of your income while you are disabled according to the terms of the policy. Benefits are calculated as a percentage of your pre-disability earnings, up to a maximum benefit, and are reduced by other income you receive or are entitled to receive. Weekly Income Benefits are paid at the end of each week for the period in which you are qualified. Benefits continue while you are disabled up to the maximum benefit period. You may be required to complete a benefit waiting period before any benefits are payable.

Other Income is subtracted from the benefit you would otherwise receive. Other Income includes income from your employer or another employer, government benefits related to disability or retirement, and benefits you receive or are entitled to receive under other insurance plans for the same disability. Disability income coverage also includes conditions under which no benefits are payable, including disabilities due to: sickness or injury which occurs in any armed conflict, whether declared as war or not, involving any country or government; sickness or injury which occurs while you are on military service for any country or government; intentionally self-inflicted injury or illness, whether you are sane or insane; injury which occurs when you commit or attempt to commit a felony; sickness or injury due to cosmetic or reconstructive surgery, except for surgery necessary to correct a deformity caused by sickness or accidental injury; pre-existing conditions; and for some Weekly Income Benefits plans, sickness or accidental injury for which you have or had a right to payment under a workers' compensation or similar law, including payment you would have been entitled to receive if the Policyholder had not declined to workers' compensation insurance as allowed by the Policyholder's state of domicile, and sickness or accidental injury arising out of or in the course of work for pay, profit or gain.

Your coverage will continue under the Group Policy, while it remains in force, as long as you continue to meet the eligibility requirements. The Policyholder may change the terms of the Group Policy at any time with the insurer's agreement. The Policyholder or the insurer may terminate the Group Policy at any time. The insurer reserves the right to change premiums at any time according to the terms of the Group Policy.

NOTICE OF PROTECTION PROVIDED BY
NORTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the North Dakota Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under North Dakota law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with North Dakota law, with funding from assessments paid by other insurance companies. For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).

The protections provided by the Association are based on contract obligations up to the following amounts:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values

- Health Insurance
  - $500,000 for health benefit plans (see definition below)
  - $300,000 in disability income insurance benefits
  - $300,000 in long term care insurance benefits
  - $100,000 in other types of health insurance benefits

- Annuities
  - $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of type of coverage, is $300,000; however, may be up to $500,000 with regard to health benefit plans.

"Health benefit plan" is defined in North Dakota Century Code Section 26.1-38.1-02(10) and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance, and long-term care insurance (LTC).

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life policy or annuity contract to which it relates.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. If coverage is available, it will be subject to substantial limitations. There are also various residency requirements and other limitations under North Dakota law. To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ndlifega.org, or contact:

North Dakota Life and Health Insurance Guaranty Association
P.O. Box 2422
Fargo, North Dakota 58108

North Dakota Insurance Department
600 East Boulevard Avenue, Dept. 401
Bismarck, ND 58505

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

A written complaint to allege a violation of any provision of the Life and Health Insurance Guaranty Association Act must be filed with the North Dakota Insurance Department, 600 East Boulevard Avenue, Dept. 401, Bismarck, North Dakota, 58505; telephone (701) 328-2440. Financial information for an insurance company, if the information is not proprietary, is available at the same address and telephone number and on the Insurance Department website at www.nd.gov/ndins.

Insurance companies and agents are not allowed by North Dakota law to use the existence of the Association or its coverage to sell, solicit, or induce you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and North Dakota law, then North Dakota law will control.

NOTICE OF PROTECTION PROVIDED BY
PENNSYLVANIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** regarding the protections provided to the policyholders by the Pennsylvania Life and Health Insurance Guaranty Association ("the Association"). This protection was created under Pennsylvania law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, or health insurance company, RANLI PPO, hospital plan corporation, professional health services plan corporation or health maintenance organization (member insurer) becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to provide coverage, pay claims, or otherwise provide protection in accordance with Pennsylvania law. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

Persons Covered

Generally, individuals will be protected by the Association if the member insurer was a member of the Association and the individual lives in Pennsylvania at the time the member insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees of such individuals.

Amounts of Coverage

The basic coverage protections provided by the Association per insured in each insolvency are limited in the aggregate to $300,000 (or $500,000 in the case of health benefit plans), including specific limits for the following types of coverage but not in excess of the contractual obligations of the member insurer;

Life insurance:

- Up to $300,000 in death benefits including up to $100,000 in net cash surrender or withdrawal value.

