YOUR
GROUP
WEEKLY INCOME DISABILITY
PLAN

For Employees of

Sotera Health Holdings, LLC

CONTENTS

B-19111 (01-20)

SCHEDULE OF BENEFITS

Disability Income Coverage – Weekly Income Benefits

Weekly Income Benefit Percentage 70%

Maximum Weekly Income Benefit $3,000

The **Weekly Income Benefit** is calculated as follows:

Weekly Income Benefit (A divided by B) times C, minus Other Income.

A = your Basic Weekly Earnings minus Recovery Work Earnings.
B = your Basic Weekly Earnings.
C = your **Gross Weekly Benefit**, defined as follows:
• Take the Benefit Percentage and multiply by your Basic Weekly Earnings.
• Compare this result to the Maximum Weekly Income Benefit and take the lesser of the two amounts.

Other Income is described in the Disability Income Coverage section of this booklet.

Recovery Work Earnings is defined in the Definitions section of this booklet.

In no event will your Weekly Income Benefit plus Other Income be greater than your pre-disability Basic Weekly Earnings.

Basic Weekly Earnings – the basic salary or wage you received on the last day you worked for the Employer, before becoming disabled. It does not include bonuses, commissions or overtime pay.

Benefit Waiting Period
• Disability caused by accidental injury ..... 7 days
• Disability caused by sickness ..... 7 days

Maximum Benefit Period ..... 26 weeks

EMPLOYEE'S COVERAGE

Eligibility
You are eligible on the first day of the month on or after the date you complete 6 months of continuous service with the Employer.

You must meet the following conditions to become covered:
- Be eligible for the coverage.
- Be actively at work.

Effective Date of Employee's Coverage
Your coverage starts on the latest of the following dates:
- The date you become eligible.
- The date you return to active work if you are not actively at work on the date coverage would otherwise start. **Exception:** Your coverage starts on a nonworking day if you were actively at work on your last scheduled working day before the nonworking day.

You must be actively at work for 5 working days in a row before coverage starts. The fifth working day must fall on or after the effective date of Employee's Coverage.

Continuity of Coverage
If you are not actively at work on the date coverage would otherwise start, the Plan will waive the actively at work requirement if both of the following are true:
- You are eligible for coverage except for meeting the actively at work requirement on the Plan's Effective Date.
- You were covered under the Employer's prior group disability income plan on the day before the Plan's Effective Date.

Your coverage is subject to payment of cost contributions. Before you return to active work, any benefit will be limited to the amount that would have been paid under the prior plan. The Plan reduces the amount it pays by any amount for which the prior plan is liable. Your coverage will stop on the date benefits would have ended under the prior plan had it remained in force.

Effective Date of Change in Amount of Coverage
If there is an increase in the amount of your coverage, the increase will take effect on:
- The date of the increase, if you are actively at work on that date.
- The date you return to active work, if you are not actively at work on the date your coverage increases.
- The nonworking day on which the increase was effective, if you were actively at work on your last scheduled working day before the nonworking day.

A decrease in the amount of your coverage will take effect on the date of the decrease.

Termination of Coverage
Your coverage stops on the earliest of the following dates:
- The date you are no longer actively at work for the Employer.
- The date you are no longer eligible for coverage under the Plan.
- The date the Plan stops.

The Plan stops providing a specific benefit to you on the date that benefit is no longer provided under the Plan.

Family and Medical Leave Act of 1993
Certain employers are subject to the FMLA. If you have a leave from active work certified by your employer, then for purposes of eligibility and termination of coverage you will be considered to be actively at work. Your coverage will remain in force so long as you continue to meet the requirements as set forth in the FMLA.

EMPLOYEE'S COVERAGE

Reinstatement
The Plan will reinstate your coverage if you stop work and then return to work within 6 months. You will be eligible for coverage on the date you return to active work with the Employer.

DISABILITY INCOME COVERAGE

Weekly Income Benefits

Qualifying for Benefits
The Plan pays benefits if you become disabled and qualify to receive benefits. The benefit payable is based on the Schedule of Benefits in effect on the date you became disabled.

To qualify for benefits, all of the following conditions must be met:
You must –
- be covered on the date you become disabled and the condition causing your disability is not excluded from coverage.
- be covered on the date the benefit waiting period begins.
- send notice of the disability as described in the Claim Procedures Section.
- be receiving regular and appropriate care and treatment.
- have the length of your disability approved by the disability management program.

