

**SUMMARY PLAN DESCRIPTION**

**FOR THE**

**VANTIVA**

**DISABILITY PLAN**

**Revised January 1, 2024**

**VANTIVA  
DISABILITY PLAN**

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## **SUMMARY PLAN DESCRIPTION FOR THE VANTIVA DISABILITY PLAN**

The following is a Summary of the principal provisions of the Vantiva Employee Benefit Plan, a component of which is the Vantiva Disability Plan. This Summary Plan Description was prepared for Eligible Employees. Generally, the Plan provides benefits to you if you are unable to work as a result of an Injury, Illness, pregnancy, childbirth, or related medical conditions and you are under a Physician's care. For employees in certain states, benefits are provided only if you satisfy the state law requirements to be entitled to short-term disability benefits. In addition, for certain employees there is a "Core benefit" option and a "Buy-Up benefit" option.

**Caution:** This Summary contains information which should help you understand your rights and benefits under the Plan; however it is merely an overview of important provisions and features and does not describe all provisions, potential situations, possible benefits or requirements of the Plan, if any. Further, the terms used in this Summary have technical meanings defined in the Plan. The Definitions Section XV at the end of the Summary includes definitions for many of the terms used in the Summary. In some cases, the definitions provided here have been summarized or simplified.

This Summary is intended to provide only information and guidance to employees about the Plan. It is not intended to be a contract or to establish contractual obligations. This Summary does not create any right to employment and your status remains that of an at-will employee.

For the self-funded benefits described in this Summary, the Plan document governs your rights. The Plan documents consist of the Employee Benefit Plan and the documents incorporated by reference. For the fully-insured benefits described in this Summary, Reliance Standard's policy and certificate are the governing legal documents of those benefits. In either case, you should not rely on this Summary as creating any legal rights.

Vantiva has appointed an Administrative Committee which acts on behalf of Vantiva. The Administrative Committee, in turn, has delegated certain administrative responsibilities to specific employees. In addition, the Plan Administrator has delegated some of its responsibilities under the plans to Reliance Standard Life Insurance Company, as specified in this Summary. The Plan Administrator or its designee(s) has full discretion and final authority to determine eligibility for benefits under the plans and to interpret provisions of the plans.

If you have any questions regarding the Plan or any action of the Administrative Committee, you should contact the Plan Administrator in writing at the Benefits Department at Vantiva USA Shared Services Inc., 4855 Peachtree Industrial Blvd., Suite 200, Norcross, GA 30092, USA.

## I. ELIGIBILITY

### Short-Term Disability

You are an Eligible Employee covered under this Plan for short-term disability benefits if you are one of the following classifications:

- **VSCS Hourly Employee:** A Non-represented Full-time Employee or Wholly-Eligible Part-Time Employee employed by Vantiva Supply Chain Solutions, Inc. who works on an hourly basis.
- **New Jersey Employee:** An employee working in the state of New Jersey (including Part-Time Employees and Full-Time Employees without regard to whether you participate in a union) who is eligible for benefits as provided under New Jersey Temporary Disability Benefits Law.
- **New York Employee:** An Employee working in the State of New York (including Part-Time Employees and Full-Time Employees without regard to whether you participate in a union) who is eligible for benefits as provided under New York Disability Benefits Law.
- **General Employee:** Any Non-represented salaried and exempt Full-time Employee or Non-represented salaried and exempt Wholly-Eligible Part-Time Employee of a Participating Employer who is not a VSCS Hourly Employee, New Jersey Employee, or New York Employee.

Except for New Jersey Employees and New York Employees to the extent required by New Jersey or New York law, as applicable, you are not eligible to participate in the short-term disability benefits offered under this Plan (whether or not also classified or determined to be an Employee) if you are one of the following:

- Partially-Eligible Part-Time Employee.
- Summer student.
- Intern.
- Temporary (full-time, part-time, summer and other).
- Casual (full-time, part-time, supplemental and other).
- Non-resident alien with no U.S.-source income.
- Person who is seconded or otherwise assigned to a Participating Employer in the United States under the terms of the Vantiva International Assignment Policy, or any other training or exchange program, unless such policy or program specifically provides that such person is eligible to participate in the Plan.