Accident, accident and health, or health insurance (including HMOs):

- Up to $500,000 for health benefit plans, with some exceptions.
- Up to $300,000 for disability income benefits.
- Up to $300,000 for long-term care insurance benefits.
- Up to $100,000 for all other types of health insurance.

Individual Annuities

- Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association also does not provide coverage for:

- any policy or contract or portion of a policy or contract which is not guaranteed by the member insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

- claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields or increases based on an index that exceed an average rate specified by statute;
- dividends, experience rating credits, or credits given in connection with the administration of a policy or contract by a group contract holder;
- employers' plans that are self-funded (that is, not insured by member insurer, even if member insurer administers them);
- unallocated annuity contracts (which give rights to group contract holders, not individuals) other than in limited circumstances and amounts;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the member insurer; or
- policies providing health care benefits for Medicare Parts C or D coverage, for Medicaid or under the Pennsylvania program for Comprehensive Health Care for Uninsured Children.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in Pennsylvania when it issued the policy or contract.
- If the person is provided coverage by the guaranty association of another state.
- A policy issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

NOTICES

Member insurers or their agents are required by law to give or send you this notice, and are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance or other coverage. Policyholders with additional questions should first contact their member insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.palifega.org. You can obtain additional information from the Association by contacting it at the address below. You may also contact the Pennsylvania Insurance Department to file a complaint with the Pennsylvania Insurance Commissioner to allege a violation of any provisions of Pennsylvania laws and regulations relating to insurance including the law establishing the Association:

Pennsylvania Life and Health Insurance
Guaranty Association
290 King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, PA 19087
(610) 975-0572

Pennsylvania Insurance Department
1209 Strawberry Square
Harrisburg, PA 17120
1-877-881-6388
www.insurance.pa.gov

The summary provided by this notice and on the Association's website do not limit or alter the more comprehensive and detailed provisions of the law and are subject to change without notice. The statements made herein are for information purposes only. The Association has not reviewed any specific policy, or verified the information provided regarding residency or other relevant factors. Moreover, whether coverage will be provided to any specific policyholder can only be determined by reference to the statute in effect, at the earliest, at the time that the member insurer is declared insolvent. No final determination of coverage can be made until a member insurer is declared insolvent and the specific factual and legal circumstances can be reviewed. Nothing contained herein is intended to guarantee coverage for any insured, or to bind the Association in any way. Finally, this summary and the Association's website are for general information purposes and should not be relied upon as legal advice.

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE SOUTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of South Dakota who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the South Dakota Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policy owners, contract owners, and certificate owners will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Guaranty Association does not provide coverage for all types of life, health, or annuity benefits, and the Guaranty Association may not provide coverage for this policy or contract. If coverage is provided, it may be subject to substantial limitations or exclusions, and required continued residency in South Dakota. You should not rely on coverage by the South Dakota Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy or contract.

Coverage is NOT provided for your policy or contract for any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any kind of insurance policy or contract.

The South Dakota Life and Health Insurance Guaranty Association
Charles D. Gullickson, Executive Director
206 West 14th Street
Sioux Falls, South Dakota 57104
Tel. (605) 336-0177
www.sdlifega.org

South Dakota Division of Insurance
124 S. Euclid Avenue, 2nd Floor
Pierre, South Dakota 57501
Tel. (605) 773-3563
www.dlr.sd.gov/insurance

(Please turn to back of page)

The state law that provides for this safety-net coverage is called the South Dakota Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are an insured certificateholder under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state. Coverage is also provided by the Guaranty Association to persons eligible to receive payment under structured settlement annuities who are residents of this state and, under certain conditions, such persons even if they are not a resident of this state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by the Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy or contract was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy owner, contract owner or certificate owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does **not** provide coverage for:

- any policy or contract or portion of a policy or contract which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy or contract by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals);
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer; or
- policies providing health care benefits for Medicare Parts C or D Coverage.