Disability Management
The disability management program evaluates disability to approve the length of disability and establish a target date for return to work. When you become disabled, you must call the number on your disability I.D. card to start the disability management process. If your disability is expected to continue beyond the number of approved days, your doctor must call to have the extended period of disability reviewed. Benefits are not payable until approval is obtained. Benefits are not payable for non-approved days.

Benefit Waiting Period
The benefit waiting period is the length of time you must be continuously disabled before you qualify to receive any benefits. **Exception:** You may return to work for up to 5 days during the benefit waiting period without having to begin a new benefit waiting period. The days you work and are not disabled do not count toward meeting the benefit waiting period.

The benefit waiting period begins on the first day you see a doctor and he or she states in writing that you are disabled because of sickness or accidental injury.

The benefit waiting period is shown on the Schedule of Benefits.

Benefit Payments
Weekly income benefits are paid at the end of each week for the period for which you qualified. If you are disabled for part of a week the benefit payable is based on 1/7 of your weekly income benefit for each day you are disabled.

The weekly income benefits are determined as shown on the Schedule of Benefits. Benefits continue while you are disabled up to the maximum benefit period shown on the Schedule of Benefits. You must complete the benefit waiting period before any benefits are payable.

Other Income
Other Income is subtracted from the benefit you would otherwise receive, as shown on the Schedule of Benefits. Other Income includes any of the following:
- The amount you receive or are entitled to receive under:
  - Salary continuance benefits provided through the Employer.
  - Paid Time Off benefits provided through the Employer.
  - Sick leave benefits provided through the Employer.
  - Unemployment benefits under any law or compulsory program.
- The amount you receive or are entitled to receive as disability income payments under any:
  - Automobile liability insurance benefits.

  - Plan or arrangement of disability coverage, whether insured or not, resulting from your employment by or association with any employer, or resulting from your membership in or association with any group, association, union or other organization.
  - Group life or group accident insurance policy.
  - Individual insurance policy where the premium is wholly or partially paid by an employer or for which an employer makes payroll deductions.
- The amount of any judgments or settlements you receive as the result of the act or omission of a third party.
- The amount you and your dependents receive or are entitled to receive as disability payments because of your disability under:
  - The Federal Social Security Act.
  - The Canada Pension Plan.
  - The Quebec Pension Plan.
  - The Railroad Retirement Act.
  - The Jones Act.
  - State Disability benefits.
  - Any similar act or plan.
  - Other government disability income.
- The amount you receive as retirement payments or income your dependents receive as retirement payments because you are receiving retirement payments under:
  - The Federal Social Security Act.
  - The Canada Pension Plan.
  - The Quebec Pension Plan.
  - The Railroad Retirement Act.
  - The Jones Act.
  - Any similar act or plan.
  - Other government retirement income.

Other income includes the following benefits provided under an employer's retirement plan:
- Disability benefits.
- Retirement benefits attributable to employer contributions. These retirement benefits include only:
  - Early retirement benefits you are receiving that are voluntarily selected.
  - Retirement benefits that are unreduced by age for which you are eligible on the later of the following:
    - the date you reach age 62.
    - normal retirement age.

The Plan considers retirement benefits received before age 62, or if later, before normal retirement age, to be voluntarily elected until you provide written proof satisfactory to the Plan that you did not elect to receive benefits voluntarily.

Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit that would have been paid if the disability had not occurred. If disability benefits reduce the retirement benefit under the plan, they will be considered a retirement benefit.

Except for Other Income retirement benefits, Other Income includes only income which is payable for the same period of disability for which you are claiming benefits under the Plan.

The Plan considers you to be eligible to receive Other Income benefits whether or not you apply for them, until you send the Plan written proof that the benefits were denied or contested. When the Plan receives written proof that Other Income benefits were denied or contested, the Plan will pay benefits you are qualified to receive. However, if the denial of Other Income benefits is not final, you must pursue the Other Income benefits to the fullest extent possible.