- Person who performs services for a Participating Employer pursuant to an agreement with a third party, an independent contractor agreement, leasing agreement, consulting agreement, vendor agreement, or any other persons employed under contract unless such agreement or contract specifically provides that such persons are eligible to participate in the Plan.

### **Long-Term Disability**

You are an Eligible Employee for the long-term disability benefits offered under this Plan if you are a Full-Time Employee or Wholly-Eligible Part-Time Employee of a Participating Employer, or a Full-time or Wholly-Eligible Part-Time Non-represented Employee working in Memphis, Tennessee and if you are a member of an Eligible Class as shown on the Reliance Standard Life Insurance Company's schedule of benefits.

You are not eligible to participate in the long-term disability benefit offered under this Plan (whether or not classified or determined to be an Employee) if you are one of the following:

- Temporary (full-time, part-time, summer or other).
- Seasonal (full-time, part-time, summer or other).

Eligible Employees receiving long-term disability benefits are divided into three classes of coverage as follows:

- Class 1: Executives
- Class 2: Salaried Employees, excluding an Executive
- Class 3: hourly Non-represented employee of Vantiva Supply Chain Solutions, Inc. located in Memphis TN, Camarillo, CA or Calexico, CA.

## **II. WHEN YOUR COVERAGE BEGINS**

### **Short-Term Disability**

If you are an Eligible Employee for short-term disability benefits, you are automatically covered under the Plan on your 91st day of Continuous Service. You must be at work for short-term disability coverage to begin. If your 91st day of Continuous Service occurs on a Saturday, Sunday, or scheduled holiday, coverage will begin on that date, provided you were at work on your last scheduled work day.

If you are an Eligible Employee for short-term disability benefits due to state law requirements (for example, in New Jersey or New York), your coverage date under the Plan may be adjusted as necessary to comply with applicable state law requirements.

### **Long-Term Disability**

If you are an Eligible Employee for long-term disability benefits, you may enroll for coverage at any time within the 30-day enrollment period after you begin employment. If you do not enroll when first hired, you cannot enroll for long-term disability benefits until the next annual open

enrollment period. If you enroll during your first 30 days of employment, you will be covered after working 30 consecutive days as described in Reliance Standard's certificate if you are a Class 1 or 2 employee. For Class 3 employees, you will be covered after working 90 consecutive days of employment.

If you enroll or re-enroll during an annual open enrollment period after the original 30-day enrollment period, your coverage will begin as of January 1 following open enrollment.

If you were not eligible at initial enrollment and you enroll within 30 days after becoming eligible, you will be covered under the Plan as of the latter of the day you became eligible or your 31st consecutive day as described in Reliance Standard's certificate.

### **III. WHEN BENEFITS ARE PAYABLE**

#### **Short-Term Disability**

Short-term disability benefits under the Plan are payable if:

- You are Totally Disabled and unable to do any work as a result of an Injury, Illness, or pregnancy, childbirth, or related medical condition.
- Your Total Disability begins while you are covered under the Plan,
- You are under a Physician's care, and
- You are not receiving Full Pay.

Short-term disability benefits for VSCS Hourly Employees are as provided in the certificate from Reliance Standard, but are generally payable after the greater of (i) fifteen (15) consecutive business days, or (ii) the day immediately following the number of accumulated sick days applicable to you, if you are Totally Disabled, confined in a Hospital or treatment center, or you have surgery performed in an ambulatory surgical center or have scheduled surgery performed in the out-patient department of a Hospital.

Short-term disability benefits for General Employees are payable after seven (7) consecutive calendar days in which you are Totally Disabled, confined in a Hospital or treatment center, or you have surgery performed in an ambulatory surgical center or have scheduled surgery performed in the out-patient department of a Hospital.

Short-term disability benefits for New Jersey Employees and New York Employees are payable after seven (7) consecutive calendar days in which you are Totally Disabled within the meaning of applicable state law.

You will continue to receive short-term disability benefits while you are Totally Disabled up to a maximum of 25 weeks following the waiting period for each Total Disability for New Jersey

Employees, New York Employees and General Employees and generally for 13 weeks for VSCS Hourly Employees, unless otherwise provided in the certificate from Reliance Standard.

