

YOUR  
GROUP  
**SHORT-TERM DISABILITY**  
INCOME PLAN

For Employees of

**P.L. Marketing, Inc.**

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Your Employer provides a Plan of salary continuation (also known as short term Disability benefits) for eligible employees during a Period of Disability. Please contact the Employer for information about the Plan. In the event of any discrepancy between this document and the Plan documents, the Plan documents will govern.

The Employer manages the payment of benefits under the Plan and is considered the Plan Administrator. The Employer has the final responsibility for determining eligibility of covered persons and liability for payment of claims in accordance with the provisions of the Plan.

ReliaStar Life Insurance Company provides Disability management services on behalf of the Employer, as described by the "Disability Management Program" provisions of this document. ReliaStar Life Insurance Company acts only as an agent of the Employer. It is not liable or responsible for the payment of claims under the Plan, nor does it insure the Plan.

# SCHEDULE OF BENEFITS

## Short Term Disability Coverage

Contact the Employer for information about eligibility, coverage effective and termination dates, and benefit amounts under the Plan.

## Benefit Waiting Period

- Disability caused by Accidental Injury .....7 calendar days
- Disability caused by Sickness .....7 calendar days

**Maximum Benefit Period** .....13 weeks

## 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.

**Disability, Disabled** – 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.

**Disability Management Program** – The evaluation of Your Disability by the Employer or its agent to determine the length of Disability and establish a target date for return to work.

**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 Accidental Injury.
- He or she possesses 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.

**Employer** – P.L. Marketing, Inc.

**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, You will be considered to be 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.

**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 10 working days.

**Plan** – the plan of short term Disability coverage provided by the Employer under 73428-4SFDIS.

**Reasonable Employment Option** – an employment position for which You are able to perform the Essential Duties given Your education, training and experience.

**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 Accidental Injury.
- You are receiving care which conforms with generally accepted medical standards for treating Your Sickness or Accidental 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.

**Regular Occupation** – the activity which, immediately prior to Disability, You were regularly performing and which was Your source of income from the Employer. This occupation will be assessed 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.

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

**You, Your** – an employee covered for short term Disability coverage under the Plan.

## SHORT TERM DISABILITY COVERAGE

### Qualifying for Benefits

Benefits are payable under the Plan if You become Disabled and qualify for benefits. 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.
- Provide notice of Disability as described in the CLAIMS section.
- Be receiving Regular and Appropriate Care and treatment.
- Have the length of Your Disability approved by the Disability Management Program.

### Disability Management Program

The Disability Management Program evaluates Disability to determine the length of Disability and establish a target date for return to work. If Your Disability is expected to continue beyond the number of approved days, You need to notify the Disability Management Program. 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 length of the benefit waiting period is shown on the SCHEDULE OF BENEFITS.

### Benefit Payments

Contact the Employer for information about benefit payments under the Plan.

### Termination of Benefits

Benefits will stop according to the terms of the Plan, for reasons that may or may not relate to Your Disability. Benefits will stop on the earliest of the following dates related to Your Disability:

- 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 fail to provide written proof of Disability that is satisfactory to the Disability Management Program.
- The date You cease to be under Regular and Appropriate Care of a Doctor, or refuse to undergo an examination by a Doctor of the Disability Management Program's choosing.
- 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 terminates after You qualify to receive benefits, the Employer may continue Your benefit payments according to the terms of the Plan on the date You became Disabled.

**Recurrent Disability**

If You are receiving short term Disability 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 10 working days.

Benefits are payable 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 policy or plan.

**Exclusions**

Benefits are not payable if Your Disability results from any of the following:

- Sickness or Accidental Injury which occurs in any armed conflict, whether declared as war or not, involving any country or government.
- Sickness or Accidental 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.
- Accidental Injury which occurs when You commit or attempt to commit a felony.
- Accidental Injury suffered in a fight in which You are the aggressor.
- Sickness or Accidental 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.

Benefits are not payable 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.

No additional benefit will be payable for Disability caused by both Sickness and Accidental Injury or by more than one Sickness or Accidental Injury.

# CLAIMS

## **Free Choice of Doctor**

You have the right to choose any Doctor.

## **Submitting a Claim**

You or someone on Your behalf must contact the Disability Management Program in order to submit a Disability claim. The Disability Management Program will gather information from You, the Employer and Your Doctor to determine eligibility and verify proof of Disability.

## **Benefit Payments**

Contact the Employer for information about benefit payments under the Plan.

If Your Disability is expected to continue beyond the number of approved days, You need to notify the Disability Management Program.