Exceptions: Benefits will not be reduced by –

- retirement benefits attributable to employee contributions.
- retirement or disability benefits you receive from a past employer, if these benefits have been paid continuously to you for more than 2 years before you become eligible to receive benefits under the Plan.
- benefits paid by a group or franchise creditor disability plan.
- income received from a profit sharing plan, thrift plan, individual retirement account, tax sheltered annuity, stock ownership plan, or a non-qualified plan of deferred compensation.
- disability or retirement benefits which are received under an employer's retirement plan but are rolled over or transferred to any eligible retirement plan as defined by the Internal Revenue Code.
- Federal Social Security benefits if your disability begins after age 70 and you were receiving Social Security benefits while continuing to work.
- a cost of living increase to any other income benefit after the initial other income benefit becomes payable.

Lump Sum Payments

Other Income you receive as a lump sum will be prorated into weekly amounts. The prorated amount will be subtracted from the benefit you would otherwise receive, until the total amount subtracted equals the lump sum payment. The Plan will determine the prorated amount using the first of the following methods that applies:

- Divide the Other Income lump sum into weekly amounts based on the amount of Other Income you were receiving from the same source prior to receiving the lump sum payment.
- Divide the Other Income lump sum into weekly amounts based on the weekly amount you could have received in lieu of the lump sum payment.
- Divide the Other Income lump sum into weekly amounts over the remaining maximum benefit period.

Overpayment

If the Plan pays you a larger benefit than you should have received, the Plan may recover any overpayments it made.

The Plan will recover from you the full amount of the overpayment through one or more of the following means:

- Require you to return the overpayment in one lump sum.
- Stop payment of benefits until the full overpayment is repaid.
- Require you to assign any Other Income to the Plan.

Waiver of Contribution

The Plan waives your contribution during any period for which benefits are payable. If the Plan waives your contribution it is the Employer's responsibility to refund to you any contribution you may make after qualifying for benefits.

Termination of Benefits

The Plan stops paying benefits on the earliest of the following:

- The date you are no longer disabled.
- The end of the maximum benefit period for any one period of disability. The maximum benefit period is shown on the Schedule of Benefits.
- The date you no longer qualify for benefits under all the conditions listed.
- The date of your death.
- The date you fail to provide written proof of disability that the Plan determines to be satisfactory.
- The date you cease to be under regular and appropriate care of a doctor, or refuse to undergo an examination or testing by a doctor of the Plan's choosing.
- The date you refuse to undergo vocational or rehabilitation testing that the Plan requires.
- The date you refuse to receive medical treatment that is generally acknowledged by doctors to cure or improve your condition so as to reduce its disabling effect.

- The date you refuse to work with the assistance of modifications made to your work environment, functional job elements or work schedule, or adaptive equipment or devices, that a qualified doctor has indicated will accommodate the limiting factors of your sickness or accidental injury.

If the Plan or the Disability Income Coverage part of the Plan terminates after you qualify to receive benefits, the Plan continues your benefit payments. Benefits are paid as long as you continue to qualify according to the terms of the Plan in effect on the date you qualified.

Recurrent Disability

If you are receiving weekly income benefits, a recurrent disability is a disability due to the same cause which occurs after you have returned to full-time work for the Employer for less than 30 working days. The Plan pays benefits for a recurrent disability which is a continuation of a previous disability.

A recurrent disability has –

- no additional benefit waiting period.
- the same maximum benefit period as the previous disability.

Benefits payable under this recurrent disability provision will stop if benefits are payable to you under any other group disability plan.

Exclusions

The Plan will not pay benefits if your disability results from any of the following:

- 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.
- Injury suffered in a fight in which you are the aggressor.
- Sickness or injury due to cosmetic or reconstructive surgery, except for surgery necessary to correct a deformity caused by sickness or accidental injury.
- Sickness or accidental injury for which you have or had a right to payment under a workers' compensation or similar law. This includes payment you would have been entitled to receive if the Employer had not declined to provide workers' compensation insurance as allowed by the Employer's state of domicile.
- Sickness or accidental injury arising out of or in the course of work for pay, profit, or gain.

The Plan will not pay benefits for the portion of any period of disability that you are confined in a penal or correctional institution as a result of conviction for a criminal or other public offense.

The Plan will not pay an additional benefit for disability caused by both sickness and accidental injury or by more than one sickness or accidental injury.

CLAIM PROCEDURES

Submitting a Claim
You or someone on your behalf must contact the Plan as instructed on your disability I.D. card in order to submit a claim.