### ***Partial Disabilities***

If you are receiving Full Pay after the first week of your Total Disability, short-term disability benefit payments will not begin until your Full Pay stops. If you are receiving less than Full Pay while Totally Disabled, the maximum weekly short-term disability benefit for which you are eligible is (i) the difference between your Base Weekly Salary or Wage and the pay actually received or (ii) the scheduled weekly benefit under the Plan, whichever is less. If you begin receiving long-term disability benefits, then your short-term disability benefit payments under this Plan will stop.

### ***Returning to Work, Partial and Recurrent Disabilities***

If you are a New York Employee or General Employee, you return to work on a full-time basis for less than one week (five work days), and you become Totally Disabled again for the same cause, the two Periods of Absence will be considered as one Total Disability. If you return to work on a full-time basis for one week or more and become Totally Disabled again, each period of Total Disability will be considered a separate Total Disability, even if due to the same cause.

If you are a New Jersey Employee, you return to work for less than 14 days, and you become Totally Disabled again for the same cause, the two Periods of Absence will be considered as one Total Disability.

If you are a New York Employee, you return to work and become Totally Disabled again for the same or a related condition within three months of your return to work, the two Periods of Absence will be considered as one Total Disability.

A Participant who has returned to work for the Company on a modified or reduced schedule, and who is working fewer hours than he or she is regularly scheduled to work, may receive benefits under this Plan. Such short-term disability benefits will be equal to the benefit which the Participant would otherwise be entitled, reduced by the amount that such income plus benefits exceed the Participant's Earnings. In no event will a Participant receive benefits under the Plan in an amount greater than 100% of the Participant's Pre-Disability Earnings.

If you return to work on a full-time basis and become Totally Disabled for a different cause, the two Periods of Absence will be considered as separate Total Disabilities. Different Periods of Absence resulting from Injuries received in one Accident will be considered as one Total Disability.

You will be required to provide medical evidence of your Total Disability while receiving weekly benefits. A new Physician's statement must be provided to Guardian upon request. In addition, Reliance Standard may request that you be examined periodically by a Physician of its choice.

### **Long-Term Disability**

After you have been Totally Disabled for a 180 consecutive day period.

## **IV. APPLICATION FOR BENEFITS**

### **Short-Term Disability**

Reliance Standard recommends filing the application for short-term disability benefits within 14 days after the first day you become Disabled to the Claims Administrator at (800) 866-2301. No short-term disability benefits will be paid until your application (and any required medical evidence) is completed, submitted, and approved by Reliance Standard.

### **Long-Term Disability**

Application for long-term disability benefits should be made as soon as possible to Reliance Standard at (800) 351-7500. To qualify for benefits under the Plan, you must furnish written proof of your Total Disability to Reliance Standard, P.O. Box 14590, Lexington, KY 40511-4590. You should read the form carefully and answer all questions and include or attach all necessary information to support your application for benefits.

## **V. COST OF COVERAGE**

### **Short-Term Disability**

Eligible Employees are not required to contribute to the cost of their STD Core benefit. If you are a General Employee you may purchase an extended short-term disability payment plan under the Buy-Up benefit, but the Buy-Up benefit is 100% employee paid.

When you elect the Buy-Up benefit, you authorize payroll deductions for the cost for the coverage. The rate may be changed by the Insurance Company but not more than once every 12 months.

### **Long-Term Disability**

Eligible Employees in Class 1, Class 2, and Class 3 do not have to make any contributions for their long-term disability benefits.

When you elect the Buy-Up benefit, where applicable, you authorize payroll deductions for the cost for the coverage. The rate may be changed by the Insurance Company but not more than once every 12 months.

## **VI. AMOUNT OF DISABILITY BENEFIT**

### **Short-Term Disability**

The amount of your weekly short-term disability benefit under the Plan is outlined in the below tables depending on the classification of Eligible Employee and Core or Buy-Up benefit.

