YOUR GROUP LONG TERM DISABILITY INSURANCE PLAN

For Employees of

North American Division of Seventh-day Adventists

Non-COLA

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GROUP LONG TERM DISABILITY INCOME INSURANCE
CERTIFICATE OF COVERAGE

RELIASTAR LIFE INSURANCE COMPANY
20 Washington Avenue South
Minneapolis, Minnesota 55401

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POLICYHOLDER:	North American Division of Seventh-day Adventists
GROUP POLICY NUMBER:	67807-4LTD2011
POLICY EFFECTIVE DATE:	January 1, 2013
GOVERNING JURISDICTION:	Maryland

ReliaStar Life Insurance Company (ReliaStar Life) certifies that it has issued the group policy listed above to the **Policyholder.** The policy is available for **you** to review if **you** contact the **Policyholder** for more information. **This is your Certificate of Coverage as long as you are eligible for coverage and you become insured. Please read it carefully and keep it in a safe place.** This Certificate of Coverage replaces any other certificates ReliaStar Life may have given **you** under the policy.

The Certificate of Coverage summarizes and explains the parts of the policy which apply to **you.** The Certificate of Coverage is part of the group policy but by itself is not a policy. **Your** coverage may be changed under the terms and conditions of the policy.

The policy is delivered in and is governed by the **laws** of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security **Act** of 1974 (ERISA) and any amendments.

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

The policy does not replace or affect any requirements for coverage by any Workers' Compensation or state disability insurance. The policy covers disabilities due to an occupational sickness or injury.

Registrar

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BENEFITS AT A GLANCE

The Long Term Disability policy provides benefits to replace a portion of **your** income while **you** are disabled. The amount **you** receive is based on the amount **you** earned before **your** disability began, subject to all policy provisions.

ELIGIBLE CLASS(ES)
All **employees** in **active employment** with the **Employer** in the United States.

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

Temporary and seasonal workers are excluded from coverage.

MINIMUM HOURS REQUIREMENT
30 hours per week for Southeastern California Conference, La Sierra Academy, Loma Linda Academy, and Loma Linda University **employees** or 35 hours per week for all other **employees.**

WAITING PERIOD
For persons in an eligible class on or before the policy effective date: None

For persons entering an eligible class after the policy effective date: None

CREDIT PRIOR SERVICE
We will apply any prior period of work with **your Employer**

BENEFITS AT A GLANCE

MAXIMUM PERIOD OF PAYMENT

For a disability which begins before **you** reach age 60, the **maximum period of payment** will be until the Social Security Normal Retirement Age (SSNRA) as shown in the following table:

Before 1938	65 years
1938	65 years and 2 months
1939	65 years and 4 months
1940	65 years and 6 months
1941	65 years and 8 months
1942	65 years and 10 months
1943-1954	66 years
1955	66 years and 2 months
1956	66 years and 4 months
1957	66 years and 6 months
1958	66 years and 8 months
1959	66 years and 10 months

DEFINITIONS

ACTIVE EMPLOYMENT means **you** are working for **your Employer** for earnings that are paid regularly and that **you** are performing the **material and substantial duties** of **your regular occupation. You** must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT in the BENEFITS AT A GLANCE.

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

On any day of absence permitted under **your Employer's** Human Resource policy, **you** will meet the **active employment** requirement if **you** are not disabled and **you** were in **active employment** on the last preceding working day before the day of absence.

Temporary and seasonal workers are excluded from coverage.

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

CONTEST means that, if **we** determine **you** made a material misrepresentation in **your** application for coverage under the policy, **we** notify **you** in writing that such coverage was therefore never effective. This is subject to the CONTESTABILITY provision.

DEDUCTIBLE SOURCES OF INCOME means income from other sources as listed in the certificate which **you** receive or are eligible to receive while **you** are disabled. This income will be subtracted from **your gross monthly payment.**

DISABILITY EARNINGS means the earnings which **you** receive while **you** are disabled and working, plus the earnings **you** could receive if **you** were working to **your maximum capacity.**

DOCTOR means a person performing tasks that are within the limits of his or her medical license, and also meets one of the following requirements:
- Is licensed to practice medicine and prescribe and administer drugs or to perform surgery.
- Has a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients.
- Is a legally qualified medical practitioner according to the **laws** and regulations of the jurisdiction where treatment occurred.

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

ELIGIBLE SURVIVOR means **your** spouse, if living; otherwise, **your** children under age 26.

EMPLOYEE means a person who is a citizen or legal resident of the United States in full-time **active employment** with the **Employer** in the United States.