The Plan will gather information from you, your employer and your doctor to determine eligibility and verify proof of loss.

Benefit Payments
Benefits under the Plan are paid when proof of loss is received.
Benefits are paid to you. Any weekly income benefit remaining unpaid at the time of your death will be paid to your survivors or your estate in the following order:
1. Your spouse.
2. Your children.
3. Your estate.

Time of Payment of Claims
Subject to due proof of loss, all accrued benefits payable under the Plan will be paid at the end of each week during the period for which the Plan is liable. Any balance remaining unpaid at the end of such period will be paid as soon as possible after receipt of proof of loss.

GENERAL PROVISIONS

Free Choice of Doctor
You have the right to choose any doctor.

Assignment
You may not transfer to anyone else –
- ownership of any booklet issued under the Plan.
- Disability Income Coverage under the Plan.

Legal Action
Legal action may not be taken to receive benefits until 60 days after the date proof of loss is submitted according to the requirements of the Plan. Legal action must be taken within 3 years after the date proof of loss must be submitted.

If the Employer's state requires longer time limits, the Plan will comply with the state's time limits.

Exam
When reasonably necessary, the Plan may have you examined while you are claiming benefits. The exam will be conducted by one or more doctors or vocational experts of the Plan's choice. The exam may include vocational testing and evaluations, or any other type of testing and evaluations the Plan determines necessary. This right will only be exercised as often as the Plan reasonably believes necessary to properly evaluate your claim and your potential for rehabilitation. The Plan has the right to defer or suspend payment of benefits if you fail to attend an exam or fail to cooperate with the doctor. Benefits may be resumed, provided that the required exam occurs within a reasonable time and benefits are otherwise payable.

Reimbursement
If the Plan pays Disability Income benefits for sickness or accidental injury caused in whole or part by the act or omission of another, you must –
- reimburse the Plan for the benefits paid if you recover damages for lost income by settlement, court order, judgment or otherwise.
- provide the Plan with a lien and order directing reimbursement for benefits. The lien and order may be filed with –
  - the person whose act caused the sickness or accidental injury,
  - their agent,
  - the court, or
  - your attorney.
- cooperate with the Plan, including execution, completion, and filing of any document deemed by the Plan necessary to protect its reimbursement rights.

The Plan has a first priority claim against –
- amounts which are or may be subject to reimbursement.
- any person who is or may be obligated to pay damages for lost income. This includes any insurer of you.

The Plan will be reimbursed first before other claims against amounts recovered or recoverable from persons who are or may be obligated to pay damages for lost income, even if the amounts are not enough to reimburse the Plan in full or compensate you in full for damages sustained.

The Plan has no obligation to pay attorney's fees or other legal fees to your attorney for recovery of amounts subject to reimbursement.

The Plan will have the right to intervene in any suit or other proceedings to protect its reimbursement rights. Any settlement proceeds received by you or your attorney will be held in trust for the Plan's benefit. The Plan's rights herein are binding upon and enforceable against your legal representatives, heirs, next of kin, and successors in interest.

GENERAL PROVISIONS

Subrogation
If the Plan pays Disability Income benefits for sickness or accidental injury caused in whole or part by the act or omission of another, the Plan will have a right of subrogation against any person, any insurer, you or any insurer of you, should you receive, or have a right to receive, any damages or payments.

You will do nothing to prejudice the Plan's subrogation rights and will cooperate with the Plan to protect such rights. This includes –
- providing information.
- signing an agreement documenting the Plan's subrogation rights .
- taking other action the Plan requests. This includes execution, completion, and filing of any document deemed by the Plan necessary to protect its rights.

The Plan's subrogation rights and amounts recoverable or recovered pursuant to such rights are a first priority claim. Such amounts will be reimbursed first even if all amounts recovered from whatever source are insufficient to compensate you in part or whole for all damages sustained.

At the Plan's option, action may be taken to preserve its subrogation rights. This includes –
- the right to bring any legal action in your name.
- seeking reimbursement out of any amount from any source recovered by you.

Any settlement proceeds received by you, or your attorney will be held in trust for the Plan's benefit. The Plan has no obligation to pay any attorney or other legal fees to your attorney for any subrogation recovery received. The Plan will have the right to intervene in any suit or proceeding to protect its subrogation rights. The Plan's rights herein are binding upon and enforceable against your legal representatives, heirs, next of kin, and successors in interest.

