Symetra Financial

Select Benefits Limited Medical Product Manual

Includes:

Limited Medical vs. Mini-Med
Select Benefits Product Overviews
Claims Scenarios
Specimen Policy
Forms

GIS
GROUP INSURANCE SERVICES

LIMITED BENEFIT MEDICAL INSURANCE

Evaluating the Differences Between Fixed Indemnity and Mini-Med Policies

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You've probably heard the terms "limited benefit" and "mini-med" used interchangeably. Technically, limited benefit is a broad category of coverage with specific policy types under this category identified as fixed indemnity and mini-med. While they both are alternatives for those who cannot afford more comprehensive coverage, these two types of policies have very distinct characteristics.

To compare the different features of a fixed indemnity policy with a mini-med policy, one can see how different the policies really are.

FIXED INDEMNITY MEDICAL INSURANCE

First dollar predetermined, fixed-payment benefits
No co-pays or deductibles
No required networks
No preexisting conditions; guaranteed issue
No coordination of benefits
No contract level annual caps
Paid per visit, with calendar year maximums

- Benefits are paid at a fixed amount regardless of the actual cost of service. The amount of the claim payment is not subject to the usual or customary charges, and will be made until the calendar year maximum is met.
- A fixed indemnity medical insurance policy does not need to coordinate with any other providers the insured might have through their own employer or through a spouse's employer. This simplifies a potentially complicated process.
- With no preexisting conditions limitation and a guaranteed issue feature, fixed indemnity policies allow those enrolled to use the benefits for any covered current or future health problem.
- Fixed indemnity plan designs can be customized to meet the needs of the group.

With a fixed indemnity policy, the insured will know exactly what is covered at what amount. What they see is what they get.

MINI-MED INSURANCE

Expense-based benefits
Co-pays and deductibles; deductibles may apply to each coverage
In and out-of-network coinsurance
Preexisting conditions limitation
Coordination of benefits
Annual cap on inpatient and outpatient benefits
Contract level annual cap on benefits

- With its co-pays and deductibles, the expense-based mini-med product may be easier for someone losing major med to understand at enrollment; however, people on a tight budget may find co-pays and deductibles to be a barrier preventing them from seeking service.
- The emphasis on in-network care may prevent them from seeing the provider of their choice.
- Like major medical, most mini-meds include preexisting condition restrictions. For individuals insured for less than 12 months (or for a minimal period of time), a preexisting condition could prevent them from receiving payment for treatment related to that condition.
- Since mini-med claims are based on the cost of service, rates are more susceptible to inflation.

With a mini-med, employees will experience a lot of the same things they do with major med: co-pays, deductibles, in-network requirements, preexisting condition limitations, and rates that are subject to inflation. Perhaps some employees are okay with these things, but for those who need an alternative to major med and want an alternative to mini-med, consider a fixed indemnity medical insurance policy.

Symetra Life Insurance Company offers a fixed indemnity group medical insurance policy called Symetra Select Benefits. For more information on how to design a plan for your clients, please contact your Symetra representative.

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Select Benefits is a fixed indemnity medical insurance policy. It is not comprehensive medical coverage, nor a replacement for major medical or any other comprehensive insurance. It is designed to cover benefits at a preselected fixed payment amount. Coverage may be subject to exclusions, limitations, reductions and termination or benefit provisions. Symetra Select Benefits is insured by Symetra Life Insurance Company, 777 108th Ave NE, Suite 1200, Bellevue, WA 98004 and is not available in all U.S. states or any U.S. territory.

SYMETRA SELECT BENEFITS

Description

Group limited benefit medical insurance designed for full-time, part-time, hourly, temporary and seasonal workers.

Benefits Provided

Allows companies who generally cannot afford health insurance to bring cost-effective, flexible coverage to all eligible employees and their eligible dependents. The policy has no preexisting condition limitations, no required networks, no restrictions with other health insurance plans and offers universal rates. Plans can be customized to fit the specific budget and coverage goals of any business.

Employee Eligibility

Full-time, part-time, temporary and seasonal workers reporting on a monthly or hourly basis. Group size requirements vary by state.

Underwriting

No medical underwriting at enrollment. Proof of good health is required only for late entrants on life and disability income benefits.

Available Benefits

Preventive care
Doctor's office visits
Major diagnostic testing
Prescription drugs
Hospital stays
Accident coverage
Employee disability income insurance
Employee accidental death and dismemberment
Survivor benefits
Diagnostic X-ray and lab tests
Outpatient surgical facilities
Surgeries
Emergency room visits
Dental
Vision
Employee life insurance
Dependent coverage

Premium Options

Hourly	Premium varies depending on the number of hours worked each month
Monthly	Provides the same level of benefits at a fixed monthly premium
Composite	Includes all eligible dependents for one premium
Tiered	Separates premium for individuals and families

Premium Payer

Standard Plan	Employer contributes a minimum percentage of premium
Core Plan	Employer pays the entire core premium
Buy-Ups	Employees purchase additional or enhanced benefits

Preexisting Condition Limitations

None

Network Access	Available for an additional monthly premium per employee.
Administration	Included at no additional employer cost. Provided by Select Benefit Administrators of America (SBAA).
Extension of Benefits	Included at no additional employer cost. SBAA handles all administration.
Dependent Coverage	Coverage can include an employee's spouse, domestic partner (as defined by state or federal law) and children ages 14 days to 19 years (or 23 if full-time students). Dependents are not eligible for disability income insurance and subject to state eligibility requirements.
Sales Tools	The Symetra Select Benefits Web site, **www.symetra.com/selectbenefits**, has everything you need to prospect, sell and enroll Select Benefits. There you will find state approvals, proposal questionnaires, pricing and marketing tools, training presentations and more.

To learn more, or request a Select Benefits proposal, work with your Symetra Financial sales representative. You may also contact the Symetra Financial Sales Center at invest@symetra.com or 1-800-706-0700.

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Select Benefit Administrators of America is a division of Employee Benefit Consultants Inc., a Symetra company.

SELECT BENEFITS HOURLY PLAN OVERVIEW

"Just how will this plan work from one month to the next?"

This might be one of the questions you have about the plan being offered to you by your employer. To put it simply, every hour worked earns you benefits.

Symetra has designed its Hourly Plans to be defined by the following levels:

Level I	1 - 90 hours
Level II	91 - 130 hours
Level III	131+ hours

Benefits are defined in the certificate you will receive in the mail after the enrollment forms are received by SBAA.

A few tips for you, the employee:

- Process your time cards in a timely manner. Discrepancies can occur if time cards are turned in late, causing your hours to be incorrectly reported to SBAA. Also, keep a record of how many hours are reported each week.
- Before you go to the doctor, call to confirm that the number of hours on your record, matches that on file at SBAA. This will help you know what level of coverage you will receive.

Your level of coverage is based on hours worked in the previous month. Your employer will communicate to the policy administrator, Select Benefits Administrators of America (SBAA), how many hours for which you were paid in the previous time period. SBAA will then adjust your benefits should your level of coverage change with this total number of hours.

One feature of this – pay as you go – coverage is your monthly premium cost is directly related to your hours worked in the month. If you worked 50 hours, your cost is 50 times the hourly premium rate; if you worked 100 hours, your cost is 100 times the hourly premium rate.

Here are a few frequently asked questions:

I think I am a Level II. Should I call SBAA before or after I go to the doctor to make sure I have the benefits covered as a Level II?

If possible, please call before you or your covered dependents go to the doctor.

When will I get my insurance card and certificate?

Approximately 7 to 10 business days after your employer sends in your enrollment form.

Whom can I contact if I have questions about my benefits?

Please contact SBAA at 1-800-497-3699 or sbaa@selectbenefit.net. Customer service representatives are available Monday through Friday, 6:30 a.m. to 5:00 p.m. (CT).

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SYMETRA SELECT BENEFITS
LIMITED BENEFIT MEDICAL INSURANCE

DESCRIPTION OF BENEFITS

The following is a description of the coverages available under the Select Benefits limited benefit medical insurance policy. The figures shown represent the range of benefits as well as the monthly rate for a single participant. Availability of benefits can vary by state.

Combination Doctor's Office Visit, Diagnostic X-Ray and Lab, and Preventive Care Benefit

This benefit includes all of the following and is paid at a preselected fixed dollar amount, up to a maximum number of visits per calendar year.

- Visits to a doctor's office, urgent care facility or outpatient hospital.
- Diagnostic X-ray and lab tests ordered or performed by a doctor, when hospital confinement is not required.
- Annual physical examinations and well-child care for children up to age six.

Available Options	$65 to $80 per visit[1]
Calendar Year Maximum	10 to 20 visits per person
Monthly Single Rate	$28 to $43

You can choose to offer doctor's office visits, diagnostic X-rays and preventive care as the combination benefit or you can select each one separately as shown below. If you elect separate coverages, you can choose one, two or all three benefits.

Doctor's Office Visit, Urgent Care and Outpatient Hospital Benefit

Doctor's office visits are paid at a preselected fixed dollar amount, per visit, up to a calendar year maximum. This benefit excludes preventive care and vaccinations.

Available Options	$20 to $70 per visit[1]
Calendar Year Maximum	$300 to $500 per person
Monthly Single Rate	$6 to $20

Outpatient Diagnostic X-Ray and Lab Benefit

Diagnostic X-ray and lab tests ordered or performed by a doctor are paid at a preselected fixed dollar amount, per visit, up to a calendar year maximum, when a hospital confinement is not required.

Available Options	$20 to $80 per visit[1]
Calendar Year Maximum	$300 to $500 per person
Monthly Single Rate	$4 to $15

Preventive Care Benefit

This benefit includes routine exams, immunizations and medical treatments per event paid at a preselected fixed dollar amount.

Available Options	$50 to $150 per visit[1]
Calendar Year Maximum	$150 to $300 per person
Monthly Single Rate	$4 to $10

Major Diagnostic Testing Benefit

Benefits will be paid at a preselected fixed dollar amount for a calendar year maximum number of tests, per person, for the following: magnetic resonance imaging (MRI), computed tomography (CT, CAT scan), mammography, stress tests, electrocardiogram (ECG, EKG), ultrasound, bone density, amniocentesis and chromosome analysis.

Available Options	$75 to $200 per test
Calendar Year Maximum	1 to 5 tests per person
Monthly Single Rate	$1 to $8

Emergency Room Benefit

Benefits will be paid for eligible services or supplies received in an emergency room when the visit results from an accident or illness that occurs while covered under this benefit.

Available Options	$50 to $200 per visit[1]
Calendar Year Maximum	$150 to $500 per person
Monthly Single Rate	$2 to $9

Inpatient Hospital Benefits

Benefits are paid on the first day of a covered stay. Each benefit has maximums of 10 to 90 days per calendar year, 500 days per lifetime, unless otherwise noted. Intensive care unit, substance abuse, mental health, and nursing facility stays are included with the hospital stay.

Available Options	
Hospital Stay	$100 to $1,500 per day
Intensive Care Unit	$200 to $3,000 per day
Substance Abuse Facility	$100 to $1,500 per day
Mental Health Facility	$50 to $750 per day, 180 days lifetime maximum
Nursing Facility	$50 to $750 per day, 60 consecutive days per stay maximum. This benefit is paid only if following a covered hospital stay of at least three consecutive days and the insured is younger than age 65.
Monthly Single Rate	$4 to $91

Hospital Inpatient Admission Benefit

This benefit pays for admission to a healthcare facility for a minimum of 24 hours when confinement is medically necessary and is the result of a nonoccupational illness or injury. This benefit will be paid regardless of any other inpatient hospital benefits available to the insured.

Available Options	$500 to $2000 per confinement
Calendar Year Maximum	1 to 3 admittances per person
Monthly Single Rate	$5 to $22

Ambulance Transportation Benefit

This pays a preselected fixed dollar amount for transport of insureds by a licensed ground or air ambulance service to the nearest accredited hospital where adequate facilities for treatment are available.

Available Options	$250 to $1000 per ground trip (air trip at 2 times ground)
Calendar Year Maximum	5 trips per person
Monthly Single Rate	$2 to $10

Surgical Benefit

This pays a preselected fixed dollar amount for fees associated with surgeries performed by a doctor. Benefits for surgeon's fees are paid according to the surgical schedule. Please contact your Select Benefits representative for a schedule.

Calendar Year Maximum	$400 to $5,000 per person
Monthly Single Rate	$6 to $23

Surgical Anesthesia

Surgical anesthesia will be automatically included with the Surgical Benefit, unless requested otherwise.

Available Options	20 to 40 percent of each covered surgical procedure
Calendar Year Maximum	$80 to $2,000 per person
Monthly Single Rate	$0.50 to $4

Outpatient Surgical Facility Benefit

Benefits will be paid at a preselected fixed dollar amount for an outpatient surgical facility that is used during surgical procedures not ordinarily performed in a private physician's office, but not requiring inpatient hospitalization. This is provided the facility is neither part of a hospital nor the private office of a health-care provider who there engages in the lawful practice of surgery.

Available Options	$250 to $500 per surgery
Calendar Year Maximum	1 to 5 surgeries per person
Monthly Single Rate	$5 to $16

Generic Prescription Drug Benefit

This benefit pays 100 percent of all generic out-of-hospital prescription drugs after the co-payment is met. There is no calendar year maximum. Brand name drugs are not covered under this benefit; however, a discount is available through the Pharmacy Discount Benefit which is included in all plan designs at no additional cost.

Co-Pay Options	$5 to $20
Calendar Year Maximum	None
Monthly Single Rate	$20 to $12

Prescription Drug Benefit

Covered out-of-hospital prescription drugs will be paid up to the calendar year maximum after the prescription drug co-payment is paid. Prescription drugs must be ordered by a doctor and dispensed by a licensed pharmacist for the care and treatment of the patient.