## **Exam**

When reasonably necessary, the Disability Management Program may have You examined while You are claiming benefits. The exam will be conducted by one or more Doctors of the Disability Management Program's choice. This will only be exercised as often as the Disability Management Program reasonably believes necessary to properly evaluate Your claim. The Employer has the right to defer or suspend payment of benefits if You fail to attend an exam or fail to cooperate with the Doctor.

## **[DENIALS AND APPEALS FOR PLANS SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)]**

If ReliaStar Life Insurance Company (we, us, our) deny a claim in whole or in part (an "adverse benefit determination"), we will provide written notice of the adverse benefit determination to You as soon as possible, but no more than 45 days after receipt of the claim unless an extension is needed. An extension of 30 days will be allowed for processing the claim for matters beyond our control. You will be given notice of any such extension before the end of the initial 45-day period. If, before the end of the 30-day extension period, we are still unable to render a decision on the claim for matters beyond our control, a second extension of 30 days will be allowed for processing the claim. You will be given notice of any such second extension before the end of the first 30-day extension period. The notice(s) will state the circumstances requiring the extension and the date a decision is expected. The notice(s) will also specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. If additional information is needed, You will have 45 days to provide the specified information. If an extension is needed due to Your failure to submit information necessary to decide a claim, the extension period will be tolled from the date on which notification of the extension is sent to You until the date on which You respond to the request for additional information.

A notice of an adverse benefit determination will be written in an understandable manner and include the following:

- The specific reason(s) for the adverse benefit determination.
- Reference to the specific provision on which the determination is based.
- A description of additional information, if any, which would enable You to receive the benefits sought and an explanation of why it is needed.
- A description and a copy of relevant claim review procedures and the time limits applicable to such procedures, including a statement of Your right to bring a civil action following an adverse benefit determination on review.
- A statement that if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, a copy of such rule, guideline, protocol or other criterion will be provided free of charge to You upon request.

You may request a review of an adverse benefit determination (an “appeal”) at any time during the 180 day period following receipt of the notice of the determination. We will consider an appeal upon written application of You or Your duly authorized representative. As part of the appeal You also have the right, upon request and free of charge, to reasonable access to and copies of all documents, records and other information relevant to Your claim. This includes the identification of any medical or vocational experts whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. You may, in the course of this appeal, review relevant documents and submit to us written comments, documents, records and other information relevant to Your claim.

Our review of the appeal will be conducted by someone who is neither the individual who made the original adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. If the determination was based in whole or in part on a medical judgment, our review of the appeal will include consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be someone who is neither an individual who was consulted in connection with the original adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

Prior to rendering an adverse decision on appeal, we will provide notice to You of any new or additional evidence considered, relied upon, or generated by the Plan, insurers or other persons making the benefit determination. We will also notify You if we have new or additional rationale for an adverse appeal determination. We will then provide You with a reasonable opportunity to review and respond to this new information before making our decision. The time period we have to make our determination will be tolled while we are waiting for Your response.

Following our review of the appeal, we will provide You with a written decision of the final determination of the claim. This decision will be issued as soon as possible, but no more than 45 days after the receipt of the appeal unless an extension is needed. An extension of 45 days will be allowed for making this decision if special circumstances are present. You will be given notice of any such extension before the end of the 45-day period. The notice will state the special circumstances involved and the date a decision is expected. If an extension is needed due to Your failure to submit information necessary to decide a claim, the extension period will be tolled from the date on which notification of the extension is sent to You until the date on which You respond to the request for additional information.

If we send an adverse benefit determination following our review of the appeal, the notice of the determination will be written in an understandable manner and include the following:

- The specific reason(s) for the adverse benefit determination.
- Reference to the specific provision on which the determination is based.
- A statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to Your claim.
- A statement of Your 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.
- 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.
- 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.”

# SUMMARY PLAN DESCRIPTION

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:**

Group Life AD&D Insurance for Employees  
73428-4SFDIS  
P.L. Marketing, Inc.  
300 Dave Cowens Drive, Floor 8  
Newport, KY 41071

**Name, Address, and Telephone Number of the Plan Administrator:**

P.L. Marketing, Inc.  
300 Dave Cowens Drive, Floor 8  
Newport, KY 41071  
859-292-4657

**Identification Numbers**

IRS Employer Identification Number: 31-1276521  
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 pays 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.

# SUMMARY PLAN DESCRIPTION

## 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 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 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

## SUMMARY PLAN DESCRIPTION

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.

# 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.