<b>VSCS HOURLY EMPLOYEE SHORT TERM DISABILITY</b>	
<b>STD Core</b>	60% of Base Weekly Salary, up to a maximum of \$500: 26 weeks, as provided in the certificate by Reliance Standard
<b>STD Buy-Up</b>	Not available

<b>NEW JERSEY EMPLOYEES SHORT TERM DISABILITY</b>	
<b>STD Core</b>	The benefit you would be eligible for under New Jersey's state funded disability program. The New Jersey Commissioner of Labor and Workforce Development adjusts this maximum annually. For additional information about the benefit, go to: <a href="https://myleavebenefits.nj.gov/worker/fli/">https://myleavebenefits.nj.gov/worker/fli/</a> .
<b>STD Buy-Up</b>	Not available

<b>NEW YORK EMPLOYEES SHORT TERM DISABILITY</b>	
<b>STD Core</b>	50% of Base Weekly Salary or Wages, up to a maximum of \$170 per week, reduced by the applicable state benefit after 14 days. For additional information about the benefit, go to: <a href="http://www.wcb.ny.gov/content/main/DisabilityBenefits">http://www.wcb.ny.gov/content/main/DisabilityBenefits</a>
<b>STD Buy-Up</b>	Not available

<b>GENERAL EMPLOYEE SHORT-TERM DISABILITY</b>		
<b>PLANS</b>	<b>100% of Base Weekly Salary or Wages</b>	<b>66.67% of Base Weekly Salary or Wages</b>
<b>STD Core</b>	8 weeks	17 weeks
<b>STD Buy-Up</b>	17 weeks	8 weeks

The minimum weekly benefit from the Plan is \$20.00 for General Employees and \$25.00 for VSCS Hourly Employees, unless provided otherwise in the certificate from Reliance Standard.

If you live in a state where state funded disability benefits are provided (including, but not limited to, New Jersey and New York), you will be required to apply for such benefits. After 14 days the benefit provided by the Plan will be reduced by the applicable state benefit provided.

If you live in a state where there are state-mandated benefits, the amount of your weekly benefit under the Plan will equal the benefit required by the state, unless the formula above

would provide a higher weekly benefit. If the amount determined using the benefit formula under this Plan (including the Buy-Up benefit, if available and elected) exceeds the state-mandated benefit amount, this Plan will pay the difference between the state-mandated amount you receive from the state-funded program and the benefit determined under the Plan.

Social Security (FICA) tax and federal income tax will automatically be withheld from your weekly benefit.

If you are Totally Disabled for less than one full week (7 consecutive calendar days), there will be no short-term disability benefit paid under the Plan.

### **Long-Term Disability**

See the certificate from Reliance Standard for details on your long-term disability benefit.

## **VII. SHORT TERM DISABILITY BASE WEEKLY SALARY OR WAGE**

Except for VSCS Hourly Employees, New Jersey Employees, and New York Employees, Base Weekly Salary or Wage is your gross weekly regular earnings in effect just prior to the date of your Total Disability. Base Weekly Salary or Wage equals:

- For hourly paid Employees, base hourly rate multiplied by 40.
- For weekly paid Employees, base weekly wage.
- For bi-weekly paid Employees, base bi-weekly salary divided by 2.
- For monthly paid Employees, base monthly salary multiplied by 12, and the result divided by 52.

If you are an hourly paid Part-Time Employees your Base Weekly Salary or Wage is calculated as above but then reduced by the number of hours in your 40-hour workweek. For example, if you work 20 hours a week you have a Base Weekly Salary or Wage of 20/40, or 50 percent, of a full-time Base Weekly Salary or Wage.

Base Weekly Salary or Wage does not include compensation for overtime or extended workweek, bonuses, incentive compensation, or any other form of pay. If you are actively at work when your Base Weekly Salary or Wage changes, your benefit amount will be automatically adjusted on the date your Base Weekly Salary or Wage changes.

For VSCS Hourly Employees, New Jersey Employees, and New York Employees, the Base Weekly Salary is described in the applicable certificate provided by Reliance Standard.

## **VIII. PAYMENT OF BENEFITS**

Plan benefits are payable directly to you. The timely payment of all benefits requires that you submit completed claim forms and supplemental Physician statements promptly.

In the event that benefits under the Plan are coordinated with benefits provided through another program, such as a state disability plan, benefits paid through the Plan will be reduced by the amount of the state disability benefit received. This coordination will begin no later than the fourth week of Total Disability.