Incontestability
Any statement you make to obtain coverage or an increase in coverage is a representation and not a warranty. No misrepresentation by you will be used to reduce or deny a claim or to deny the validity of your coverage or an increase in coverage unless all of the following are true:
- Your coverage or increase in coverage would not have been approved if the truth had been known.
- Your misrepresentation is contained in a written instrument signed by you.
- You or your beneficiary, if applicable, have been given a copy of the written instrument containing your misrepresentation.

After your coverage or increase in coverage under the Plan has been in effect for two continuous years during your lifetime, the Plan will not use a misrepresentation by you to reduce or deny a claim or to deny the validity of your coverage or increase in coverage unless it was a fraudulent misrepresentation made with an actual intent to deceive. However, the Plan has the right at any time to assert as a defense to a claim that you were not eligible for coverage or for the increase because you did not meet the requirements of the Plan. These requirements include, but are not limited to any requirements that you:
- Satisfy the eligibility requirements.
- Submit and have approved proof of good health.
- Meet the actively at work requirement.

DEFINITIONS

Accidental Injury – bodily injury resulting from a sudden, violent, unexpected and external event. All injuries are considered to be received in one accident as one accidental injury. Infection resulting from a cut or wound caused by an accident is also an accidental injury.

Accidental injury does not include poisoning, disease or any other type of infection, except as stated above.

Active Work, Actively at Work – the employee is physically present at his or her customary place of employment with the intent and ability of working the scheduled hours and doing the normal duties of his or her job on that day.

Damages for Lost Income – any payments which in whole or part can reasonably be considered compensatory for lost income, regardless of designation.

Disability, Disabled – The Plan's determination that a change in your functional capacity to work due to sickness or accidental injury has caused your inability to perform the essential duties of your regular occupation or a reasonable employment option offered to you by the Employer, and as a result you are unable to earn more than 80% of your basic weekly earnings.
Economic factors such as, but not limited to, recession, job obsolescence, paycuts, and job sharing will not be considered in determining whether you meet the requirements stated above.

You will not be considered disabled solely because of the loss or restriction of your license to engage in your regular occupation.

Doctor – a medical practitioner of a healing art which is recognized by applicable state law, who meets all of the following conditions:
- He or she is practicing within the scope of his or her license.
- He or she is certified or credentialed by the appropriate medical or professional board that provides certification or credentialing for practitioners who perform the type of treatment or service the practitioner is providing for your sickness or injury.
- He or she posseses the necessary training and qualifications, according to generally accepted medical standards, to evaluate and treat your condition.

The term doctor does not include you, an employee of the Employer, anyone related to you by blood or marriage, or anyone living in your household.

Employee – an active full-time employee residing in the United States who is employed by the Employer and is regularly scheduled to work on at least a 24-hour-per-week basis. Such employees of companies and affiliates controlled by the Employer are included. Temporary and seasonal employees are excluded.

Employer – Sotera Health Holdings, LLC.

Essential Duties – duties which are normally required for the performance of an occupation as it is normally performed in the national economy and which cannot be reasonably omitted or modified. If you were normally required to perform essential duties in excess of 40 hours per week or 8 hours per day prior to becoming disabled, the Plan will consider you still able to perform the essential duties if you are working or have the capacity to perform such duties at least 40 hours weekly or 8 hours daily.

DEFINITIONS

Nonworking Day – a day on which the employee is not regularly scheduled to work, including time off for the following:
- Vacations.
- Personal holidays.
- Weekends and holidays.
- Approved nonmedical leave of absence.
- Paid Time Off for nonmedical-related absences.

Nonworking day does not include time off for any of the following:
- Medical leave of absence. Time off for a medical leave of absence will be considered a scheduled working day.
- Temporary layoff.
- The Employer suspending its operations, in part or total.
- Strike.

Period of Disability – a new period of disability begins if the new disability results from a cause or causes unrelated to that of any previous disability, separated by active work with the Employer. All periods of disability which have the same cause are considered one period of disability. **Exception:** A new period of disability begins when you become disabled due to the same cause after you have been actively at work on a full-time basis with the Employer continuously for at least 30 working days.

Plan – Sotera Health Holdings, LLC, ASO-70836-4.