Co-Pay Options	Generic: $5 to $15 Brand name: $10 to $30
Calendar Year Maximum	$150 to $1,500 per person
Monthly Single Rate	$68 to $12

Group Accident Benefit

This benefit pays billed charges up to a calendar year maximum for covered services by a doctor or hospital. The expenses must be incurred: a) within 52 weeks from the date of the Accident; and b) the first expense must be incurred within 60 days of the date of the Accident.

Calendar Year Maximum	$300 to $5,000 per person
Monthly Single Rate	$7 to $22

An indemnity accident benefit is also available. For details, contact your Select Benefits representative.

Vision Benefit

The vision benefit provides the following:

- $50 towards one routine eye examination per calendar year
- $100 per pair of glasses, per person, every two consecutive calendar years, or $75 for contact lenses, per person, every two consecutive calendar years

Monthly Single Rate	$4

Dental Benefit

The options noted are for regular and preventive care. Benefits for special dental care (crowns, inlays, etc.), orthodontia and periodontal work are dependent upon the elected amount.

Available Options	$50 to $100 per visit[1]
Calendar Year Maximum	$500 to $1,500 per person for all treatment except orthodontia
Monthly Single Rate	$14 to $28

Employee Disability Income Weekly Benefit

Benefits are paid beginning on the first day after the chosen elimination period (8, 15, or 31 days) following a covered nonoccupational injury or illness. Claim benefits will not exceed $66^2/_3$ percent of basic weekly earnings, and benefits may be reduced by any other income amounts for which the employee may be eligible; exclusions apply. Maternity is covered as any other condition. Maximum benefit period is 26 weeks.

Available Options	$100 or $300 per week
Elimination Period	7, 14 or 30 days
Monthly Single Rate	$6 to $16

Employee Life Insurance/Accidental Death and Dismemberment Benefit

Life insurance and accidental death and dismemberment amounts reduce by 35 percent at age 65 and by an additional 35 percent each five-year period thereafter.

Available Options	$5,000 to $50,000 each for life insurance and accidental death and dismemberment
Monthly Single Rate	$2 to $16

Dependent Life Insurance Benefit

Coverage for a spouse, domestic partner (as permitted by state or federal law) and children is available. The definition of a child varies by state. Please refer to the policy for more information.

Available Options	$2,500 to $12,500 for spouse/domestic partner
Monthly Dependent Rate	Up to $10

The following are included in all plans at no additional cost.

Pharmacy Discount Program

A discount from usual and customary drug charges will be given to the eligible person when prescriptions are purchased through a contracting pharmacy. This benefit is only available when the Generic or Prescription Drug Benefits are not chosen, or when all such benefits are exhausted.

Survivor Benefit

If an employee dies while covered under the policy, any covered dependents will be extended benefits (except Dependent Life) without premium payments for up to two years after the employee's death. This is as long as the employer's plan remains in force and the covered dependent meets the eligibility requirements in the policy.

Note: The rates shown here are for illustrative purposes only. Actual rates may vary.

PLAN DESIGN WORKSHEET

Use this worksheet to determine which benefits and amounts best fit the needs of your company and its employees.

Coverages	Benefit Amount
Combination Doctor's Office Visit, Diagnostic X-Ray and Lab and Preventive Care Benefit	**$**
OR	
Doctor's Office Visit, Urgent Care and Outpatient Hospital Benefit	**$**
Outpatient Diagnostic X-Ray and Lab Benefit	**$**
Preventive Care Benefit	**$**
Major Diagnostic Testing Benefit	**$**
Emergency Room Benefit	**$**
Inpatient Hospital Benefits	**$**
Hospital Inpatient Admission Benefit	**$**
Ambulance Transportation Benefit	**$**
Surgical Benefit	**$**
Surgical Anesthesia	**$**
Outpatient Surgical Facility Benefit	**$**
Generic Prescription Drug Benefit	**$**
Prescription Drug Benefit	**$**
Group Accident Benefit	**$**
Vision Benefit	**$**
Dental Benefit	**$**
Employee Disability Income Weekly Benefit	**$**
Employee Life/Accidental Death and Dismemberment	**$**
Dependent Life	**$**
Pharmacy Discount Program	**Included**
Survivor Benefit	**Included**

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[1] A visit means one meeting with a doctor in a nonhospital setting, one sitting for one or multiple diagnostic X-ray procedures, or one sitting for one or multiple diagnostic laboratory procedures.

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SYMETRA SELECT BENEFITS CRITICAL ILLNESS INSURANCE

Description

An insurance benefit that provides either a $5,000 or $10,000 lump-sum payment (reduced by 50 percent at age 65) upon the first diagnosis of a number of covered conditions.[1] This benefit is offered in combination with an approved Select Benefits policy, or on a stand-alone basis.

Due to market demand, the critical illness benefit is now available on a stand-alone basis, provided the following requirements are met:

- Employer pays 100 percent of premium for all rating tiers
- $5,000 benefit, must have 50 or more enrolled employees
- $10,000 benefit, must have 25 or more enrolled employees

Benefit of Coverage

Allows employers to offer a benefit that may help to provide peace of mind to families facing financial hardship as the result of a critical illness. Insureds have the flexibility to use the payout as needed, whether it is to help pay for treatment, living expenses, child care or any other obligations.

Guaranteed Issue Amounts

Groups with 5 to 199 eligible employees	$5,000 (reduces by 50% at age 65)
Groups with 200 or more eligible employees	$5,000 and $10,000[1] (reduces by 50% at age 65)

Covered Conditions

Please refer to the policy, LGC-9095 2/07, for complete definitions

Critical Illness	Employee Benefit [2]	Spouse Benefit [2,3] (Percentage of primary insured's benefit)	Child Benefit (Percentage of primary insured's benefit)
Invasive cancer	100%	100%	25%
Heart attack	100%	100%	25%
Stroke	100%	100%	25%
End-stage renal failure	100%	100%	25%
Major organ transplant	100%	100%	25%
Severe burns	100%	100%	25%
Paralysis	100%	100%	25%
Coma	100%	100%	25%

[1] Benefit depends on group size and state availability. Underwriting considerations apply.

[2] Reduces by 50 percent at age 65

[3] Includes domestic partners as permitted by state or federal law

Medical Underwriting	No medical underwriting is required
First Diagnosis Requirement	Benefits will only be paid upon first diagnosis of a covered condition by a legally qualified physician. First diagnosis means this diagnosis is the first time ever in an insured's lifetime that he/she has been diagnosed with a covered critical illness condition as defined in the Select Benefits policy.
Separate Condition Payment	A benefit is provided for each covered condition once it qualifies and meets the first diagnosis requirement as stated in the policy.
Employee Eligibility	The employer determines eligibility. The policy may be offered to any full-time, part-time, temporary or seasonal worker reporting on a monthly or hourly basis. Minimum group size requirements vary by state. Contact your Select Benefits representative for details.
Minimum Participation (Non-stand alone)	The greater of five lives or 10 percent of eligible employees. If sold with another Select Benefits policy, this requirement applies to the entire Select Benefits plan, including the critical illness benefit.
Minimum Participation (Stand alone)	**$5,000 benefit**: 50 or more enrolled employees **$10,000 benefit**: 25 or more enrolled employees

For more information, please contact your Select Benefits representative.

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SYMETRA SELECT BENEFITS CRITICAL ILLNESS INSURANCE BENEFIT

The critical illness benefit is available on any approved monthly Select Benefits plan for an additional rate.[1] The price is dependent upon the amount of benefit offered and whether it is a composite or tiered plan.

Available Benefit Amounts

Groups with 5 to 199 lives	$5,000[1]
Groups with 200 or more lives	$5,000 or $10,000[1]

Monthly Rates

COMPOSITE RATE	
	Employee + All Eligible Dependents
$5,000 Benefit	$12.14
$10,000 Benefit	$24.29

2-TIER RATES		
	Employee	**Family**
$5,000 Benefit	$7.29	$17.01
$10,000 Benefit	$14.58	$34.02

3-TIER RATES			
	Employee	**Employee + 1**	**Employee + 2 or more**
$5,000 Benefit	$7.29	$13.37	$17.01
$10,000 Benefit	$14.58	$26.73	$34.02

4-TIER RATES				
	Employee	**Employee + Children**	**Employee + Spouse**	**Family**
$5,000 Benefit	$7.29	$9.72	$14.58	$17.01
$10,000 Benefit	$14.58	$19.44	$29.15	$34.02

The critical illness rate will be added to the monthly Select Benefits plan price. All rates are subject to change.

[1] Benefit amount offered depends on group size and state availability. Underwriting considerations may also apply.

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SYMETRA SELECT BENEFITS INSURANCE

Mike works through a temporary employment agency. His hours vary from month to month, based on jobs available. He is currently enrolled in his agency's Select Benefits plan. His agency pays 100 percent of the monthly premium.

In October, Mike worked 120 hours, making him eligible for Level II benefits. In November, Mike goes to his regular family doctor, complaining of a severe sore throat and fever. The doctor takes a throat culture and sends it to the lab. The results show Mike has strep throat. His doctor prescribes an antibiotic, which Mike gets filled at his local pharmacy. Two days later, Mike's four-year-old son has similar symptoms and is also diagnosed with strep throat.

Here is how Select Benefits hourly plan 6 could pay for strep throat.

Event	Select Benefits Payment
Doctor's office visit for Mike	$45
Lab work for throat culture	$45
Prescription for generic antibiotic ($40) $10 co-pay	$30
Doctor's office visit for son	$45
Lab work for son	$45
Prescription for generic antibiotic for son ($35) $10 co-pay	$25
Total benefits paid	**$235**

Once Mike's Prescription Drug Benefit reaches its limit, Mike may be eligible for discounts on prescriptions, depending on the prescribed drug and pharmacy provider.

This example shows what Select Benefits pays in each listed event. It does not represent the actual billed charges, as these can vary depending on where insureds live and the doctors they visit.

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SYMETRA SELECT BENEFITS INSURANCE

This example shows what Select Benefits pays in each listed event.

Jennifer works as a hostess at a large restaurant. She is currently participating in the Select Benefits plan that her employer offers to all eligible employees and their dependents.

One day Jennifer visits her doctor for a routine check-up. Her doctor orders lab tests which reveal that she is pregnant. During her pregnancy, Jennifer visits her OB/GYN several times and has additional lab work. She has a smooth delivery, so she and her newborn son stay in the hospital for only two days.

Here is how Select Benefits could pay benefits for Jennifer's pregnancy. In this example, the restaurant offers monthly standard plan 5.

Event	Select Benefits Payment	
Preventive care check-up	$75 per visit	= $ 75
Lab work	$55 per visit, up to $300 pp/pcy* max.	= $300
Visits to OB/GYN	$45 per visit, up to $300 pp/pcy max.	= $300
Jennifer's hospital stay	$300 daily hospital x 2 days	= $600
Baby's hospital stay	$300 daily hospital x 2 days	= $600
Total benefits paid		**= $1,875**

*per person, per calendar year

Jennifer may be eligible for discounts on prescriptions, depending on the prescribed drug and pharmacy provider. She also receives a $5,000 life insurance policy and $5,000 accidental death and dismemberment benefit. Her son is entitled to the same health insurance benefits as Jennifer since he is an eligible dependent. When the baby is 14 days old, he also receives a $200 life insurance policy.

This example shows what Select Benefits pays in each listed event. It does not represent the actual billed charges as these can vary depending on where Insureds live and the doctors they visit.

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SYMETRA SELECT BENEFITS INDEMNITY INSURANCE

Claims Scenario for a Typical Year in the Life of a Family

Keith works part-time for a tool and die manufacturer. He is married and has a two-year-old son. During the year, several events requiring visits to the doctor and emergency room occur. Fortunately, Keith is enrolled in his company's Select Benefits plan. His company pays 75 percent of the monthly $94.06 premium so Keith pays $23.52 a month for his medical benefits.

Here is how Select Benefits Monthly Standard Plan 6 could pay for a family's year of medical needs.

Event	Select Benefits Payment	
January Keith takes his son, Brian, to his pediatrician for his annual checkup. No problems were discovered.	Preventive Care Benefit	$75
March Keith's wife, Marcia, visits her dermatologist complaining of a skin irritation. The doctor scrapes the affected area and sends it to the lab for biopsy.	Doctor's Office Visit Benefit	$45
Lab work for Marcia. The results show no malignancy. The doctor gives her a prescription for a topical ointment.	Outpatient Diagnostic X-Ray & Lab Benefit	$45
Prescription ($55) $10 co-pay	Prescription Drug Benefit	$45
June Brian falls off a jungle gym and breaks his arm. Keith and Marcia take him to the emergency room at the nearest hospital.	Emergency Room Benefit	$50
X-rays	Outpatient Diagnostic X-Ray & Lab Benefit	$55
November Keith goes to the doctor complaining of abdominal pain. He is diagnosed with a hernia and scheduled for surgery.	Doctor's Office Visit Benefit	$45
December Keith undergoes surgery for hernia repair, develops complications, and spends two nights in the hospital.	Surgical Benefit Inpatient Hospital Benefit	$500 $800
Total benefits paid		**$1,660**

Once Keith's Prescription Drug Benefit reaches the calendar year maximums, Keith may be eligible for discounts on prescriptions, depending on the prescribed drug and pharmacy provider.

This example shows what Select Benefits pays in each listed event. It does not represent the actual billed charges, as these can vary depending on where insureds live and the doctors they visit.