## **IX. WHEN BENEFITS ARE NOT PAYABLE**

Plan benefits are not payable for:

- Any period for which you receive or are entitled to receive benefits under:
  - Social Security disability benefits.
  - Unemployment compensation or similar benefits.
  - Disability or similar benefit, including state disability programs, in an amount greater than or equal to the benefit payable under the Plan.
  - Workers' Compensation, occupational disease, or similar benefits.
- Total Disability resulting from Injuries sustained while engaged in any occupation for wage or profit.
- Any period for which you receive Full Pay.
- Total Disability for which you are not being treated by a duly qualified Physician, Dentist, or chiropractor.
- Total Disability that commenced while you are on Layoff or an Approved Absence other than for personal Illness, Injury or pregnancy disability.
- Total Disability that commenced before you became covered under the Plan.
- Any period during which you have been disqualified for unemployment compensation unless the Total Disability commenced prior to such disqualification.

If you are an Eligible Employee due to state law requirements, there may be additional conditions that could cause Plan benefits not to be payable. You should review the applicable state law to determine if any additional conditions apply.

## **X. CLAIMS AND APPEALS PROCEDURE**

The process used to review your initial claim for a benefit under the Plan and any appeal of a denied claim is referred to as the Plan's "claims procedure." For benefits provided through an insurance contract with a Claims Administrator, the Claims Administrator's claim's procedure must be followed. For benefits paid via the general assets of Vantiva, the claims procedure is as described below.

### ***Initial Claim Determination***

The Claims Administrator has 45 days to respond to your claim. Medical evidence will be required from your medical provider in order to decide your claim, so you should make every effort to assemble the medical records that demonstrate your Disability before you file your claim. If the Claims Administrator requests medical records from your provider and they are not provided within the 45-day period, the Claims Administrator will decide your claim based on the information available.

The 45-day deadline may be extended for 30 days, if necessary. If the Claims Administrator determines that an extension is necessary, you will be furnished with a written notice of the extension prior to the end of the initial 45-day period. This notice will indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to make a determination. If, before the end of the initial 30-day extension, the Claims Administrator determines that it needs additional time to consider your claim, the Claims Administrator may extend the decision time for an additional 30 days. If the Claims Administrator determines that an additional extension is necessary, you will be furnished with a written notice of the second extension prior to the end of the first 30-day extension period.

Any denial of a claim for benefits will be provided by the claims administrator and consist of a written explanation which will include:

- The specific reason or reasons for the denial;
- Reference to the specific Plan provisions on which the determination was based.
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- A statement disclosing any internal rules, guidelines, protocols, standards or other similar criteria relied upon in the decision or alternatively, a statement that there are no such rules, guidelines, protocols, standards or other similar criteria.
- An explanation of the scientific or clinical judgment applying the terms of the Plan to your medical circumstances, if applicable.
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;or

- A disability determination made by the Social Security Administration regarding the claimant and presented by the claimant to the Plan.
- A statement regarding your right, upon request and free of charge, to reasonable access to review or copy documents relevant to your claim.

Any reference to an “authorized representative” means a person you authorize, in writing, to act on your behalf, which authorization is filed with the Claims Administrator. The Plan will also recognize a court order giving a person authority to submit claims on your behalf.

### ***Appealing Denied Claim***

If your claim(s) is denied, in whole or in part, and you want to pursue the matter further, you, your beneficiary (when an appropriate claimant) or an authorized representative must appeal the decision in writing and request further review. You must file your written appeal with the Claims Administrator no later than 180 days after you receive written notification of the denial of your claim.

During the 180-day period you have to file your appeal, you will have the opportunity to review upon request documents, records and other information relevant to your claim for benefits. You may also request copies (free of charge).

Your written appeal must describe all the reasons why you believe the claim denial was in error, and should include all written comments, documents, records and other information that you have relating to your claim and that you have considered in support of your appeal. Your appeal will be decided based on all of the available information, and the information you submit will be considered even if it was not considered in the initial claim decision. So, you should make sure that your submission is complete. A request for a review must be filed within 180 days after the date you receive written notice of a denial of a claim. A review will be conducted, and a decision rendered by the Claims Administrator no later than 45 days after receipt of your written appeal request. If special circumstances require more time, the review period may be extended up to an additional 45 days. You will be notified of this extension within the original appeal period. The notice of extension will include a description of the circumstances requiring extra time and the date by which the Claims Administrator expects to make a decision.