EMPLOYER means the **Policyholder** and includes any division, subsidiary or affiliated company named in the policy.

ENROLLMENT FORM means the application **you** complete and submit to **us** to apply for coverage under the policy.

EVIDENCE OF INSURABILITY means a statement of **your** medical history that **we** will use to determine if **you** are approved for coverage.

EVIDENCE OF INSURABILITY FORM means the supplement to the **enrollment form** that **you** complete and submit to **us** that contains a statement of **your** medical history. Only the **evidence of insurability form** provided by **us** will be accepted. Completion of the **evidence of insurability form** is at **your** own expense.

DEFINITIONS

FAMILY MEMBER means an individual who can be claimed as a dependent by **you** for federal income tax purposes.

GAINFUL OCCUPATION means an occupation that is or can be expected to provide **you** with an income of the lesser of **your gross monthly payment** or $9,000 per month within 12 months of **your** return to work.

GRACE PERIOD means the 30 day period following the premium due date during which premium payment for the policy may be made by the **Policyholder.**

GROSS MONTHLY PAYMENT means **your** benefit before any reduction for **deductible sources of income** and **disability earnings.**

HOSPITAL, HEALTH FACILITY or INSTITUTION

DEFINITIONS

MONTHLY EARNINGS means **your** gross monthly income from **your Employer** as stated in the BENEFITS AT A GLANCE.

MONTHLY PAYMENT means **your** benefit after any **deductible sources of income** and **disability earnings** have been subtracted from **your gross monthly payment.**

OCCUPATIONAL SICKNESS OR INJURY means a **sickness** or **injury** that was caused by or aggravated by any employment for pay or profit.

PART-TIME BASIS means the ability to work and earn from 20% through 80% of **your**

GENERAL PROVISIONS

CERTIFICATE OF COVERAGE

This Certificate of Coverage is a written statement prepared by **us** and may include riders, endorsements and/or amendments. It tells **you:**

- The coverage to which **you** may be entitled.
- To whom **we** will make a payment.
- The limitations, exclusions and requirements that apply within the policy.

ELIGIBILITY DATE

If **you** are working for **your Employer** in an eligible class, the date **you** are eligible for coverage is the later of the following:

- The policy effective date.
- The day after **you** complete **your** waiting period.

WHEN COVERAGE BEGINS

When the **Policyholder your Employer** pays 100% of the cost of **your** coverage under the policy, **you** will be covered at 12:01 a.m. standard time at the **Policyholder's** address on the date **you** are eligible for coverage.

In order for **your** coverage to begin, **you** must be in **active employment. Your** coverage is subject to payment of premium.

CHANGES TO YOUR COVERAGE

Once **your** coverage begins, any increased or additional coverage will take effect immediately if **you** are in **active employment.** or if **you** are on a covered **leave of absence.** If **you** are not in **active employment** due to **injury** or **sickness,** any increased or additional coverage will begin on the date **you** return to **active employment.**

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

LEAVE OF ABSENCE AFTER YOUR COVERAGE BEGINS

If **you** are on a **leave of absence,** and if premium is paid, **your** coverage may be continued beyond the date **you** are no longer in **active employment,** limited to the time periods described below.

If **you** are on a **leave of absence** as described under the Family and Medical Leave **Act** of 1993 ("FMLA") or applicable state family and medical leave **law** ("State FML"), and **your Employer's** Human Resource Policy provides for continuation of disability coverage during an FMLA or State FML **leave of absence, your** coverage will be continued until the end of the later of:

- The leave period permitted by the federal Family and Medical Leave **Act** of 1993 and any amendments.
- The leave period permitted by applicable state **law.**

If **you** are on a **leave of absence** other than an FMLA or State FML **leave of absence,** and if premium is paid, **your** coverage will be continued through the end of the month that immediately follows the month in which **your leave of absence** begins.

If **you** are on a **leave of absence** for active military service as described under the Uniformed Services Employment and Reemployment Rights **Act** of 1994 (USERRA) and applicable state **law, your** coverage may be continued until the end of the later of:

- The length of time the coverage may be continued under the Certificate of Coverage for an FMLA or State FML **leave of absence.**
- The length of time the coverage may be continued under the Certificate of Coverage for a **leave of absence** other than an FMLA or State FML **leave of absence.**

If **your Employer** has approved more than one type of **leave of absence** for **you** during any one period that **you** are not in **active employment, we** will consider such leaves to be concurrent for the purpose of determining how long **your** coverage may continue under the policy.