Select Benefits is not a replacement for a major medical policy or other comprehensive policy. It is designed to cover benefits, at a preselected fixed dollar amount, used on a routine basis. Coverage may be subject to exclusions, limitations, reductions and termination of benefit provisions. Select Benefits is insured by Symetra Life Insurance Company.

SYMETRA FINANCIAL

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004
www.symetra.com

LGS-5718

11/05

LGS-5652 3/05

WHAT CAN YOU BUY FOR $100

That daily cup of coffee? The weekly tank of gas?

Would you believe that employers could offer their employees a group medical plan for only $100 a month?

SELECT BENEFITS, a limited benefit medical insurance policy, insured by Symetra Life Insurance Company is an option:

- **For those employers** struggling with the cost of major med.*
- **For those employees** who want access to basic benefits when they — or their dependents — need to go to the doctor.
- **For those brokers** who want to give their clients a way to prevent their employees from being classified as the "working uninsured."

POLICY FEATURES:

- No Preexisting Conditions Limitations
- No Medical Underwriting
- No Deductibles or Co-Pays
- Dependent Coverage Available

Since each plan is customized to accommodate the needs of the group, you may find it hard to visualize a typical plan design. We've created three different plans at the popular price point of $100 to show you the variety of benefits that can be chosen.

To see what $23 a week can buy an employee — or $57 a week for the entire family — take a look at these three distinctly different plans.

To customize a plan for your clients, contact your Select Benefits representative.

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777 108th Avenue NE, Suite 1200
Bellevue, WA 98004
www.symetra.com

* **Select Benefits is not comprehensive medical coverage or a replacement for major medical.** It is designed to cover benefits at a preselected fixed payment amount. Coverage may be subject to exclusions, limitations, reductions, and termination of benefit provisions.

Select Benefits is insured by Symetra Life Insurance Company, 777 108th Ave NE, Suite 1200, Bellevue, WA 98004.

3 LIMITED BENEFIT POSSIBILITIES FOR $100

EMPLOYEE ONLY

Select Benefits Plan Possibilities

	Possible Outpatient Care Plan	Possible Outpatient + Inpatient Plan	Possible Precautionary Plan
Combination Doctor's Office Visit, Diagnostic X-Ray & Lab, & Preventive Care Benefit	$80 per visit 20 visits pp/pcy[1] max.	$65 per visit 10 visits pp/pcy[1] max.	$65 per visit 10 visits pp/pcy[1] max.
Major Diagnostic Testing Benefit	$200 per test 2 tests pp/pcy max.	$200 per test 1 test pp/pcy max.	$200 per test 1 test pp/pcy max.
Emergency Room Benefit	$150 per visit $300 pp/pcy max.	$75 per visit $150 pp/pcy max.	$75 per visit $150 pp/pcy max.
Inpatient Hospital Benefits 10 days pp/pcy, 500 days per lifetime unless noted			
Hospital Stay	--	$500 per day	$600 per day
Intensive Care Unit		$1,000 per day	$1,200 per day
Substance Abuse Facility		$500 per day	$600 per day
Mental Health Facility 180 days lifetime maximum		$250 per day	$300 per day
Nursing Facility 60 consecutive days per stay maximum		$250 per day	$300 per day
Hospital Inpatient Admission Benefit Coverage per confinement, Admittances	$2,000, 1 pp/pcy max.	--	$1,000, 1 pp/pcy max.
Surgical Benefit (Schedule A)	--	$2,000 pp/pcy max.	--
Surgical Anesthesia Benefit (Schedule A)	--	$500 pp/pcy max.	--
Ambulance Transportation Benefit			
Coverage per ground trip /air trip	$500 / $1000	--	$250 / $500
Trips	5 pp/pcy max.		5 pp/pcy max.
Employee Life/AD&D[2] Insurance Benefit	--	--	$5,000 / $5,000
Generic Drug Benefit		$20 co-pay, no pp/pcy[1] max.	
Group Accident Benefit	$4,000 pp/pcy max.	$2,000 pp/pcy max.	$2,000 pp/pcy max.
Critical Illness Benefit Per first diagnosis covered critical illness condition			$5,000 (Employee)

FAMILY COVERAGE IS AVAILABLE FOR AN ADDITIONAL $150

[1] Per person, per calendar year

[2] Accidental Death & Dismemberment

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www.symetra.com

Select Benefits is not comprehensive medical coverage or a replacement for major medical. It is designed to cover benefits at a preselected fixed payment amount. Coverage may be subject to exclusions, limitations, reductions, and termination of benefit provisions. Select Benefits is not available in all U.S. states or any U.S. territory. Specific benefits also vary by state.

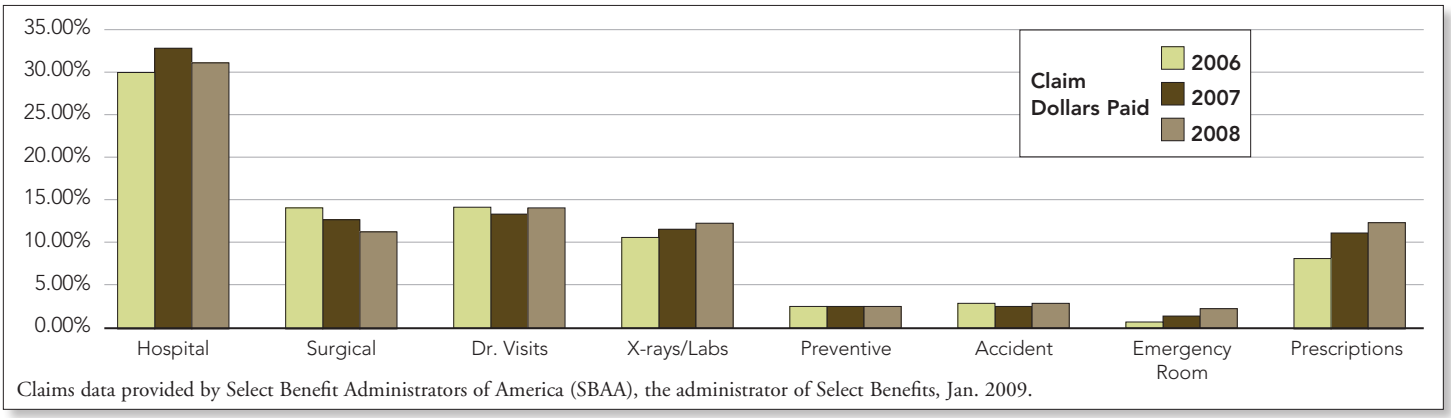
Insurance benefits are provided under the Select Benefits Indemnity Policy, form number LGC-8786 2/03, and/or Critical Illness Policy, form number LGC-9095 2/07, and/or Outpatient Prescription Drug Policy, form number LGC-8787 2/03, and/or Group Accident Policy, form number LGC-9072 11/05. Select Benefits is insured by Symetra Life Insurance Company, 777 108th Ave NE, Suite 1200, Bellevue, WA 98004.

CHOOSING COVERAGE THAT WORKS

SELECT BENEFITS CLAIMS UTILIZATION

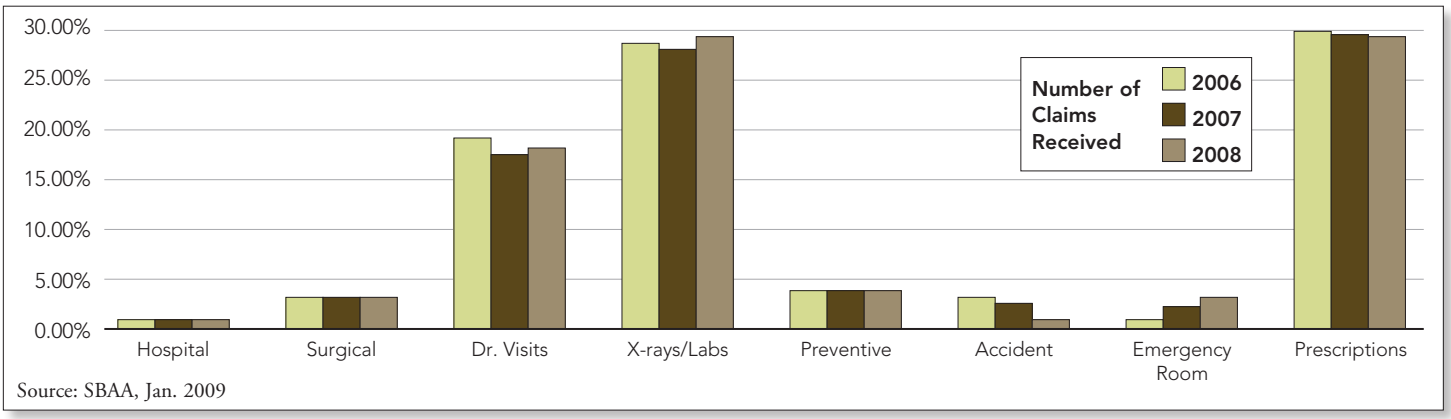
When deciding what benefits to include in their Select Benefits plan, policyholders need to consider the types of coverage most likely to be used by the insured.

You might think the best way to determine this is to look at claims payment history. The chart below compares Select Benefits claim dollars paid over the past three years. Looking at this, you would think Hospital, Surgical and Doctor Visits are the benefits most utilized.



Claims data provided by Select Benefit Administrators of America (SBAA), the administrator of Select Benefits, Jan. 2009.

But what if you were to look at the number of claims *received*, instead of paid? This chart shows that for the past three years, the highest number of Select Benefits claims came from routine things like X-rays/Labs, Prescriptions and Doctor Visits.



Source: SBAA, Jan. 2009

What these charts tell us is that those insured use their medical insurance for mostly common occurrences. Select Benefits is designed to do just that by providing medical coverage so that the insured can go to the doctor, get an X-ray taken, or have a prescription filled.

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Being able to go to the doctor today, might prevent a visit to the hospital later.

Select Benefits is not a replacement for major medical or any other comprehensive policy. It is designed to provide a preselected fixed dollar amount for commonly used benefits. SBAA is a division of Employee Benefit Consultants, Inc., a Symetra company. Select Benefits is insured by Symetra Life Insurance Company, 777 108th Ave. NE, Bellevue, WA 98004, and is not available in all U.S. states or any U.S. territories.

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777 108th Avenue NE
Belleuve, WA 98004

SELECT BENEFITS

INDEMNITY POLICY

This Policy contains medical, dental, vision, decreasing term life insurance, disability income and accident, death and dismemberment insurance. Benefits available to the [Employee] will be listed in the Summary of Benefits .

POLICY SPECIFICATIONS

[Employer]:

Policy Number:

Policy Effective Date:

Premium Due Date:

Policy Anniversary:

Governing Jurisdiction: This **Policy** is delivered in and governed by the laws of the state of Tennessee.

This **Policy** has been issued in consideration of the signed Application and payment of **Premium**. This **Policy** renews on each **Policy Anniversary**.

Symetra Life Insurance Company issues this **Policy** and agrees to pay the **Benefits** of this **Policy** subject to its terms and conditions.

Symetra Life Insurance Company has, by its President and Secretary, executed this **Policy** as of this **Policy Effective Date** and caused it to be duly countersigned at Redmond, Washington.

Randall H. Talbot,
President

George Pagos,
Secretary

INTRODUCTION

This **Policy** is divided into two sections:

a. The **[Employer]** section
b. The **[Employee]** section

Both sections together form the **Policy** and include all of the **Benefits** available under a plan.

The **[Employer]** will be responsible for giving the **[Employee]** section to the covered **[Employee]**.

Whenever **We** use the terms "**You** or **Your**" in the **[Employer]** section, **We** mean the **[Employer]**.

Whenever **We** use the terms "**You, Your** or **Yourself**" in the **Employee** section, **We** mean the **[Employee]** and/or **[Employee's] Dependents**.

Notice to Buyer: This is a Hospital indemnity/limited Benefit health Policy/certificate. This Policy/certificate provides limited Benefits. Benefits are supplemental and are not intended to cover all medical expenses.

SYMETRA FINANCIAL
Symetra Life Insurance Company

5069 154TH Place NE
Redmond, WA 98052

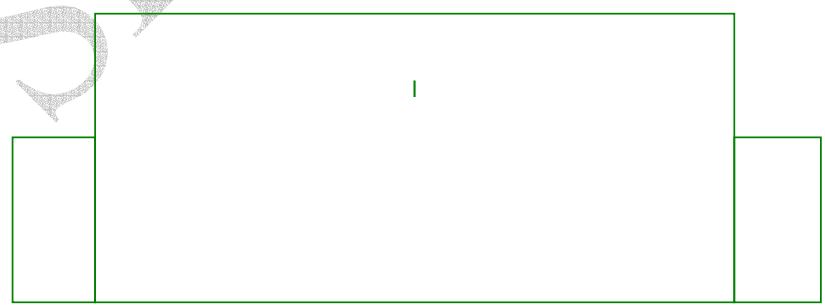
SELECT BENEFITS

INDEMNITY POLICY

[EMPLOYER NAME]

[POLICY NUMBER]

[EMPLOYER] SECTION



SCHEDULE OF PREMIUM RATES

[Employer: XXXXXXXX]
[Policy Number: XXXXXXX]
[Effective Date XX-XX-XXXX]

[

Coverage	Rate	Monthly

]

ASSOCIATED ENTITIES

[Employer: XXXXXXXX]
[Policy Number: XXXXXXX]
[Effective Date XX-XX-XXXX]

Insurance is extended to the **[Employer]'s** associated entities, if any, listed below. Additions and deletions may only be made by **Amendment** to this **Policy**. Deletion of an associated entity is treated as termination of this **Policy** for that entity.