Reasonable Employment Option – an employment position for which you are able to perform the essential duties given your education, training and experience.

Recovery Work Earnings – is any of the following:
- Income you receive while working for the Employer.
- The excess of income you receive while working for another employer above the average income you received from the Employer prior to becoming disabled.

Regular and Appropriate Care – means:
- You personally visit a doctor as often as is medically required, according to generally accepted medical standards and consistent with the stated severity of your medical condition, to effectively manage and treat your sickness or injury.
- You are receiving care which conforms with generally accepted medical standards for treating your sickness or injury and is consistent with the stated severity of your medical condition.
- Care is rendered by a doctor whose specialty or experience is the most appropriate for your disability according to generally accepted medical standards.
- You are receiving or actively seeking appropriate physical or psychological rehabilitative services.

Regular Occupation – the activity which, immediately prior to disability, you were regularly performing and which was your source of income from the Employer. The Plan will assess this occupation as it is normally performed in the national economy, rather than how the duties and tasks are performed for a specific employer or at a specific location.

ReliaStar Life – ReliaStar Life Insurance Company, at its Home Office in Minneapolis, Minnesota, the claims paying agent for the Employer's self-funded plan. The Employer makes all final claim decisions. Whenever ReliaStar Life is referred to in this booklet it is in its capacity as a claims paying agent.

DEFINITIONS

Sickness – any physical illness, mental disorder, normal pregnancy or complication of pregnancy.

Spouse – the legal husband or wife of an employee.

Written, In Writing – signed, dated and received at ReliaStar Life's Home Office in a form ReliaStar Life accepts.

You, Your – an employee covered for Employee's Coverage under the Plan.

For a Plan of Benefits Administered by
ReliaStar Life Insurance Company
P.O. Box 20
Minneapolis, Minnesota 55440

Plan Name, Number and Name and Address of Planholder:
Sotera Health Flexible Benefits Plan
70836-4SFDIS
Sotera Health LLC
9100 South Hills Blvd.
Suite 300
Broadview Heights, Ohio, 44147

Name, Address, and Telephone Number of the Plan Administrator:
Sotera Health Holdings, LLC
9100 South Hills Blvd.
Suite 300
Broadview Heights, Ohio, 44147
440-262-1443

Identification Numbers
IRS Employer Identification Number: 47-4076134
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 Employer.

Contribution Payments: Employer contributes to the cost of the Plan.

Plan Year: January 1 through December 31

Claim Procedures: Please refer to the CLAIM PROCEDURES section.

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

Eligibility and Circumstances Limiting Eligibility: See Employee's Coverage in the Employee Booklet.

Type of Plan: As described in the Employee Booklet.

Benefits in Plan: See Employee's Coverage in the Employee Booklet. Benefits are provided by a self-funded plan and not by a policy or contract 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. Retirement does not give any retiree any vested right to continue plan benefits. The Plan Sponsor reserves the right to amend, modify, revoke or terminate the plan, in whole or part, at any time.

Benefits, Rights, and Obligations after Termination: As described in the Employee Booklet.

ReliaStar Life Insurance Company of Minneapolis, Minnesota acts only as the claim-paying agent of this self-funded employee benefit plan, and is not acting as an insurer of this Plan.

CLAIM PROCEDURES

1. Information regarding claim submission may be obtained from the Plan Administrator or Human Resources Department.
2. ReliaStar Life Insurance Company (ReliaStar Life) will process the claim and make payment or issue a denial notice on behalf of the Plan Administrator.
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. A request for an appeal of a denied claim may be made by sending a written application of the claimant or his or her duly authorized representative to ReliaStar Life. 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 written comments, documents, records and other information relating to the claim. A full and fair review will be done that takes into acount 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 the Plan Administrator.
7. Prior to rendering an adverse decision on appeal, the claimant will be provided notice of any new or additional evidence considered, relied upon, or generated by the plan, insurers or other persons making the benefit determination. The claimant will also be notified of any new or additional rationale for an adverse appeal determination. The claimant will then have a reasonable opportunity to review and respond to this new information before a decision is made. The time period the Plan Administrator 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 providing the final determination of the claim. If there is an adverse benefit determination following the 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 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. The Plan Administrator has final discretionary authority to determine all questions of eligibility and status, to interpret and construe Plan terms, and to make claim determinations.

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.