LIMITS ON AMOUNT OF COVERAGE

The Guaranty Association in no event will pay more than what an insurance company would owe under a policy or contract. In addition, state law limits the amount of benefits the guaranty association will pay for any one insured life, and no matter how many policies or contracts there are with the same company, as follows: (i) for life insurance, not more that $300,000 in death benefits and not more than $100,000 in net cash surrender and net cash withdrawal values; (ii) for health benefit plans, not more than $500,000, but not more than $300,000 for disability insurance and long term care insurance, and not more than $100,000 for other types of health insurance, and (iii) for annuities, not more than $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values. However, in no event will the Guaranty Association be obligated to cover more than an aggregate of $300,000 in benefits with respect to any one life except with respect to health benefit plans, for which the aggregate liability of the guaranty association may not exceed $500,000. These general statements of the limits on coverage are only summaries and the actual limitations are set forth in South Dakota law.

ADDITIONAL INFORMATION

The statutes which govern the Guaranty Association are contained in SDCL Chapter 58-29C. Additional information about the Guaranty Association may be found at www.sdlifega.org, which contains a link to SDCL Chapter 58-29C.

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as A.M. Best Company, Fitch Ratings, Moody's Investors Service, Inc., and Standard & Poor's. Additional information about financial rating agencies may be obtained by clicking on "Useful Links" on the website of the South Dakota Division of Insurance at www.dlr.sd.gov/insurance

The Guaranty Association is subject to supervision and regulation by the director of the South Dakota Division of Insurance. Persons who desire to file a complaint to allege a violation of the statues governing the Guaranty Association may contact the Division of Insurance. State law provides that any suit against the Guaranty Association shall be brought in Hughes County, South Dakota.

RELIASTAR LIFE INSURANCE COMPANY

Minneapolis, Minnesota

CERTIFICATE BOOKLET RIDER

Group Short Term Disability Income Insurance

Applicable to South Dakota Residents

Your Certificate has been changed as follows. Please insert this rider in your Certificate. This rider is subject to all of the terms of the Policy.

All other provisions of the Certificate apply and remain unchanged.

I. DEFINITIONS

i. The definition of **Treatment Provider** is changed to add the following statement:

> Treatment Provider includes a family member if the family member is the only Treatment Provider in your area, provided the Treatment Provider is acting within the scope of his/her practice.

ii. If your Certificate contains a definition of **Pre-Existing Condition** and that definition includes "ordinarily prudent person" language, then that language does not apply.

II. DISABILITY BENEFITS

If your Certificate contains a **Deductible Sources of Income** provision and the provision contains reference to the "Military Disability benefit plan" or to "The United States Social Security Act," then those references do not apply.

III. EXCLUSIONS AND LIMITATIONS

i. If your Certificate contains an exclusion for operating a motorized vehicle while under the influence of alcohol, then that exclusion does not apply.

ii. If your Certificate includes a **PRE-EXISTING CONDITION EXCLUSION,** it is changed to read as follows:

> We will not pay any benefits for any Disability that results from, or is caused or contributed to by, a Pre-Existing Condition during the 12 months after the effective date of your coverage.
>
> Additional coverage as described under the EFFECTIVE DATE OF CHANGES TO COVERAGE provision, is subject to this PRE-EXISTING CONDITION EXCLUSION provision, as of the date the additional coverage became effective for you.

iii. If your Certificate includes a **PRE-EXISTING CONDITION LIMITED BENEFIT,** then that provision does not apply.

IV. CLAIMS

The **AUTHORITY** provision does not apply.

V. EFFECTIVE DATE

This rider is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

Texas Residents: Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

ReliaStar Life Insurance Company

To get information or file a complaint with your insurance company:

Call: Customer Contact Center Manager at 1-800-955-7736

Toll-free: 1-888-238-4840 for Life Insurance and 1-877-236-7564 for Supplemental Benefits Insurance

Email: LifeClaims@voya.com

Mail: 250 Marquette Avenue, Suite 900, Minneapolis, MN 55401

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamacion o con su prima de seguro, llame primero a su compania de seguros. Si no puedo resolver el problema, es possible que el Departamento de Seguros de Texas (Texas Department of Insurance, pro su nombre en ingles) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, tamblen debe presenter una queja a traves del proceso de quejas o de apelaciones de su compania de seguros. Si no lo hace, podria perder su derecho para apelar.