If **your** coverage is not continued during an FMLA or State FML **leave of absence,** and **you** return to **active employment** immediately following the end of **your** FMLA or State FML **leave of absence, your** coverage will be reinstated. **We** will not apply a new **waiting period,** or require **evidence of insurability,** or apply a new **pre-existing condition** limitation.

GENERAL PROVISIONS

If **your** coverage is not continued during a **leave of absence** for active military service, and **you** return to **active employment, your** coverage may be reinstated in accordance with USERRA and applicable state **law.**

In no event will **your** coverage under the policy be continued beyond the date **your** coverage would otherwise end according to the terms of the WHEN YOUR COVERAGE ENDS provision.

WHEN YOUR COVERAGE ENDS

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

- The date the policy is canceled.
- The date **you** are no longer in an eligible class.
- The date **your** eligible class is no longer covered.
- The end of the **Policyholder's grace period,** if the **Policyholder** does not remit premium to **us** by the end of such period.
- The last day **you** are in **active employment** except as provided under a covered **leave of absence.**

We will provide coverage for a **payable claim** that occurs while **you** are covered under the policy. Termination of the policy during a disability will have no effect on a **payable claim.**

TIME LIMITS FOR LEGAL PROCEEDINGS

You can start legal action regarding **your** claim 60 days after proof of claim has been given to **us,** and

LONG TERM DISABILITY BENEFIT INFORMATION

DEFINITION OF DISABILITY

You are considered disabled when **we** review **your** claim and determine that, due to **your sickness** or **injury,** both of the following are true:

- **You** are unable to perform all the **material and substantial duties** of **your**

LONG TERM DISABILITY BENEFIT INFORMATION

3. Compare the answers from Step 1 and Step 2. The lesser of these two amounts is

LONG TERM DISABILITY BENEFIT INFORMATION

IF YOUR DISABILITY EARNINGS FLUCTUATE

If **your disability earnings** routinely fluctuate widely from month to month, **we** may average **your disability earnings** over the most recent three months to determine if **your** claim should continue.

If **we** average **your disability earnings, we** will not terminate **your** claim unless the average of

LONG TERM DISABILITY BENEFIT INFORMATION

- A retirement plan from another employer.
- Individual retirement accounts (IRA).

MINIMUM PAYMENT

The minimum payment each month for a **payable claim** is $300.

We may apply this amount to recover any outstanding overpayment.

DURATION OF PAYMENTS

We

send payment(s) during that additional confinement and for one additional recovery period up to 90 more days.

If **you** continue to be disabled after the 24 month period, and subsequently become confined to a **hospital, health facility or institution** for at least 14 days in a row, **we** will send payment(s) during the length of the reconfinement.

We will not make payments beyond the limited pay period as indicated above, or the **maximum period of payment,** whichever occurs first.

We will not apply the **mental illness** limitation to a disability due to dementia if it is a result of stroke, trauma, viral infection or Alzheimer's disease.

CONTINUITY OF COVERAGE

If **you** are not in **active employment** due to **injury** or **sickness** or **leave of absence** on the date **your Employer** changes insurance carriers to **our** policy, and **you** were covered under the prior policy at the time **your Employer's** coverage under **our** policy became effective, **we** will provide continuity of coverage under **our** policy. In order for this provision to apply, the prior policy's coverage must be similar to **our** policy.

If **you** are not in **active employment** due to **injury** or **sickness** or **leave of absence** on the effective date of **our** policy, and **you** would otherwise be eligible to become insured under **our** policy, **we** will provide limited coverage under **our** policy. Coverage under this provision will begin on **our** policy effective date and will continue until the earliest of the following:

- The date **you** return to **active employment.**
- The end of any period of continuance or extension provided under the prior policy.
- The date coverage would otherwise end, according to the provisions of **our** policy.

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

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

If coverage ends under this provision, or if **you** were not covered under **your Employer's** prior policy on the date that policy terminated, the WHEN COVERAGE BEGINS provision under **our** policy will apply.

CONTINUITY OF COVERAGE AND PRE-EXISTING CONDITIONS

We may pay benefits if **your** disability is caused by, contributed by or results from a **pre-existing condition** if both of the following are true:

- **You** were insured by the prior policy at the time **your Employer** changed insurance carriers to **our** policy.
- **You** have been continuously covered under **our** policy from the effective date of **our** policy through the date **your** disability began.

In order to receive a payment, **you** must satisfy the **pre-existing condition** provision under either **our** policy or under the prior policy, if benefits would have been paid had that policy remained in force.

If **you** satisfy the **pre-existing condition** provision of **our** policy, **we** will determine **your** payments according to **our** policy's provisions.