Before denying your appeal, the Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with its consideration of your appeal. Likewise, before denying your claim based on a new or additional rationale, the Claims Administrator will provide you, free of charge, with a statement of the rationale. The new or additional evidence or rationale will be provided to you as soon as possible and sufficiently in advance of the date by which your appeal must be decided so that you have a reasonable opportunity to respond.

Any denial of an appeal for benefits will be provided by the Claims Administrator and consist of a written explanation which will include:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the denial is based;
- 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;
- A statement describing voluntary appeal procedures, if any, and the time limits applicable to such procedures; and
- A statement of your rights to bring a civil action under ERISA Section 502(a) following a denial after an appeal.
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or
  - A disability determination made by the Social Security Administration regarding the claimant and presented by the claimant to the Plan.

In addition:

- If any internal rule, guideline, protocol, or similar criterion is used in deciding the appeal, the Claims Administrator will provide the participant with a copy of that internal rule, guideline, protocol, or similar criterion free of charge upon request; and
- If an appeal is denied due to medical judgment, the Claims Administrator will provide an explanation of the scientific or clinical judgment for the decision, applying the terms of the plan to the claimant's medical circumstances, free of charge upon request.

The Claims Administrator or Reliance Standard, as applicable, will act as the fiduciary in reviewing a claim and in making its decision, with full discretion and final authority, to determine eligibility for benefits and to interpret the provisions of the Plan applicable to the claim. The Claims Administrator's (or Reliance Standard's, as applicable) decision regarding your appeal will be final and binding on you and all other parties involved. If you disagree with the

Claim's Administrator's (or Reliance Standard's, as applicable) decision and you have followed all of these claims procedures, you have the right to bring a civil action in a court of law under ERISA Section 502(a) within **one year** of the date of the final denial of your claim. Failure to file a lawsuit within this time period will cause your right to expire.

You should be aware that if you do not follow the general claims procedures described above, you will have no right to bring action, at law or in equity, in any court, and the denial of the claim will become final and binding. For more details on the claims procedures, contact the Claims Administrator.

## **XI. WHEN YOUR COVERAGE ENDS**

Coverage under the Plan ends when:

- For New Jersey Employees, when you no longer meet the earnings requirements as outlined by the State of New Jersey. The New Jersey Commissioner of Labor and Workforce Development adjusts these minimums annually at <https://www.nj.gov/labor/ea/rates/rateindex.html>.
- Your employment terminates, you retire or die.
- Your employment status changes to an ineligible classification.
- You transfer to an employer not covered by the Plan.
- You become covered by a collective bargaining agreement that does not provide for the Plan.
- Your active employment ceases, except during an Approved Absence for personal Illness, Injury, or pregnancy disability.
- For VSCS Hourly Employees, you fail to pay for the cost of coverage during an Approved Absence.
- The Plan is discontinued by Vantiva.
- As provided in a certificate provided by Reliance Standard.

## **XII. OTHER IMPORTANT INFORMATION**

### **Fraud/Misrepresentation**

If you knowingly and with intent attempt to defraud the Plan by filing a claim that contains any materially false information including eligibility information, conceal information in order to mislead, or commit a fraudulent act, you may be subject to disciplinary action, up to and including termination of employment, and possible criminal and civil penalties.

**Right of Recovery**

Vantiva and Guardian have the right to recover, on the behalf of the Plan, any benefits that are overpaid, and reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

The Plan has established policies to determine which recoveries to pursue, and when to incur expenses and settle or compromise recovery amounts.

**Right to Amend or Terminate**

Vantiva may amend, terminate, suspend, withdraw, or modify the Plan in whole or in part at any time, subject to the provisions of the applicable collective bargaining agreements.