ReliaStar Life Insurance Company

Para obtener informacion o para presenter una queja ante su compania de seguros:

Llame a: Customer Contact Center Manager at 1-800-955-7736

Telefono gratuito: 1-888-238-4840 for Life Insurance and 1-877-236-7564 for Supplemental Benefits Insurance

Correo electronico: LifeClaims@voya.com

Direccion postal: 250 Marquette Avenue, Suite 900, Minneapolis, MN 55401

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacion ada con los seguros o para presenter una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electronico: ConsumerProtection@tdi.texas.gov

Direccion postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

Notice of Protection Provided by
Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms “insurance company and “insurer” include health maintenance organizations (HMOs) and limited health plans.)

The basic protections provided by the Association are:

- Life Insurance
  - o $500,000 in death benefits
  - o $200,000 in cash surrender or withdrawal values
- Health Insurance
  - o $500,000 in hospital, medical and surgical insurance benefits
  - o $500,000 in long-term care insurance benefits
  - o $500,000 for disability income insurance benefits
  - o $500,000 in other types of health insurance benefits
- Annuities
  - o $250,000 in the present value of annuity benefits in aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical, and surgical insurance benefits.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Utah law.

To learn more about the above protections, please visit the Association's website at www.utlifega.org, or contact:

Utah Life and Health Insurance Guaranty Assoc.
32 West 200 South #150
Salt Lake City, UT 84101
(801)320-9955

Utah Insurance Department
State Office Bldg., Rm. 3110
Salt Lake City, UT 84114
(801) 538-3800

RELIASTAR LIFE INSURANCE COMPANY

Minneapolis, Minnesota

CERTIFICATE BOOKLET RIDER

Group Short Term Disability Income Insurance

Applicable to Utah Residents

Your Certificate has been changed as follows. Please insert this rider in your Certificate. This rider is subject to all of the terms of the Policy.

All other provisions of the Certificate apply and remain unchanged.

I. EXCLUSIONS AND LIMITATIONS

i. If your Certificate contains a **PRE-EXISTING CONDITION EXCLUSION** provision, the exclusion will be no longer than 12 months following the effective date of your coverage.

ii. If your Certificate contains a **PRE-EXISTING CONDITION LIMITED BENEFIT** provision, the limited benefit is payable according to the SHEDULE OF BENEFITS if your Disability begins no longer than 12 months following the effective date of your coverage.

II. EFFECTIVE DATE

This rider is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

NOTICE OF PROTECTION PROVIDED BY
VERMONT LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Vermont Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. This safety net was created under Vermont law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Vermont law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).) The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender and withdrawal values
- Health Insurance
  - $500,000 for health benefit plans (see definition below)
  - $300,000 in disability [income] insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to health benefit plans.

"Health benefit plan" is defined in 8 V.S.A. Section 4175 (11) and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance (LTCI).

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Vermont law.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

To learn more about the above protections, [as well as protections relating to group contracts or retirement plans,] please visit the Association's website at www.vtlifega.org, or contact:

Vermont Life and Health Insurance Guaranty Association
One National Life Drive, Suite M585
Montpelier, Vermont 05604
802 -552-3698

Vermont Department of Financial Regulation
89 Main Street
Montpelier, Vermont 05620
802-828-3301

Insurance companies and agents are not allowed by Vermont law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Vermont law, then Vermont law will control.

The Summary Plan Description on the following pages is provided to you at the request of the Policyholder. It is not part of the insurance certificate.

SUMMARY PLAN DESCRIPTION

For a Plan of Insurance Underwritten by
ReliaStar Life Insurance Company
P.O. Box 122
Minneapolis, Minnesota 55440-0122

Plan Name, Number and Name and Address of Plan Sponsor:
ODP International, LLC
74634-7STD2
ODP International, LLC
6600 North Military Trail
Boca Raton, FL, 33496

Name, Address, and Telephone Number of the Plan Administrator:
ODP International, LLC
6600 North Military Trail
Boca Raton, FL, 33496

Identification Numbers
IRS Employer Identification Number: 87-2687219
Plan Number: 501

Agent for Legal Process: Plan Administrator

Trustees: None

Collective Bargaining or Multiple-Employer Agreements under which Plan is Established: None

Type of Administration: Records maintained by Policyholder.

Premium Payments: Premiums are 100% Employee paid.

Plan Year: January - December

Claim Procedures: Please refer to CLAIM PROCEDURES section(s).

Statement of ERISA Rights: Please refer to STATEMENT OF ERISA RIGHTS section.

Eligibility and Circumstances Limiting Eligibility: As described in the Certificate of insurance.