[Name]	[Effective Date]	[Termination Date]

[EMPLOYER] PROVISIONS

Assignment

The coverage provided under this **Policy** is not assignable, except as otherwise stated in this **Policy**.

Conformity with State Statutes

Any provision of this **Policy**, which is in conflict with the statutes of the state in which this **Policy** is issued, is hereby amended to conform to the minimum requirements of such statutes, unless otherwise forbidden by the laws of the state where the **[Employee]** lives.

Inadvertent Error

The **Insured** will not lose the amount of coverage due him because of inadvertent error by **You**:

a. To provide the name of the **Insured** to **Us**; or
b. To report a change in the amount of the **Insured's** coverage to **Us**.

Failure to report the termination of coverage of any **Insured** to **Us** will not continue the coverage beyond the date it would otherwise end.

You have no authority to pay **Premium** for individuals that are not **[Employees]** or to continue coverage of terminated **[Employees]**.

Legal Actions

No legal action may be brought to recover a disputed claim amount under this **Policy**:

a. Until 60 days have elapsed after **Proof of Loss** has been filed; or
b. After 5 years from the end of the time within which **Proof of Loss** is required by this **Policy**.

Misstatement of Age

If the age of an **Insured** has been misstated, the **Benefit** payable will be the **Benefit** to which he is entitled due to actual age.

Policy Changes

This **Policy** may be changed at any time by written agreement between Symetra and officers of the **[Employer]**. Changes will be valid only if approved by an officer of Symetra and endorsed or attached to this **Policy**, and do not require the consent of any **[Employee], Dependent,** or **Beneficiary**. No agent has the authority to change this **Policy** or to waive any of its provisions.

Entire Contract

This **Policy**, master application, and all **Amendments**, **Endorsements** or **Riders** and the applications, if any, of the **Insured** persons form the entire contract.

[EMPLOYER] PROVISIONS ◈ Continued

Statements Not Warranties

In the absence of fraud, all statements made by **You** or by any **[Employee]** will be deemed representations and not warranties. These statements will not be used to reduce or deny **Benefits** unless the statements are in a written application signed by **You** or **Your [Employee]**.

Pronouns

Masculine pronouns used in this **Policy** will apply to both genders.

Records of the [Employer]

You will give such data as may be required by **Us** to provide the coverage. This includes data on persons becoming covered, changes in the amount of coverage, and terminations of coverage. Payroll and other personnel records pertaining to **Your** coverage under this **Policy** will be open for review by **Us** at any reasonable time. Any additional records of **Yours** as may have a bearing on the coverage shall also be open for review by **Us** at any reasonable time.

Incontestability of Policy

We will not contest this **Policy** after it has been in force for two years with respect to **You**, except for nonpayment of **Premium**.

No statement made by an **Insured** relating to his insurability will be used to contest his coverage:

a. After his coverage has been in force during his lifetime for two years; and
b. Unless such statement is in writing and signed by him.

Workers' Compensation

This **Policy** is not in lieu of and does not affect any requirements for coverage by **Workers' Compensation Insurance.**

Premium Rates

Premium Rates will be the **Rates** shown in this **Policy** in accordance with coverage elected in the **[Employer's]** Application. The initial **Rate** guarantee period will be shown on the **[Employer's]** Application.

[EMPLOYER] PROVISIONS ◈ Continued

Payment of Premiums

The first **Premium** will be due on **Your Effective Date of Coverage** under this **Policy**. After that, **Premium** will be due monthly, unless **You** and Symetra agree on some other method of **Premium** payment.

Premiums are payable to **Us** at **Our** administrator's office, Select Benefits Administrators of America.

Grace Period

If **You** have not given written notice to **Us** before the **Premium** due date to terminate coverage under this **Policy**, a grace period of 31 days will be given in which to pay the **Premium** then due. Coverage will continue in force during this grace period. If the **Premium** is not paid before the end of the grace period, coverage will cease on the last day of the grace period and **You** will be liable to **Us** for any unpaid **Premium** for the time coverage was in force.

If, before the end of the grace period, **You** give written notice to **Us** at **Our** administrator's office, Select Benefits Administrators of America, that coverage is to be terminated, coverage will terminate on the later of the date contained in the notice or the date such notice is received by **Us**. A pro rata **Premium** will be paid for the period between the date the **Premium** was due and the date coverage ends.

Reinstatement

If **Your** coverage ceases, **We** may reinstate such coverage, if requested in writing by **You**, and:

a. All past due **Premiums**, including the grace period **Premium** are paid; and
b. The current **Premium** is paid.

Change in Premium Rates

We may change the **Premium Rate** for any coverage by giving **You** 31 days written notice. **We** may change the **Rates** on:

a. The first **Policy Anniversary**; or
b. Any **Premium** due date after the first **Policy Anniversary**; or
c. Any **Amendment, Endorsement** or **Rider** effective date.

Premium Adjustment

Premium adjustment will be made when necessary. Refunds and credits are limited to the 3-month period prior to receipt of request for adjustment.

Termination by the [Employer]

You may terminate **Your** coverage provided under this **Policy** by mailing to **Us** 31 days prior written notice stating when such termination will be effective.

Termination by **Symetra**

Comment:

We may terminate **Your** coverage under this **Policy** by giving at least 45 days prior written notice, when:

a. **You** fail to comply with the minimum participation and contribution rules; or
b. Fraud upon **Us** has occurred; or
c. **You** do not duly perform in good faith **Your** obligations under this **Policy**.

We may terminate **Your** coverage under this **Policy** by giving at least 10 days prior written notice, when **You** do not pay all **Premiums** that are due by the end of the grace period**.**

We may also terminate **Your** coverage under this **Policy** at any time for any reason after it has been in force for 12 months, provided **We** give 45 days prior written notice.

All written notices will be delivered to **You**, or mailed to **Your** last known address as shown on **Our** records and **We** will indicate in that notice the reason for the termination.

Renewal

We may renew **Your** coverage under this **Policy** on each **Policy Anniversary** by giving **You** 20 days prior written notice, indicating in that notice the amount of **Premium** due.

We may refuse to renew **Your** coverage under this **Policy** by giving **You** 45 days prior written notice indicating in that notice the reason for nonrenewal of **Your** coverage under this **Policy**,

ERISA

This **Policy** is delivered in and is governed by the laws of the state of Tennessee and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments to ERISA.

SYMETRA FINANCIAL
Symetra Life Insurance Company

5069 154TH Place NE
Redmond, WA 98052

SELECT BENEFITS

INDEMNITY POLICY

[POLICY NUMBER]

[EMPLOYEE] SECTION

INTRODUCTION

This section is **Your [Employee]** Certificate of Coverage. It describes the **Benefits** provided through **Your [Employer]** under the **Policy** issued by Symetra Life Insurance Company to **Your [Employer]**.

The complete terms of the coverage provided are set forth in this **Policy**.

YOU DO NOT HAVE COVERAGE FOR THE **BENEFITS** DESCRIBED IN THIS SECTION UNLESS THEY ARE LISTED IN THE **SUMMARY OF BENEFITS** IN THIS SECTION, OR AS AMENDED.

Keep this section in a safe place. Instructions for submitting a **Claim** for **Benefits** appear at the end of this section.

This **[Employee]** section replaces all others previously issued.

Notice to Buyer: This is a Hospital indemnity/limited Benefit health Policy/certificate. This Policy/certificate provides limited Benefits. Benefits are supplemental and are not intended to cover all medical expenses.

PART 1. ~ TABLE OF CONTENTS

[Employer: XXXXXXXX]
[Policy Number: XXXXXXX]
[Effective Date XX-XX-XXXX]

[

TABLE OF CONTENTS ◈ Continued

]

PART 2. ~ SUMMARY OF BENEFITS

Formatted: Heading 1 Char Char, Font: 12 pt

[
[Employer]:

Policy Number:

[Employer] Effective Date:

Policy Anniversary:

Eligible Classes of [Employees]

[All eligible **[Employees]** of the **[Employer]** who are defined as follows:**]**

Class	Description
[	]

Hourly [Employees]

Benefit amounts are based on:

The following Levels and the amount of coverage selected by the **[Employer]** for each Level.

[Level 1:	1-90 Hours of Work per month**]**
[Level 2:	91-130 Hours of Work per month**]**
[Level 3:	131+ Hours of Work per month**]**

The Level of coverage for which an **Insured** is eligible during the current month will be based on the number of hours worked in the prior month.

Service Waiting Period

[The first of the month following the date of employment.**]**

[Employer: XXXXXXXX]
[Policy Number: XXXXXXX]
[Effective Date XX-XX-XXXX]

[Employee] Only Benefits

LIFE INSURANCE BENEFITS — **[**$5,000 - $50,000**]**

Benefit amounts reduce by 35% at age 65 and by an additional 35% each five-year period thereafter.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS — **[**$5,000 - $50,000**]**

Benefit amounts reduce by 35% at age 65 and by an additional 35% each five-year period thereafter.

DISABILITY WEEKLY BENEFIT — **[**66 2/3%**]** of **Basic Weekly Earnings** to a Maximum Amount of **[**$100 - $300**]** per week

Elimination Period: **[**7**]** days, **Benefits** begin on the **[**8th **]**day

Maximum Benefit Period: **[**26**]** weeks

Dependent Only Benefits

LIFE INSURANCE BENEFITS

ELIGIBLE DEPENDENTS:

Spouse: **[**$2,500 - $12,500**]**
Child: 14 days to 6 months **[**$200 - $1,000**]**
6 months to **[**19**]** years **[**$1,250 - $6,250**]** (to **[**23**]** years if **Full-time Student)**

[Employer: XXXXXXXX]
[Policy Number: XXXXXXX]
[Effective Date XX-XX-XXXX]

[Employee] and Dependent Benefits

ACCIDENT BENEFIT	**[**$20 - $60**]** per visit/per person up to a maximum of **[**$100 - $300**]** per person/per **Calendar Year**
EMERGENCY ROOM BENEFIT	**[**$50 - $200**]** per visit/per person up to a maximum of **[**$150 - $500**]** per person/per **Calendar Year**
INPATIENT HOSPITAL BENEFITS	
Hospital:	**[**$100 - $1,500**]** per day/per person, up to a maximum of 30 days per person/per **Calendar Year** and 500 days per lifetime/per person
Intensive Care:	**[**$200 - $3,000**]** per day/per person, up to a maximum of **[**30**]** days per person/per **Calendar Year** and **[**500**]** days per lifetime/per person
Substance Abuse Facility:	**[**$100 - $1,500**]** per day/per person, up to a maximum of **[**30**]** days per person/per **Calendar Year** and **[**500**]** days per lifetime/per person
Mental Health Facility:	**[**$100 - $1,500**]** per day/per person, up to a maximum of 30 days per person/per **Calendar Year** and 500 days per lifetime/per person
Nursing Facility:	**[**$50 - $750**]** per day/person, only if following a covered **Hospital** stay of at least 3 consecutive days and the **Insured** is less than age **[**65**]** up to a maximum of 60 consecutive days per stay/per person and **[**500**]** days per lifetime/per person

[Employer: XXXXXXXX]
[Policy Number: XXXXXXX]
[Effective Date XX-XX-XXXX]

DOCTOR'S OFFICE VISIT, URGENT CARE AND OUTPATIENT HOSPITAL BENEFIT	**[**$10 - $70**]** per visit/per person up to a maximum of **[**$300 - $500**]** per person/per **Calendar Year**
PREVENTIVE CARE BENEFIT	**[**$50 - $150**]** per visit/per person up to a maximum of **[**$150 - $300**]** per person/per **Calendar Year**
OUTPATIENT DIAGNOSTIC X-RAY & LAB BENEFIT	**[**$10 - $80**]** per visit/per person up to a maximum of **[**$300 - $500**]** per person/per **Calendar Year**
SURGICAL BENEFIT	
[Schedule of Surgical Procedures A; B; C**]**	A maximum of **[**$400 - $5,000**]** per person/per **Calendar Year** when Surgeries are performed by a **Doctor** and are paid according to the Schedule of Surgical Procedures
DENTAL BENEFIT	
Type I & II	**[**$50 - $100**]** per visit/per person
Type III	**[**$200 - $400**]** per visit/per person
Type IV	**[**$150 - $250**]** per visit per/person up to a maximum of **[**$250 - $750**]** per lifetime/per person
The **Calendar Year** Maximum applies to the combined amounts of Types I, II, and III:	**[**$500 - $1,500**]**
Periodontal Benefit lifetime maximum:	**[**$1,500**]**
VISION CARE BENEFIT	Exam: **[**$50**]** per exam/per person limited to one exam per person/per **Calendar Year** Glasses: **[**$100**]** per pair/per person every 2 consecutive **Calendar Years** **OR** Contact Lenses: **[**$75**]** per person every 2 consecutive **Calendar Years]**

PART 3. ~ DEFINITIONS

Accident — an **Injury** sustained by **You,** which is a sudden, unforeseen, unexpected and involuntary event definite as to time and place and which is independent of disease or bodily infirmity.

Activities of Daily Living — activities, normally including:

a. Mobility;
b. Dressing;
c. Bathing;
d. Toileting;
e. Transferring;
f. Eating.

that are used to assess degree of impairment and determine eligibility for **Benefits**.

Amendment — a document that modifies this **Policy**, and becomes part of this **Policy**, also known as an **Endorsement** or **Rider**.

Ancillary Hospital Services — are those services rendered by a **Hospital** to a **Hospital Inpatient** or **Hospital Outpatient**, which supplement the diagnosis and treatment of **Illness** and **Injury** and which may or may not be **Medically Necessary** services. These services include but are not limited to:

a. Educational;
b. Nutritional;
c. Rehabilitative;
d. Social;
e. Laboratory;
f. Radiology.