**Scope of Discretionary Authority**

For VSCS Hourly Employees and long-term disability benefits, the Claims Administrator is the Plan fiduciary for benefit claims and appeals. For all other employees, Reliance Standard is the Plan fiduciary for benefit claims and appeals. The Plan fiduciary has the final and discretionary authority to determine claims and appeals, and has the final and discretionary authority to interpret benefits payable under the Plan and make factual determinations necessary to make the benefit claim and appeal determinations. The decision made by the Plan fiduciary on review is final and binding, subject to your right to file a lawsuit under ERISA or other applicable law. This decision-making authority is broad and is limited only by the duties imposed under ERISA. The determination is intended to be given deference by courts to the maximum extent allowed under ERISA.

**Request for Eligibility Determination**

If you believe that you are eligible to participate in the Plan under its terms, or if you believe that your participation should be on different terms than what has been offered to you, you should contact Vantiva Benefits Solution Center at (800) 284-7876.

If you are informed that you are not eligible to participate in the Plan, and you disagree with this response, you or your authorized representative may file a written eligibility determination request under this procedure at the following address. You must file your eligibility determination request within 30 days of the date the Administrative Committee responds to your request.

Address your eligibility determination request to:

Vantiva USA Shared Services Inc.  
Benefits Department  
4855 Peachtree Industrial Blvd., Suite 200  
Norcross, GA 30092

The Administrative Committee will review your eligibility determination request and will respond to you in writing as soon as administratively practicable. The Administrative

Committee has authority over all questions of eligibility and any decisions by the Administrative Committee as to an individual's eligibility to participate in the Plan will be final and binding.

### **XIII. OTHER ERISA INFORMATION**

Plan Name

Vantiva Employee Benefit Plan, a component of which is the Vantiva Disability Plan

Plan Number Assigned by Plan Sponsor

501

Type of Plan

The Plan contains a weekly short-term disability benefit funded as follows:

- Self-Insured and funded by the general assets of Vantiva for General Employees.
- Fully-Insured through The Guardian Life Insurance Company of America for VSCS Hourly Employees, New Jersey Employees, and New York Employees.

The Plan also contains a fully-insured monthly long-term disability benefit.

Plan Year End Date

December 31

Plan Administrator

Vantiva USA Shared Services Inc.  
Benefits Department  
4855 Peachtree Industrial Blvd., Suite 200  
Norcross, GA 30092

Telephone Number: (818) 260-4903

Employer Identification Number: 35-1724835

Service of legal process may be made upon the Plan Administrator at the address given above. Service of legal process with respect to the Plan may also be made upon the Plan Administrator at the address given above.

If you write to the Plan Administrator, be sure to give enough information so that your records can be located for a prompt reply. Give your name, address, employee identification number, and location where you work or worked. You may also contact the Claims Administrator below:

Claims Administrator

The Guardian Life Insurance Company of America  
PO Box 14315  
Lexington, KY 40512

(800) 268-2525

Participating Employers

Vantiva USA Shared Services Inc. EIN: 35-1724835  
4855 Peachtree Industrial Blvd., Suite 200  
Norcross, GA 30092, USA

Vantiva Supply Chain Solutions, Inc. EIN: 95-3779864  
(formerly Technicolor Home Entertainment Services, Inc.)

Vantiva USA LLC  
(formerly Technicolor Connected Home USA LLC) EIN: 46-2926832

#### **XIV. YOUR RIGHTS UNDER ERISA**

A statement of rights under the Employee Retirement Income Security Act of 1974 (ERISA) is required by federal law and regulation to be included in every summary plan description. The following is the model statement taken verbatim from regulations of the Department of Labor after deleting items of information that are not applicable to this Plan.

As a participant, 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.

Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement

must be requested in writing and is not required to be given more than once every twelve (12) months. The plan must provide the statement free of charge.

### **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 pension or welfare benefit or exercising your rights under ERISA.

### **Enforcing Your Rights**

If your claim for a pension or welfare 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 up to \$100 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 Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## **XV. DEFINITIONS**

### **Accident**

A trauma which arises suddenly under unforeseen conditions.

### **Administrative Committee**

The committee appointed by Vantiva to act on its behalf.

### **Approved Absence**

A leave of absence authorized by a Participating Employer. Includes all military leaves and other leaves of absence covered by USERRA.

### **Base Weekly Salary or Wage**

Defined in Section VII.