Type of Plan: As described in the Certificate of insurance.

Benefits in Plan: As described in the Certificate of insurance.

Amendment or Termination of Plan: The Plan Sponsor makes no promise to continue these benefits in the future and rights to future benefits will never vest. The Plan Sponsor reserves the right to amend, modify, revoke or terminate the plan, in whole or part, at any time. ReliaStar Life Insurance Company's policy may be amended or terminated as set forth in the Policy.

Benefits, Rights, and Obligations after Termination: As described in the Certificate of insurance.

SUMMARY PLAN DESCRIPTION

CLAIM PROCEDURES FOR DISABILITY INCOME INSURANCE

1. Information regarding claim submission may be obtained from the Plan Administrator or Human Resource Department.
2. ReliaStar Life Insurance Company (ReliaStar Life) will process the claim and make payment or issue a denial notice.
3. Written notice of denial of a claim will be furnished to the claimant within 45 days after receipt of the claim. Up to two extensions of 30 days each will be allowed for processing the claim for matters beyond the Plan's control or if additional information is needed from the claimant. The claimant will be given notice of any such extension. The notice will state the standards on which the entitlement to the benefit is based, the unresolved issues that prevent a decision on the claim, the additional information needed to resolve those issues, if any, and the date a decision is expected.
4. The notice of denial will be written in an understandable manner and include the following:
   a. The specific reason(s) for the denial.
   b. Specific reference to the provision, internal rule, guideline or protocol which forms the basis of the denial.
   c. A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed.
   d. A description and a copy of relevant claim review procedures, including the time limits applicable to such procedures and notice of the claimant's right to bring a civil action pursuant to Section 502(a) of ERISA following an adverse decision on appeal.
5. The claimant may request an appeal at any time during the 180-day period following receipt of the notice of denial of the claim.
6. ReliaStar Life will consider requests for an appeal of a denied claim upon written application of the claimant or his or her duly authorized representative. As part of the appeal, the claimant has the right, upon request and free of charge, to access or obtain copies of all documents, records and other information that is relevant to the claim for benefits. The claimant may, in the course of this appeal, submit to ReliaStar Life written comments, documents, records, and other information relating to the claim. ReliaStar Life will provide a full and fair review that takes into account all comments, documents, records and other information submitted by the claimant without regard to whether such information was submitted or considered in the initial benefit determination. Review of claim denials and final decisions on appeal are the responsibility of ReliaStar Life.
7. Prior to rendering an adverse decision on appeal, ReliaStar Life will provide notice to the claimant of any new or additional evidence considered, relied upon, or generated by the plan, insurers or other persons making the benefit determination. ReliaStar Life will also notify the claimant if it has new or additional rationale for an adverse appeal determination. ReliaStar Life will then provide the claimant with a reasonable opportunity to review and respond to this new information before making its decision. The time period ReliaStar Life has to make its determination will be tolled while it is waiting for the claimant's response.
8. ReliaStar Life will provide the claimant with a written decision of the final determination of the claim. If ReliaStar Life sends an adverse benefit determination following its review of the appeal, the notice of the determination will be written in an understandable manner and include the following:
   a. The specific reason(s) for the adverse benefit determination.
   b. Reference to the specific provision on which the determination is based.
   c. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim.
   d. A statement of the claimant's right to bring a civil action and any contractual statute of limitations period, including the specific calendar date on which such limitations period will expire.
   e. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, then a copy of any such rule, guideline, protocol or other criterion will be provided free of charge.
   f. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

   This decision will be issued as soon as practicable from the date of appeal, but not longer than 45 days unless an extension is needed. An extension of 45 days will be allowed for making the decision for matters beyond the Plan's control or if additional information is needed from the claimant. The claimant will be given notice if this extension is necessary, stating the reason for the extension, the date a decision is expected, and the additional information needed from the claimant, if any. If the decision on review is not received within these time limits,

the claim may be considered denied. If the claimant receives an adverse benefit determination, the claimant will then have the right to bring a civil action pursuant to Section 502(a) of ERISA.

9. ReliaStar Life has final discretionary authority to determine all questions of eligibility and status, to interpret and construe the terms of this policy(ies) of insurance, and to make claim determinations.

SUMMARY PLAN DESCRIPTION

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. 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, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance 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 these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Office of Participant Assistance, 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.

This Page has been left blank.