Assignment — the legal transfer of one person's interest in this **Policy** to another person.

Basic Weekly Earnings — **Your** weekly earnings (excluding commissions, bonuses, incentive pay, unscheduled overtime, or other compensation earned prior to **Your** coverage under this **Policy**) as updated on the anniversary of the **Your [Employer]'s Effective Date** each year.

Beneficiary — the person or entity to whom **Benefits** for loss of life are payable.

Benefit — the dollar amount payable by **Us** to a claimant or assignee under this **Policy**.

Birthing Center is a facility, other than a **Hospital**, that creates a home-like atmosphere for the birth of infants.

Calendar Year the period from January 1 through December 31 of the same year.

Claim is a request for payment of **Benefits**.

Codependency is when a person has difficulty experiencing appropriate levels of self-esteem, setting functional boundaries, owning and expressing his own reality, taking care of his adult needs and wants, and experiencing and expressing his reality moderately.

Compulsive Gambling is gambling behavior that interferes with social or occupational functioning.

Confined/Confinement an **Inpatient** in a **Hospital** or other health care facility.

Contract Year a period of one year commencing on the **[Employer's] Effective Date of Coverage** and ending at 12:00 midnight on the last day of the one-year period.

Custodial Care services (including room and board) or supplies that are provided to an **Insured**:

a. primarily to help the **Insured** perform the **Activities of Daily Living**; and
b. that can safely be provided by **Non-Skilled Persons**; and
c. are not **Medically Necessary** to treat the condition

regardless of where these services or supplies are provided or who recommends them.

Dentist a person who is:

a. Licensed to practice dentistry and is operating within the scope of that license; or
b. Any other **Doctor** furnishing any dental services he is licensed to perform.

Dental prophylaxis performed by a hygienist employed and directly supervised by a **Dentist** will be considered the same as if performed by a **Dentist**.

Dependent the following persons:

a. **Your** spouse, as defined by state law;
b. **Your** unmarried child who is under **[**19**]** years of age (limiting age), or is a **Full-time Student** and primarily dependent upon **You** for support and maintenance and is under **[**23**]** years of age (limiting age); or
c. A child, who is incapable of self-support due to **Developmental Disability** or physical disability, provided the condition occurs prior to age **[**19**]**.

A child can include stepchildren, adopted children, or foster children, a judicially appointed minor ward of **Yours**, or a child legally placed for adoption and primarily dependent upon **You** for support.

A child can include any child you are legally responsible to provide for by virtue of a court order specifically naming you as the permanent responsible party.

Developmental Disability

a. A disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or another neurological condition closely related to mental retardation; or from
b. A condition that requires treatment similar to that required for mentally retarded individuals, which disability originates before such individual attains age **[**19**]**, which has continued or can be expected to continue indefinitely, and which constitutes a substantial handicap to such individual.

Doctor a person who is:

a. Licensed and recognized as a **Doctor** by the State in which he practices; and
b. Practicing within the scope of his license; and
c. Performing a service for which **Benefits** are provided under the **Policy**.

Is not a person who:

a. Ordinarily resides in **Your** household; or
b. Is a member of **Your** immediate family; or
c. Is **Your [Employer].**

Doctor's Office Visit medical evaluation and/or care received in a **Doctor's** office, **Outpatient** clinic, or **Urgent Care** facility (not a **Hospital Emergency Room**).

Durable Medical Equipment equipment that is made to:

a. Withstand prolonged use;
b. Be used mainly in the treatment of an **Illness** or **Injury**;

c. Be used while not **Confined** as an **Inpatient**; and
d. Be used mainly by persons who have an **Illness** or **Injury**.

Effective Date — the date on which coverage under this **Policy** begins.

Effective Date of Coverage — the date coverage under this **Policy** goes into effect for an **[Employer]** and for any eligible **[Employees]** and **Dependents**.

Eligible Services Or Supplies — **Medically Necessary** services or supplies received by or on behalf of an **Insured** for treatment of a covered **Illness** or **Injury** that are not excluded under this **Policy**.

Emergency Room — a staffed and equipped **Hospital** room or **Hospital** area for the reception and treatment of persons with conditions, such as **Illness** or **Injury**, requiring immediate medical care.

[Employee] — a person who is employed by, and paid by, the **[Employer]**.

[Employer] — the entity named on the Application and the **Summary of Benefits,** who has applied for coverage under this **Policy**.

Endorsement — a document that modifies this **Policy**, and becomes part of this **Policy**, also known as an **Amendment** or **Rider**.

Experimental/Investigative — is a treatment, procedure, facility, equipment, drug, device, or supply which meets one or more of the following criteria as determined by **Us:**

a. The treatment cannot be lawfully marketed without approval of the U.S. Food and Drug Administration, an approval for marketing has not been given at the time it is provided; or
b. The treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
c. If **Reliable Evidence** shows that the treatment is the subject of ongoing clinical trials, or is under study to determine its maximum tolerated dose, toxicity, safety, efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
d. If **Reliable Evidence** shows that the prevailing opinion among experts regarding the treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

"**Reliable Evidence**" shall mean only published reports and articles in the authoritative medical and scientific literature, the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure, or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Full-time Student a **Dependent** who:

a. Attends an accredited college, vocational or high school; and
b. Is enrolled in sufficient courses to maintain full-time status as defined by the institution in which the **Dependent** is enrolled.

Full-time Student status will continue during school vacation if the **Dependent**:

a. Was enrolled as a **Full-time Student** immediately prior to the vacation; and
b. Intends to return as a **Full-time Student**.

We may require proof of **Full-time Student** status.

Hospital a licensed health care facility which:

a. Provides acute care; and
b. Provides 24-hour nursing services; and
c. Provides **Inpatient** therapeutic and diagnostic services for **Injury** or **Illness**; and
d. Provides facilities for major surgery or has a formal arrangement with another health care facility for surgical facilities; and
e. Is approved by the Joint Commission on the Accreditation of Health Care Facilities as a **Hospital**.

Hospital does not include:

a. A rest home or nursing home, home for the aged, or convalescent home;
b. A **Nursing Facility**;
c. A **Hospice** or a place for **Custodial Care** or a **Birthing Center**;
d. A place primarily for the treatment of **Substance Abuse Disorders**; or
e. A place primarily for the treatment of **Mental Disorders**.

Hospice is a health care facility, other than a **Hospital**, providing medical care and support services for terminally ill persons.

Hours of Work Credit — the hours worked by **You** for whom contributions have been made on **Your** behalf by **Your [Employer]**.

Illness

a. Physical sickness or disease; or
b. A **Mental Disorder** as defined under this **Policy**; or
c. Complications of pregnancy; or
d. Congenital abnormalities.

Injury — bodily harm that is caused by an **Accident** and results directly from the **Accident** and independently of all other cause.

Inpatient — a person who has been admitted to a **Hospital** or other health facility to receive diagnosis, treatment or other health services.

Insured — a person who is eligible for coverage under this **Policy** as an **[Employee]** or as a **Dependent**, is enrolled, and for whom **Premium** is paid.

Lifetime Maximum — the dollar limitation on **Benefits** that will be paid for **You** during **Your** lifetime while covered under this **Policy**.

Medically Necessary — any services or supplies provided for the diagnosis and treatment of a specific **Illness** or **Injury**, which are:

a. Ordered or recommended by a **Doctor**;
b. Required for the treatment or management of a medical condition or symptom;
c. The most appropriate supply or level of service which can safely be provided to **You**;
d. Provided in accordance with approved and generally accepted medical or surgical practice;
e. Not for the convenience of **You**, **Your Doctor**, or another **Provider**;
f. Not for services or supplies which are **Experimental or Investigational**;
g. Necessary for detoxification as an emergency medical condition provided **You** are not yet enrolled in other chemical treatment; and
h. Furnished in the least intensive type of medical care setting required by **Your** condition.

Services and supplies will not automatically be considered **Medically Necessary** because a **Doctor** ordered them.

Medical Community — a majority of **Doctors** who are Board Certified in the appropriate specialty.

Medicare — the benefits provided under Part A and Part B of Title XVIII of the Federal Social Security Act.

Mental Disorder — those neuropsychiatric, mental, or personality disorders which are listed in the International Classification of Diseases as psychoses, neuroses, personality disorders, and other non-psychotic mental disorders.

Non-Skilled Persons — are persons without special occupational skills and experience.

Nursing Facility — is a non-**Hospital**, non-acute care facility for patients who need 24-hour nursing supervision, in order to ensure that their medical, psychological, or social needs are met. The facilities offer a full range of care including rehabilitation, and specialized nutritional, social service and activity programs.

Nursing Facility does not include:

a. A rest home or nursing home, home for the aged, or convalescent home, to the extent such facility does not satisfy the above definition;
b. A **Hospice** or a place for **Custodial Care** or a **Birthing Center**;
c. A place primarily for the treatment of **Substance Abuse Disorders**; or
d. A place primarily for the treatment of **Mental Disorders**.

Outpatient — an individual who receives health care services where he is not admitted to a **Hospital** or other health care facility.

Policy — this contract.

Policy Anniversary — the date twelve months after the date of the **[Employer's] Effective Date of Coverage** under this **Policy**, or as indicated on the **Policy** Specification page.

Premium — the dollar amount paid by **Your [Employer]** and/or **You** to keep this **Policy** in force.

Proof of Good Health — evidence satisfactory to **Us** that the person meets **Our** requirements for good health.

Proof of Loss — a statement that must be furnished by **You** to **Us** before any **Benefits** may be paid under this **Policy**.

Provider	any **Doctor**, health professional, **Hospital**, **Nursing Facility**, home health agency or other person or recognized entity licensed to provide **Hospital** or medical services to **Insureds** covered under this **Policy.**
Rate	the pricing factor upon which **Your [Employer's]** and/or **Your Premium** is based.
Reinstatement	the resumption of coverage, which has lapsed under this **Policy**.
Renewal	Continuance of coverage under this **Policy** beyond its original term by **Our** acceptance of the **Premium** for a new **Policy** term.
Rider	a document that modifies this **Policy**, and becomes part of this **Policy**, also known as an **Endorsement** or **Amendment**.
Service Waiting Period	the length of time **You** must wait from **Your** date of employment or application for coverage, until **Your** coverage is effective.
Substance Abuse Disorder	the psychological or physical dependence on, or addiction to, alcohol, drugs, and other controlled substances.
Summary of Benefits	are the pages of this **Policy,** which list the **Benefits** selected by **Your [Employer]** and **You**.
***Temporomandibular Joint Syndrome* (TMJ)**	the symptoms associated with, or exhibited as a malfunction of, the temporomandibular joint. These are frequently caused by, but not exclusive to: **a.** Improper or incorrect space between the maxilla and mandible; **b.** Improper dental occlusion; and/or **c.** Muscular spasm in the **TMJ** area.
Totally Disabled/ Total Disability	**Your** inability to perform the substantial and material duties of a gainful occupation for which **You** are fitted by education, training and experience.
Urgent Care	is medical treatment for non-life threatening injuries that require immediate medical attention, medical treatment for acute minor **Illness** and general family medical care on a walk-in basis.
We/Us/Our/Company	Symetra Life Insurance Company.

Well Child Care the periodic review of a child's physical and emotional status and includes the following in keeping with prevailing medical standards:

a. A medical history;
b. Complete physical examination;
c. Developmental assessment;
d. Anticipatory guidance;
e. Appropriate immunizations;
f. Laboratory tests; and
g. Hearing and vision screening.

Workers' Compensation insurance against liability imposed on certain employers to pay insurance benefits and furnish care to employees injured, and to pay benefits to dependents of employees killed in the course of or arising out of their employment.

PART 4. ~ [EMPLOYEE] ELIGIBILITY

Eligible [Employees] - Hours of Work Credit

Each **[Employee]** of a **[Employer]** who meets all of the following conditions is eligible for coverage under this **Policy**:

a. Performing all the normal duties of his job at the normal place of business of the **[Employer]**;
b. Working in an eligible class as shown in the **Summary of Benefits** section of this **Policy**; and
c. Has worked and been paid for at least the minimum required hours at the normal place of business of the **[Employer]**.

The Date You are Eligible for Coverage

You become eligible for coverage upon completion of the **Service Waiting Period**. The **Service Waiting Period** is shown in the **Summary of Benefits**.

Effective Date of Your Coverage

In order to become covered under this **Policy**, **You** must first enroll in writing on a form approved by **Us** giving the information **We** require.

If **You** are not required to contribute to the cost of **Your** coverage, coverage will become effective on the first day of the month following the latest of the following dates:

a. The date **Premium** is received; or
b. The date following completion of the **Service Waiting Period,** if any; or
c. The date **We** approve the **Proof of Good Health,** which is required when **You** had previously rejected coverage for any reason. **Proof of Good Health** must be submitted to **Us** at **Your** expense.

[EMPLOYEE] ELIGIBILITY ◈ Continued

If **You** are required to contribute to the cost of **Your** coverage, the date coverage begins will depend on the date **You** enroll for coverage. However, it will be the first day of the month following the latest of the following dates:

a. The date **Premium** is received; or
b. The date following completion of the **Service Waiting Period**, if any; or
c. The date **You** enroll for coverage; or
d. The date **We** approve the **Proof of Good Health**, which is required when:

i. Enrollment is more than 31 days after the date **You** become eligible; or
ii. Coverage ceases at **Your** request and **You** again elect to be covered; or
iii. **You** failed to pay the required **Premium** and **You** again elect to be covered.