### **Continuous Service**

The period of time (counted in years, months and days) beginning with your most recent date of employment as an Eligible Employee with a Participating Employer, or any predecessor of a Participating Employer (as determined by the Plan Administrator), or any other corporation which is a member of the group related to a Participating Employer.

### **Eligible Employee**

An Employee who satisfies the definition of Eligible Employee in Section I.

### **Employee**

A person in a common-law employee-employer relationship with a Participating Employer, as determined by Vantiva.

### **ERISA**

The Employee Retirement Income Security Act of 1974, as amended from time to time.

### **Full Pay**

100% of your compensation from before Total Disability.

### **Full-Time Employee**

Unless noted otherwise, a Full-Time Employee is an Employee hired by a Participating Employer for an indeterminate period of time and who is regularly scheduled to work a minimum of 30 hours per week. For Vantiva Supply Chain Solutions, Inc., a Full-Time Employee is an Employee hired for an indeterminate period of time and who is regularly scheduled to work a minimum of 20 hours per week.

### **General Employee**

An Eligible Employee who satisfies the definition of General Employee in Section I.

**Hospital**

An institution licensed by the appropriate state agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty.

“Hospital” does not mean other than incidentally:

- An extended care facility; nursing home; place for rest; facility for care of the aged;
- A custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- An institution for exceptional or handicapped children.

**Illness**

A sickness or disease which is not due to an Injury, which requires treatment by a Physician or other Licensed Health Care Professional, and is incurred by an Employee on or after the date of coverage under the applicable plan.

**Injury**

A harm or damage to an Employee occurring on or after the date of coverage under the Plan and as a result of an Accident, either directly or indirectly, along with all other related conditions.

**Layoff**

For an Employee covered by a collective bargaining agreement, the period of “Layoff” described in such collective bargaining agreement. Layoff does not include discharge, leave of absence, or voluntary termination of employment such as resignation or retirement.

**New Jersey Employee**

An Eligible Employee who satisfies the definition of New Jersey Employee in Section I.

**New York Employee**

An Eligible Employee who satisfies the definition of New York Employee in Section I.

**Non-represented Employee**

An Employee who is not represented by a collective bargaining agent or included in a collective bargaining unit recognized by a Participating Employer.

**Part-Time Employee**

An Employee hired by a Participating Employer for an indeterminate period of time and who is regularly scheduled to work less than 30 hours per week at his or her work location. See also, Partially-Eligible Part-Time Employee and Wholly-Eligible Part-Time Employee.

**Partially-Eligible Part-Time Employee**

A Part-Time Employee who is regularly scheduled to work less than 20 hours per week.

**Participating Employer**

Vantiva and each subsidiary or affiliated company of Vantiva that adopts the Plan. The Participating Employers are listed in Section XIII of the Summary.

**Physician**

A legally licensed doctor of medicine, osteopathy, or optometry, or other legally licensed practitioner of the healing arts rendering services which are covered by the Plan, required by law to be covered when rendered by such practitioner, and within the scope of his or her license. Physician does not include you or your spouse, parent, child, sister, brother, or in-law.

**Plan**

The Vantiva Employee Benefit Plan, a component of which is the Vantiva Disability Plan.

**Plan Administrator**

Vantiva USA Shared Services Inc.

**Total Disability or Totally Disabled**

Your complete inability, because of Injury, Illness, or pregnancy, to perform any and every duty pertaining to your occupation or employment. You must be under the care of a Physician while Totally Disabled. For long-term disability benefits, after monthly benefits have been paid for 24 months, Totally Disabled means you cannot perform the material duties of any occupation (not just your occupation or employment).

For Eligible Employees who are eligible for Disability benefits due to state law, Total Disability or Totally Disabled has the meaning determined under the applicable state law.

**Vantiva**

Vantiva USA Shared Services Inc. as now constituted or as may be constituted hereafter, or any person, firm, corporation or partnership which may succeed to its business and which adopts the Plan.

**VSCS Hourly Employee**

An Eligible Employee who satisfies the definition of VSCS Hourly Employee in Section I.

**Wholly-Eligible Part-Time Employee**

A Part-Time Employee who is regularly scheduled to work between 20 and 29 hours per week.

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