If **you** do not satisfy the **pre-existing condition** provision of **our** policy, but **you** do satisfy the prior policy's **pre-existing condition** provision, then both of the following apply:

- **Your monthly payment** will be the lesser of:
  - the **monthly payment** that would have been payable under the terms of the prior policy had it remained in force.
  - the **monthly payment** under **our** policy.
- Benefits will end on the earlier of:
  - the date benefits end under **our** policy, as described under the WHEN PAYMENTS END provision.
  - the date benefits would have ended under the prior policy if it had remained in force.

If **you** do not satisfy either **our** policy's or the prior policy's **pre-existing condition** provision, **we** will not make any payments.

LONG TERM DISABILITY BENEFIT INFORMATION

We will require proof that **you** were insured under the prior policy. All other provisions of **our** policy will apply.

RECURRENT DISABILITY

If **you** have a **recurrent disability,** and after **your** prior disability ended, **you** returned to work for **your Employer** for 6 months or less, **we** will treat **your** disability as part of **your** prior claim and **you** do not have to complete another elimination period. Only one **maximum period of payment** will apply when **your** disability is considered part of **your** prior claim.

Your monthly payment will be based on **your monthly earnings** as of the date of **your** initial claim. **Your** disability, as outlined above, will be subject to the same terms of the policy as **your** prior claim.

Your disability will be treated as a new claim if either of the following is true:

- **Your** current disability is unrelated to **your** prior disability.
- After **your** prior disability ended, **you** returned to work for **your Employer** for more than 6 consecutive months.

The new claim will be subject to all of the provisions of the policy and **you** will be required to satisfy a new elimination period. A new **maximum period of payment** will apply. In order for this provision to apply, coverage must remain in force.

If **our** policy terminates and **you** become eligible for coverage under any other group disability plan that replaces **our** policy, **you** will not be eligible for coverage under **our** policy.

VOCATIONAL REHABILITATION SERVICES

We have vocational rehabilitation services available to assist **you** in returning to work to the extent of **your** ability. **We** will review **your** disability claim to determine whether **you** are eligible for these ser-

- After 24 months of **Family Member** Care Expense Benefits have been paid for each **family member.**
- Any other date on which **monthly payments** would stop in accordance with the policy.

To receive this benefit, **you** must provide satisfactory proof that **you** are incurring a **family member** care expense.

Family member care means care or supervision of **your family member** and care is given by a licensed child-care center or a licensed caregiver who is not related to **you** by blood or marriage.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as **deductible sources of income.** However, the Total Benefit Cap will apply.

WORKPLACE MODIFICATION BENEFIT

If **you** are disabled and are receiving a payment under the policy from **us,** a Workplace Modification Benefit may be payable to **your Employer.** Subject to the maximum amount below, **we** will reimburse **your Employer** for 100% of the reasonable costs **your Employer** incurs through modifications to the workplace to accommodate **your** return to work, and to assist **you** in remaining at work.

The amount **we** pay will not exceed the lesser of the following:
- Three times **your** last **monthly payment.**
- $5,000.

You must meet both of the following requirements:
- Be disabled according to the terms of the policy.
- Have the reasonable expectation of returning to **active employment** and remaining in **active employment** with the assistance of the proposed workplace modification.

Your Employer must give **us** a written proposal of the proposed workplace modification. This proposal must include all of the following:
- Input from the **Employer, you** and **your doctor.**
- The purpose of the proposed workplace modification.
- The expected completion date of the workplace modification.
- The cost of the workplace modification.

We will reimburse the costs of the workplace modification when all of the following are true:
- **We** approve the proposal in writing.
- **We** receive proof from **your Employer** that the workplace modification is complete.
- **We** receive proof of the costs incurred by **your Employer** for the workplace modification.

The Workplace Modification Benefit is available on a one-time basis for each **insured person** under the policy.

SURVIVOR BENEFIT

When **we** receive proof that **you** have died, **we** will pay **your eligible survivor** a lump sum benefit equal to three (3) **your gross monthly payment** if, on the date of **your** death, both of the following are true:
- **Your** disability had continued for 180 or more consecutive days.
- **You** were receiving or were eligible to receive payments under the policy.

If **you** have no **eligible survivors,** payment will be made to **your** estate, unless there is none. In this case, no payment will be made.

However, **we** will first apply the Survivor Benefit to recover any overpayment that may exist on **your** claim.

The Survivor Benefit will not be pro-rated if the last **monthly payment** payable to **you** prior to **your** death was based on a partial month of disability.