Proof of Good Health must be submitted to **Us** at **Your** expense.
If **You** converted **Your** life insurance to an individual policy when **Your** employment with **Your [Employer]** ended, and if **You** are rehired, and the conversion policy is still in force, **Your** eligibility for Life Insurance under this **Policy** will be deferred until **You** surrender the individual life insurance conversion policy.

Reinstatement

If **You** have ceased to be eligible for coverage **You** may qualify for **Reinstatement** within 90 days from the date **You** were last eligible. **You** will be reinstated and eligible for coverage on the first day of the calendar month following the month in which **You** work and are paid for the minimum required hours. If **You** do not qualify for **Reinstatement** within 90 days from the date **You** were last eligible, **You** will be treated as a new **[Employee]**.

PART 5.~ DEPENDENT ELIGIBILITY

Eligible Dependents

A **Dependent** of **Yours** is eligible for coverage under this **Policy** if:

a. **You** are an **Insured** under this **Policy**;
b. **You** are in a class that qualifies for **Dependent Benefits**;
c. The **Dependent** is not covered as an **[Employee]** under this **Policy;** and
d. If both **You** and **Your** spouse are covered under this **Policy** as **[Employees]**, either, but not both, may elect to cover children who are eligible **Dependents**.

Date a Dependent is Eligible for Coverage

A **Dependent** is eligible to be an **Insured** on the later of:

a. The date **You** become eligible for **[Employee]** coverage; or
b. The date **You** acquire **Your** first **Dependent**; or
c. The first day of the month following the date the **Dependent** first meets the definition of **Dependent** under this **Policy**.

Effective Date of Dependent Coverage

In order for a **Dependent** to become an **Insured**, **You** must first enroll the **Dependent** in writing on a form approved by **Us** within 31 days of acquiring a new eligible **Dependent** for **Dependent** coverage giving the information **We** require.

If **You** are not required to contribute to the cost of **Dependent** coverage, **Dependent** coverage will become effective on the first day of the month following the latest of the following dates if the **Dependent** is not **Confined** on that date:

a. The date **Premium** is received; or
b. The date **You** become eligible for **Dependent** coverage; or
c. The date the person becomes a **Dependent**; or
d. The date **We** approve the **Proof of Good Health** for a **Dependent**, which is required when **You** reject **Dependent** coverage for any reason. **Proof of Good Health** must be submitted to **Us** at **Your** expense.

If **You** are required to contribute to the cost of **Dependent** coverage, **Dependent** coverage will become effective on the first day of the month following the latest of the following dates if the **Dependent** is not **Confined** on that date:

a. The date **Premium** is received; or
b. The date **You** become eligible for **Dependent** coverage; or
c. The date **You** enroll for **Dependent** coverage; or
d. The date **We** approve the **Proof of Good Health** for a **Dependent**, which is required when:

i. **You** enroll for **Dependent** coverage more than 31 days after the date **You** become eligible for **Dependent** coverage; or
ii. **You** reapply for coverage for a previously covered **Dependent** whose coverage:

(a) Ended at **Your** request; or
(b) Ended due to **Your** failure to make a required **Premium** contribution.

Proof of Good Health must be submitted to **Us** at **Your** expense for each **Dependent**.

If **You** did not elect **Dependent** coverage before the birth or adoption of a child, the **Hospital Benefits** of this **Policy** will be provided for that child, if:

a. **You** notify **Us** in writing of the birth or adoption of such child; and
b. **You** authorize **Your [Employer]** to make the required payroll deductions toward the cost of **Your Dependent** coverage within 60 days of the date of birth or adoption.

We require **You** to notify **Us** of additional **Dependents** to assure accurate **Claims** handling.

If a **Dependent**, other than a newborn child, is **Confined** to a **Hospital** or other health care facility on the date he would otherwise become an **Insured**, he will become an **Insured** on the first day following his release from the **Hospital** or health care facility.

Court Ordered Health Coverage for Dependent Children

This section applies to all **Benefits** shown in the **Summary of Benefits** of this **Policy**, with the exception that this section shall not apply to **[Employee]** Life, **Dependent** Life, Accidental Death

& Dismemberment, or Non-Occupational Disability Income Weekly benefits whether or not shown on the **Summary of Benefits**.

If a **You** are eligible for **Dependent** coverage under this **Policy**, and **You** are required under an **Order** to provide health insurance coverage for a child, **You** may enroll such child for **Dependent** coverage under this **Policy** regardless of enrollment period restrictions.

If **You** are enrolled under this **Policy** for coverage, but **You** did not enroll the child for **Dependent** coverage under this **Policy**, regardless of enrollment period restrictions, enrollment on behalf of such child, may be made by:

a. The non-insuring parent;
b. A child support enforcement agency; or
c. The state agency administering the Medicaid program.

You may not terminate coverage for the child unless written evidence is provided to **Us** that:

a. The order is no longer in effect;
b. The child has been or will be enrolled under other reasonable health insurance coverage that will take effect on or before the effective date of the termination;
c. **Your [Employer]** has eliminated **Dependent** coverage for all of its **[Employees]**; or
d. **Your** employment with **Your [Employer]** ceases, except if **You** elect to exercise the Extension of Coverage Benefit, coverage shall then be provided for the child consistent with the provisions of the Extension of Coverage Benefit for post-employment coverage for **Dependents**.

Enrollment for coverage of a child of **Yours** will not be denied because the child:

a. Was born out of wedlock;
b. Is not claimed as a **Dependent** on **Your** federal income tax return; or
c. Does not reside with **You**.

If the child has coverage through **You**, **We** shall:

a. Provide to the non-insuring parent membership cards, claims forms, and any other information necessary for the child to obtain **Benefits** through the coverage; and
b. Process the claims forms and make appropriate payment to the non-insuring parent, health care provider, or state Medicaid agency if the non-insuring parent incurs covered expenses for health care provided to the child.

""**Order**" means a ruling that:

a. Is issued by a court of this State or another state or an administrative agency of another state; and
b. Creates or recognizes the right of a child to receive **Benefits** under a parent's health insurance coverage.

PART 6. ~ BENEFIT CHANGES

Change in Amounts of Benefits

Any change in the amount of **Benefits** due to a change in **Your** class or status, will be effective on the first of the month following the month in which **You** work and are paid for the minimum required hours, provided:

a. **You** are performing all the normal duties of **Your** job at your **[Employer's]** normal place of business; and
b. **You** make any required payment for the change to be effective.

Changes in amounts of **Benefits,** due to an **Amendment, Endorsement** or **Rider** to this **Policy** or **Your [Employer]'s** coverage under this **Policy,** will take effect for **You** on the **Effective Date** of the **Amendment, Endorsement** or **Rider**.

Benefits payable under this **Policy** will be based on the coverage in effect at the time death occurred or the **Eligible Services or Supplies** were received.

Change in Amounts of Coverage

Once **You** have made **Your Benefit** elections for a given year, **You** can not change those elections until **Your [Employer's]** next open enrollment. Increases in the amount of **[Employee]** coverage are effective on the first of the month following the latest of the following dates:

a. The date of change; or
b. The date **We** approve any required Proof of Good Health

provided, **You** are performing all the normal duties of **Your** job at your **[Employer's]** normal place of business.

Decreases in the amount of **[Employee]** coverage are effective on the first of the month following the date of change, provided **You** are performing all the normal duties of **Your** job at your **[Employer's]** normal place of business.

PART 7. ~ TERMINATION PROVISIONS

Termination of Your Coverage

Your coverage will cease on the earlier of:

a. The date this **Policy** is canceled;
b. The date **Your [Employer's]** coverage ceases under this **Policy**; or
c. The last day of the month in which the first of the following occurs:

i. **Your** membership in an eligible class ceases;
ii. **Your** employment with **Your [Employer]** ceases;

iii. **You** or **Your [Employer]** cease **Premium** payments for **Your** coverage;
iv. **You** are pensioned or retired, as defined by **Your [Employer]**;
v. The date **You** begin active duty in the armed forces.

In addition, if **You** are classified as an hourly **[Employee] Your** coverage will cease on the first day of the month following any month in which **Your Hours of Work Credit** fall below the required number of hours, as established by **Your [Employer].**

Termination of Dependent Coverage

Dependent coverage, if applicable, will cease on the earliest of:

a. The date this **Policy** is canceled;
b. The date **Your** coverage ceases;
c. The date **We** cancel all **Dependent** coverage under this **Policy**; or
d. Last day of the month in which the first of the following occurs:

i. **You** are no longer in a class eligible for **Dependent** coverage; or
ii. The **Dependent** ceases to be an eligible **Dependent**.

In addition, coverage under this **Policy** will cease for a **Dependent** on the first day of the month following any month in which **Your** number of hours worked falls below the minimum required hours.

With respect to the **Benefits** of this **Policy**, coverage will be continued for a **Dependent** child beyond the limiting age as long as the child continues to be both:

a. Incapable of self-sustaining employment by reason of **Developmental Disability** and/or physical handicap; and
b. Primarily dependent on **You** for support and maintenance.

Proof of such incapacity must be given to **Us** not more than 31 days after the date such **Dependent** attains the limiting age and subsequently as required by **Us**, but not more often than once per year after the initial two year period from the date such **Dependent** attains the limiting age.

See "Continuation of Coverage", "Extension of Inpatient Hospital Benefits", "**[Employee]** Life Insurance Conversion Rights" and "**Dependent** Life Insurance Conversion Rights" provisions for exceptions to Part 7 Termination Provisions.

PART 8. ~ CONTINUATION OF COVERAGE

Under the conditions that follow, **Benefits** for **You** and **Your** covered **Dependents** may continue beyond the day coverage would otherwise cease under the "Benefit Changes" and "Termination Provisions" sections if the required **Premium** is paid and this **Policy** is in force for **Your [Employer]** during the continuation period.

Coverage under this **Policy** will not continue if **You** begin work for pay or profit with another employer.

CONTINUATION OF COVERAGE◈ Continued

Your Coverage

In the following circumstances, employment will be deemed to continue as shown, or until **Your [Employer]**, acting under rules that preclude individual selection, terminates **Your** employment:

Cause of Absence	Period in which Employment is Deemed to Continue	Coverage
Illness or **Injury**	6 months	All coverages
Temporary Lay-Off	2 months	All coverages
Leave of Absence	2 months	All coverages

Upon written request from **Your [Employer]**, **We** may agree in writing to continue **Your** coverage for situations other than those listed above.

Dependent Coverage

If any of the situations above apply to **You**, **Dependent** coverage may continue until **Your** coverage ends.

PART 9. ~ SURVIVOR BENEFIT

Upon **Your** death, all **Dependent** eligible **Benefits,** excluding Life Insurance, may be continued with no **Premium** due, for **Dependents** covered under this **Policy**. All of the **Dependent** coverage will cease on the earliest date below:

a. The date the **Insured** no longer qualifies as a **Dependent** as defined in this **Policy**; or
b. The date **Your** spouse remarries; or
c. The date the **Dependent** becomes eligible for any other plan that includes **Inpatient Hospital Benefits**; or
d. The date **Your** spouse qualifies for **Medicare**; or
e. The date a **Dependent** child attains this **Policy's** limiting age for children; or
f. The termination date of this **Policy**; or
g. Two years from the date of **Your** death.

PART 10. ~ [EMPLOYEE] NON-OCCUPATIONAL DISABILITY INCOME WEEKLY BENEFIT

This Benefit applies only if it is shown in the Summary of Benefits.

Benefits begin on the day shown in the **Summary of Benefits**. No more than the maximum shown in the **Summary of Benefits** will be paid for any one **Disability**.

We will pay **Weekly Benefits** only if **You**:

a. Are **Disabled** due to an **Injury** or **Illness**; and
b. Are totally and continuously **Disabled** during both the benefit waiting period and the **Benefit Period**; and
c. Are under the care of a **Doctor**; and
d. Become **Disabled** while covered under this **Policy**; and
e. Do not engage in any work for wage or profit.

Your Doctor will be required to provide **Us** with periodic confirmation of **Disability**.

We reserve the right to have **You** examined by a **Doctor** of **Our** choice at **Our** expense.

Benefits will cease if **You**:

a. Refuse to submit to an examination by **Our Doctor**; or
b. Have an examination, which does not support the continued **Disability** status.

If the **Weekly Benefit** is overpaid, **We** will have the right to recover the amount overpaid.

Definitions

As used in this **Benefit:**

"**Disabled/Disability**" means an **Injury** or **Illness** which, during the benefit waiting period and until **You** reach the end of the maximum **Benefit Period**, prevents **You** from performing each of the main duties of **Your** regular occupation.

"**Weekly Benefits**" means the amount of any **Disability** payment that will be made on a weekly basis, based on a 5-day workweek, as payment by **Us** of an approved **Claim**.

"**Benefit Period**" means:

a. Any one **Period of Disability**; or
b. Any two or more **Periods of Disability** separated by less than one full day of active work.

Separate **Benefit Periods** exist when any two or more **Periods of Disability** are:

a. Due to unrelated causes separated by at least one full day of active work; or
b. Due to the same or related causes separated by at least two weeks of active work.

"**Period(s) of Disability**" means only that **Period of Disability** following treatment by a licensed **Doctor**.

Exclusions and Limitations

Weekly Benefits will not be paid if **Your** total **Disability** results from or is contributed to by the following:

a. **Injury** or **Illness** arising out of, or in the course of, any employment for wage or profit;
b. **Injury** or **Illness** which is covered under any Workers' Compensation or similar law;
c. A period of total **Disability** when **You** are not under the care of a **Doctor**;
d. Intentional self-inflicted **Injury**;
e. Participation in an act of war, declared or undeclared;
f. Participation in a riot; or
g. Attempt or commission of an assault or felony.

PART 11. ~ [EMPLOYEE] LIFE INSURANCE BENEFITS

If **You** die while covered under this **Benefit**, **Your** amount of Life Insurance will be paid upon **Our** receipt of due proof of **Your** death. The proceeds will be paid to **Your** designated **Beneficiary**. Any amount of insurance for which there is no designated **Beneficiary** at **Your** death will be payable, at **Our** option, to:

a. **Your** estate; or
b. The following surviving relatives:

i. **Your** spouse;
ii. **Your** children, born to or legally adopted by **You**;
iii. **Your** parents;
iv. **Your** siblings;

Assignment of Benefits

You may assign **Your** Life Insurance **Benefits** under this **Policy**. An **Assignment** will transfer **Your** interest and that of any **Beneficiary** to the assignee. Any such **Assignment** will remain in force until changed by the assignee. No **Assignment** will be in effect until **We** receive and acknowledge a copy of it. **We** are not responsible for the validity or sufficiency of any **Assignment**.

Once the insurance has been assigned, **Benefits** are payable to the **Beneficiary** named by the assignee. If there is no living named **Beneficiary**, **We** will pay the assignee, if living, otherwise the assignee's estate. The Beneficiary Provisions will not apply.

PART 12. ~ [EMPLOYEE] LIFE INSURANCE CONVERSION RIGHTS

You may convert **Your** Life Insurance Benefit to an individual policy, without **Proof of Good Health**, as explained below. **You** must apply to convert by written application within 31 days of the date **Your** coverage under this **Policy** ceases.

You may convert only if **Your** insurance ceases because:

a. **Your** employment ceases for any reason; or
b. **Your** membership in an eligible class of **[Employees]** ceases; or
c. **Your [Employer's]** coverage under this **Policy** is amended to cancel the insurance of any class of **Insured [Employee]**; or
d. The coverage under this **Policy** is canceled by **Your [Employer]** or by **Us**.

In addition, if **Your** insurance ceases as stated in c. or d. above, **You** must have been continuously insured for 5 years under this **Policy** to be eligible to convert.

We will issue the individual policy of life insurance under the following conditions:

a. The policy will be any level-premium, level-benefit policy, usually issued by **Us**, except term insurance.
b. The policy will not include total and permanent disability benefits or additional benefits for accidental death.
c. The premium for the policy will be for the class of risk to which **You** belong.
d. The premium will be for the kind and amount of the policy at **Your** age, based on **Your** nearest birthday, as of the day the policy is issued.
e. The amount of the policy can be any amount up to the amount of group insurance that ceased, unless the group life insurance ceased due to termination or **Amendment** of the **[Employer's]** coverage under this **Policy**. If so, the amount that can be converted is limited to the lesser of:

  i. The amount of group insurance that **You** had when such coverage ceased, less the amount of insurance that **You** may become eligible for under any Group Life Insurance Plan issued by **Us** or by another insurer within 31 days after the coverage under this **Policy** ceases; or
  ii. **[**$2,000**]**.

f. The first payment for the policy must be made to **Us** within the 31-day period during which **You** apply for the policy.
g. Insurance under the policy will become effective at the end of the 31-day period during which application may be made. If **You** die during this 31-day period **We** will pay to **Your Beneficiary** the maximum amount for which an individual policy could have been issued under this provision. This is payable whether or not **You** made written application for conversion.

PART 13. ~ [EMPLOYEE] ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

We will pay the **Benefit** as shown in the Table of Benefits if **We** receive proof that **You** sustained a **Loss** as a result of an **Injury** that occurred while covered under this **Benefit**, and the **Loss**:

a. Was the direct result of an **Accident**;
b. Was independent of all other causes; and
c. Occurred within one year of the **Accident**.

"**Loss**" means:

a. As to hands and feet, total and irrecoverable loss by actual severance through or above the wrist or ankle joints;
b. As to eyes, the total and irrecoverable **Loss** of sight, which cannot be medically or surgically treated by artificial means.

Table of Benefits

The Benefit Amount will be shown in the **Summary of Benefits**.

In the Event of **Loss** of:	The Benefit Amount Will Be At:
Life	100%
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Sight of One Eye	100%
One Foot and Sight of One Eye	100%
One Hand	50%
One Foot	50%
Sight of One Eye	50%

The maximum paid for all **Losses** in any one **Accident** is the Benefit Amount. Only one Benefit Amount will be paid for all **Losses** resulting from one **Accident**. **We** will pay the largest Benefit Amount to which **You** are entitled. Payment will be made to **You** or in the event of **Your** death, to the named **Beneficiary**.

Exclusions and Limitations

Benefits are not provided under this **Policy** for **Loss** that results, in whole or in part, from:

a. Participation in a riot, insurrection, or rebellion, or the commission of or attempting to commit an assault, battery, felony, or act of aggression;
b. Participation in declared or undeclared war or acts thereof;
c. Serving on full-time active duty in any Armed Forces of any country or international authority (any **Premium** paid will be returned by **Us** pro rata for any period of active full-time duty);
d. Any **Injury** or **Illness** arising out of or in the course of work for wage or profit;
e. Any **Injury** or **Illness** covered by any Workers' Compensation Act, Occupational Disease Law, or similar law;
f. **Illness**, bodily or mental infirmity, or diagnosis or treatment thereof;
g. Disease or infection, other than an infection occurring through an accidental cut or wound;
h. Suicide or attempted suicide or intentional self-inflicted **Injury**; or

i. Operating a motor vehicle while legally intoxicated as defined by the laws of the state in which the **Accident** occurred, or under the influence of any excitant, hallucinogen, narcotic, other drug, or similar substance unless administered and taken under the advice of a **Doctor**.

PART 14. ~ DESIGNATION OF BENEFICIARY

Life insurance proceeds under this **Policy** will be paid to the **Beneficiary** named by **You**, on a form satisfactory to **Us**.

When more than one **Beneficiary** is shown, payments will be shared equally unless specified otherwise. If any stated **Beneficiary** dies before **You**, such deceased **Beneficiary's** share will be payable equally to the **Beneficiaries** who survive.

If on the date **You** die, there is no named **Beneficiary**, or no living named **Beneficiary** for any part of the coverage, **We** may, at **Our** option, pay that part to:

a. **Your** spouse;
b. **Your** children, born to or legally adopted by **You**;
c. **Your** parents;
d. **Your** siblings; or
e. **Your** estate.

Our liability is discharged to the extent of payment.

Change in Beneficiary

You may change the **Beneficiary** by submitting written notice to **Us**. Naming a new **Beneficiary** in a conversion application will change the **Beneficiary** under this **Policy**. Once submitted, the change is effective on the date signed, unless the prior designation has already been acted on.

Minor as Beneficiary

If the **Beneficiary** is:

a. A minor; or
b. Otherwise incapable of giving a valid release.

We may, at **Our** option, and until **Claim** is made by the duly appointed guardian, pay the **Benefit** to any person or institution appearing to have assumed the custody and support of the **Beneficiary**. The **Benefit** will be paid at a monthly rate not to exceed $50. **Our** liability is discharged to the extent of payment.

Settlement Provision

Death **Benefits** may be paid under a settlement option. Any option offered by **Us** may be chosen. **You** may choose the option and change it at any time. If no option is in force at the time of death, the **Beneficiary** may choose one. **Benefits** will not be paid under a settlement option to: an executor, an administrator, a trustee, a corporation, a partnership, or an association. The interest rate will be **Our** current option rate for the year of death. The minimum rate is 3% per year.

PART 15. ~ DEPENDENT LIFE INSURANCE BENEFITS

We will pay the amount of Life Insurance for **Dependents** shown in the **Summary of Benefits** upon **Our** receipt of due proof of the **Dependent's** death while covered under this **Benefit**.

The **Benefit** will be paid to **You**, if living at the time of death of the **Dependent**. If **You** are not living, at **Our** option payment will be made to the following:

a. The **Dependent's** estate; or
b. The following surviving relatives of the **Dependent**:

i. Spouse;
ii. Children;
iii. Parents; or
iv. Siblings.

Our liability is discharged to the extent of payment.

PART 16. ~ DEPENDENT LIFE INSURANCE CONVERSION RIGHTS

If all or part of a **Dependent's** insurance ends solely because:

a. **Your** insurance ends while this **Policy** remains in force;
b. **Your** status changes;
c. **You** die; or
d. The **Dependent's** status changes;

then the **Dependent** may convert. The largest amount that can be converted is the amount that ended.

If a **Dependent's** insurance ends because:

a. This **Policy** ends;
b. All **Dependent** Life Insurance under this **Policy** ends; or
c. **Dependent** Life Insurance for an entire class ends; and

d. **You** have been continuously insured for **Dependent** Life insurance under this **Policy** for at least 5 years on the date insurance ends, the **Dependent** may convert.

The largest amount that can be converted is the smaller of:

a. The amount which ended less any amount of **Dependent** group life insurance for which **You** become eligible within 31 days after this insurance ends; or
b. **[**$2,000**]**.

[DEPENDENT] LIFE INSURANCE CONVERSION RIGHTS ◈ Continued

Conditions:

a. No **Proof of Good Health** is required;
b. Written application must be made to **Us**. It must be delivered or mailed to **Us** with the first premium within 31 days after insurance ended;
c. **We** will issue, at **Our** option, any of **Our** current conversion policies. A conversion policy is any individual life insurance policy except term;
d. The effective date will be 31 days after this insurance ends; and
e. **We** will base the premium on:

i. The policy's current rates; and
ii. The **Dependent's** Attained age; and
iii. The **Dependent's** Class of risk; and
iv. The type and amount of insurance.

Benefit for Death During the Conversion Period

If a **Dependent** dies while eligible for conversion, **We** will pay a death benefit. This benefit is the largest amount that could have been converted. The benefit is payable whether or not application was made for the conversion policy.

Payment of Benefit

We will make payment to the **Beneficiary** if one is named, or else to **You** if living. Otherwise, **We** may, at **Our** option, pay to:

a. The **Dependent's** estate; or
b. The following surviving relatives of the **Dependent**: spouse, children, parents, or siblings.

Our liability is discharged to the extent of payment.

PART 17. ~ ACCIDENT BENEFIT

This Benefit applies only if it is shown in the Summary of Benefits.

Benefits will be paid as shown in the **Summary of Benefits** for **Eligible Services or Supplies** that are received as a result of an **Injury** or an **Accident** that occurs while the **Insured** is covered under this **Benefit.**

The following services or supplies must be received within one year of the date of the **Injury**:

a. Medical, dental or surgical treatment, or supplies;
b. **Confinement** in a **Hospital**;
c. X-ray and lab exams;
d. Registered nurses; and
e. Prescription drugs.

Exclusions and Limitations

The **Benefits** of this section will not be paid for the cost of services or supplies received in an **Emergency Room**.

PART 18. ~ EMERGENCY ROOM BENEFIT

This Benefit applies only if it is shown in the Summary of Benefits.

Emergency Room Benefits will be paid as shown in the **Summary of Benefits** for **Eligible Services or Supplies** that are received in an **Emergency Room** as a result of an **Accident** or **Illness** that occurs while **You** are covered under this **Benefit**.

Exclusions and Limitations

The **Benefits** of this section will not be paid for the cost of services or supplies received during a **Doctor's Office Visit**.

PART 19. ~ PREVENTIVE CARE BENEFIT

This Benefit applies only if it is shown in the Summary of Benefits.

Preventive Care benefits will be paid as shown in the **Summary of Benefits** for **Eligible Services or Supplies** received while **You** are covered under this **Benefit**.

Annual Physical Examination

Benefits will be paid, as shown in the **Summary of Benefits,** for an annual physical examination for **You, Your** covered spouse and **Your** covered **Dependent** child if the services are provided by, or under the supervision of, only one **Doctor** during the course of one visit. Covered services include:

a. Physical examination;
b. X-rays; and
c. Laboratory tests including, but not limited to, a Pap test, colorectal screening and prostate cancer screening.

Mammogram

Benefits will be paid, as shown in the **Summary of Benefits,** for a screening mammogram, with the following frequency:

a. For age 39 and under - one baseline mammogram; or
b. For age 40 and over - one annual mammogram; or
c. More frequently than as indicated in "a or b" above, based on **Your Doctor's** recommendation.

Well Child Care

Benefits will be paid, as shown in the **Summary of Benefits,** for **Well Child Care** from the moment of birth to age 6 years if the services are provided by, or under the supervision of, only one **Doctor** during the course of one visit.

Well Child Care rendered to a newborn child prior to initial discharge from the **Hospital**, includes, but is not limited to:

a. Services or supplies for **Hospital** nursery care;
b. Special **Hospital** services or supplies;
c. Services or supplies for circumcision;
d. Services or supplies for **Doctor** visits during this **Hospital Confinement**.

PART 20. ~ SURGICAL BENEFIT

This Benefit applies only if it is shown in the Summary of Benefits.

Surgical benefits will be paid, as shown in the **Summary of Benefits** for covered surgical procedures, as shown on the Schedule of Surgical Procedures, performed in connection with an **Illness** or **Injury** while **You** are covered under this **Benefit**. Surgical benefits will not exceed the maximum amount shown in the **Summary of Benefits**.

If two or more surgical procedures are done at the same time, the total **Benefit** amount payable will be limited to the annual surgical maximum amount shown in the **Summary of Benefits**.

Exclusions and Limitations

No Surgical benefits will be paid for the cost of surgical anesthesia.

No Surgical benefits will be paid for **Ancillary Hospital Services** or supplies received in conjunction with a surgical procedure or other **Illness,** except as stated in the **Summary of Benefits**.

No Surgical benefits will be paid for oral surgery except for:

a. Surgical excision of impacted third molars; or
b. Closed or open reduction of fracture or dislocation of the jaw.

PART 21. ~ DOCTOR'S OFFICE/URGENT CARE/OUTPATIENT HOSPITAL BENEFITS

This Benefit applies only if it is shown in the Summary of Benefits.

The **Doctor's Office Visit, Urgent Care** and **Outpatient Hospital Benefits**, will be paid as shown in the **Summary of Benefits**, for **Eligible Services or Supplies** received while **You** are covered under this **Benefit,** not to exceed the applicable maximum shown in the **Summary of Benefits**.

Exclusions and Limitations

Doctor's Office Visit, Urgent Care and **Outpatient Hospital Benefits** do not include:

a. Services or supplies for preventive care, including but not limited to routine physicals, general health exams, routine immunizations and vaccinations;
b. Care received in an **Emergency Room**; or
c. **Inpatient** or **Outpatient** surgical procedures.

PART 22. ~ INPATIENT HOSPITAL BENEFIT

This Benefit applies only if it is shown in the Summary of Benefits.

Inpatient Hospital Benefits will be paid as shown in the **Summary of Benefits**, for eligible **Inpatient Hospital** services or supplies received while **You** are covered under this **Benefit**. **We** will pay the specified daily **Benefit** for each day of **Hospital Confinement**. The **Benefits** will not exceed the maximum **Inpatient Hospital Benefit** as shown in the **Summary of Benefits**.

Inpatient Hospital Benefits will be paid only if all of the following are met:

a. The **Insured** is **Confined** in a **Hospital**; and
b. The **Confinement** is **Medically Necessary**; and
c. A charge is made for room and board; and
d. The entire duration of such **Hospital Confinement** is recommended and approved by a **Doctor**; and
e. **Confinement** is the result of a non-occupational **Injury** or **Illness**; and
f. The services and supplies are not excluded under the Exclusions and Limitations provision of this **Policy**.

In addition to **Benefits** for **Hospital Confinements**, **Benefits** will be paid as shown in the **Summary of Benefits** for **Eligible Services or Supplies** received for **Your** care in the following facilities:

a. A licensed **Nursing Facility**; or
b. A licensed substance abuse facility which is primarily for the treatment of a **Substance Abuse Disorder**; or
c. A licensed mental health facility which is primarily for the treatment of a **Mental Disorder**

provided the facility is operating within the scope of its license, and:

a. **You** are **Confined** in the facility;
b. The **Confinement** is **Medically Necessary**;
c. A charge is made for room and board;
d. The entire duration of such **Confinement** is recommended and approved by a **Doctor**; and
e. The services or supplies are not excluded under the Exclusions and Limitations provisions of this **Policy**.

Extension of Inpatient Hospital Benefits

Inpatient Hospital Benefits will continue to be paid under this **Policy** when **Your** coverage terminates, if, on the date coverage would otherwise terminate **You**:

a. Are **Totally Disabled**; and
b. Are **Confined** to a **Hospital** for the disabling **Illness** or **Injury**.

Benefits paid under this extension will continue to be paid until the earliest of these dates:

a. The date which is 90 days from the date coverage would have otherwise terminated;
b. The date on which the disabled **Insured's Inpatient Hospital Benefit** has reached the maximum amount as shown in the **Summary of Benefits**;
c. The date **Total Disability** ceases; or
d. The date **You** become covered under another group policy.

This extension of **Benefits** applies only to the disabled **Insured** and no **Premium** is due during this extension.

Exclusions and Limitations

Inpatient Hospital Benefits do not include:

a. Care received in an **Emergency Room**; or
b. Care received in an **Outpatient Hospital** department or clinic or **Urgent Care** facility;
c. **Inpatient** or **Outpatient** surgical procedures.

PART 23. ~ OUTPATIENT X-RAY AND LABORATORY BENEFIT

This Benefit applies only if it is shown in the Summary of Benefits.

Outpatient Diagnostic X-ray and Laboratory **Benefits** will be paid as shown in the **Summary of Benefits**, for **Eligible Services or Supplies** received for **Outpatient** diagnostic x-ray and laboratory tests when ordered or performed by a **Doctor** and while **You** are covered under this **Benefit**.

Exclusions and Limitations

Benefits for **Outpatient** diagnostic x-ray and laboratory tests will not be paid if **You** are **Confined** in:

a. A **Hospital**;
b. A licensed **Nursing Facility**;
c. A licensed **Substance Abuse Disorder** facility; or
d. A licensed **Mental Disorder** facility.

PART 24. ~ DENTAL BENEFIT

This Benefit applies only if it is shown in the Summary of Benefits.

Dental Benefits as shown in **the Summary of Benefits** will be paid for **Eligible Dental Services and Supplies** while **You** are covered under this **Benefit**. However, such **Benefits** will not exceed the applicable maximum shown in the **Summary of Benefits**.

Eligible Dental Services and Supplies means services and supplies for dental care that are:

a. Required to maintain generally acceptable dental health;
b. Recommended and provided by a licensed **Dentist**;
c. Commonly recognized in the dental profession as acceptable treatment for the condition; and
d. Not excluded under this **Policy**.

Eligible Dental Services and Supplies will be considered received on the following date for:

a. Fixed bridgework, crowns, inlays or onlays - the date the involved tooth is prepared;
b. Removable partial or complete dentures - the date the first impression was taken;
c. Root canal therapy - the date the pulp chamber of the tooth is opened.

Types of Dental Care

Eligible Dental Services and Supplies are limited to the following Types of Dental Care per **Insured**:

Type I

a. Oral exams - routine oral examination including diagnosis, but not more than 2 examinations per **Calendar Year**;
b. Prophylaxis - including cleaning, scaling, and polishing, but not more than 2 times per **Calendar Year**;
c. Fluoride treatment - limited to children 14 years of age or younger;
d. Space maintainers;
e. Palliative emergency treatment; and
f. X-rays - one series of full mouth x-rays every 3 consecutive **Calendar Years**, and 2 series of bitewing x-rays per **Calendar Year**.

Type II

a. Laboratory tests and other diagnostic examinations;
b. Sealants - limited to children 14 years of age or younger, only for a tooth or teeth posterior to cuspids, and not more than one application per **Calendar Year** per tooth;
c. Simple (routine) extractions;
d. Surgical extractions;
e. Oral surgery;
f. Alveolectomy;
g. Anesthesia;
h. Therapeutic injections;
i. Restorations - fillings of amalgam or synthetic process;
j. Denture repair and bridge repair;
k. Endodontics - a charge will be deemed incurred on the date the tooth was opened for root canal therapy; and
l. Periodontal treatment.

Type III

a. Inlays;
b. Onlays;
c. Crowns;
d. Prosthetics, including bridges, and dentures as follows:

i. Initial installation, or addition to full or partial dentures, fixed or removable bridgework if the installation or addition was required to replace one or more teeth extracted while **You** are covered under this **Policy**; and the denture or bridgework is completed within 12 months following the date of extraction.
ii. Replacement or alteration of full or partial dentures, fixed or removable bridgework if the existing denture or bridgework:

1. Is at least 5 years old; and
2. Cannot be made serviceable; and
3. Is completed within 12 months after one of the following:

a) An accidental **Injury** which requires surgical treatment; or
b) Oral surgical treatment which involves the repositioning of muscle attachments, or the removal of a tumor, cyst, torus, or redundant tissue.

Type IV

a. Orthodontic appliances - furnishing and attachment of any necessary orthodontic appliance.
b. Orthodontic treatment - based on a written treatment plan submitted to **Us** within 90 days before the start of treatment.

Benefits will be paid as shown on the **Summary of Benefits** for orthodontic **Eligible Dental Services and Supplies** that:

a. Are received while the **You** are covered under this **Benefit**; and
b. Are for any one course of treatment,

Alternative Course of Treatment

If alternative services are appropriate to treat a dental condition, those services will be limited to those:

a. Which are customarily employed in the treatment of the condition; and
b. Which are recognized in the dental profession to be appropriate according to broadly accepted national standards of dental practice.

Dental Examination

We will have the right to have **You** examined at **Our** expense as often as may be reasonably required while a **Claim** is pending.

Treatment Plan

If the treatment can be expected to involve **Eligible Dental Services and Supplies** in excess of $250, a treatment plan should be submitted to **Us** before treatment begins.

Replacement

The replacement of a tooth or teeth extracted but not replaced prior to the **Effective Date** of **Your** coverage under this Dental **Benefit** will be covered provided:

a. The tooth or teeth were extracted and eligible for replacement under the prior plan; and
b. The replacement was completed within the first year following **Your Effective Date** under this Dental benefit.

The replacement of full or partial dentures and fixed or removable bridgework, within 2 years after **Your Effective Date** under this Dental benefit, will be covered provided:

a. Other replacement rules listed under the "Type of Dental Care" section of this **Policy** were met; and
b. **Your** coverage was continuous for a combined period of at least 2 years with the prior plan and this Dental benefit.

Dental Exclusions and Limitations

Benefits will not be paid for the costs of services or supplies:

a. Received from the dental or medical department of any **[Employer]**, union, employee benefit association, trustee, or similar organization, or for services of a **Dentist** or clinic contracted for or by any organization;
b. Cosmetic dental care, which includes, but is not limited to:

  i. Laminates;
  ii. Veneers; or
  iii. Tooth bleaching.

c. For replacement of a tooth or teeth extracted prior **Your Effective Date** unless the replacement satisfies one of the conditions listed under "Replacement" and "Types of Dental Care";

d. For dentures, crowns, inlays, onlays, bridgework, or appliances for increasing vertical dimensions;
e. For denture or bridgework adjustments within 6 months of the placement of a denture or bridgework;
f. For replacement of a lost or stolen prosthesis or for a duplicate prosthesis;
g. For oral hygiene, dietary or plaque control instructions and programs;
h. For athletic mouth guards;
i. For porcelain veneered crowns or pontics on or replacing a tooth or teeth posterior to the second bicuspid, which exceeds the maximum **Benefit** amount as shown in the **Summary of Benefits** for acrylic veneered crowns or pontics;
j. For a temporary denture or bridge that, when combined with the charge for the permanent denture or bridge, exceeds the maximum **Benefit** amount as shown in the **Summary of Benefits** for the permanent denture or bridge;
k. For missed or broken appointments;
l. For tooth re-implantology not resulting from an **Accident**;
m. For drugs, other than injectable antibiotics administered by a **Dentist** as a result of dental treatment;
n. For procedures, services, or supplies, which do not meet accepted standards of dental practice;
o. For treatment initiated while not covered under this **Policy**, except for Orthodontic Treatment or as specified under "Replacement"; or
p. Not included in "Types of Dental Care".

PART 25. ~ VISION BENEFIT

This Benefit applies only if it is shown in the Summary of Benefits.

Vision Care benefits will be paid as shown in the **Summary of Benefits** while the **Insured** is covered under this **Benefit**.

Services and supplies must be rendered or prescribed by an ophthalmologist, optometrist, or a person licensed to provide covered vision care and is acting within the scope of his license.

Exclusions and Limitations

Vision **Benefits** will be not paid for:

a. Any medical or surgical treatment of the eye;
b. Sunglasses, plain or **Prescription**, or safety lenses or goggles; or
c. Orthoptics, vision training, or aniseikonia.

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PART 26. ~ CLAIM PROVISIONS

Notice of Claim

Written notice of **Claim** must be given to **Us** within 20 days after the date any **Injury**, **Illness**, or loss occurs or begins. If such notice is not furnished within that 20-day period, a **Claim** will still be considered for payment and will not be denied or reduced due to the delay if it is shown that notice was given as soon as was reasonably possible.

Claim Forms

We will furnish forms for filing **Proof of Loss** after **We** receive the Notice of **Claim**. If such forms are not furnished within 15 days of receipt of the notice, the claimant will be deemed to have met with the terms of this provision of this **Policy** if he submits written **Proof of Loss** within the time set forth in the **Proof of Loss** provision.

Proof of Loss

Written proof of claim must be given to **Us** within 90 days after the following:

a. For Weekly Income Benefits**,** the date of **Disability**; or
b. For any other **Benefit,** the date of loss or treatment.

However, the **Claim** will not be denied or reduced if:

a. It is not reasonably possible to give proof in that time; and
b. Proof is submitted within one year from the date of loss or treatment.

This one-year period will not apply when **You** are legally incapable of submitting proof. All **Proof of Loss** or loss must be satisfactory to **Us**.

Notice and Proof of Death

Written notice of death must be given to **Us** at **Our** administrator's office, Select Benefits Administrators of America. within 90 days after the date of death.

We will furnish forms for filing proof of death after **We** get notice of death. If such forms are not furnished within 15 days of receipt of notice of death, the claimant will be deemed to have met with the terms of this **Policy**.

If notice or proof of death is not furnished within the time limits shown, a **Claim** will still be considered for payment if it is shown that notice or proof was given as soon as was reasonably possible.

Time Payment of Claims

We will pay **Benefits** within 30 days after **We** receive all essential information needed to make a determination on the **Claim**.

For all **Disability** income **Benefits**, **We** will make payments at least as often as monthly. **We** will pay any remaining balance at the end of its period of liability.

Payment of Benefits

Benefits payable under this **Policy** will be paid directly to:

a. **You**;
b. **Your** legally appointed guardian if **You** are not legally able to accept such **Benefits**; or
c. A **Provider** of medical treatment or services upon **Your** written direction.

In the event **You** die and on the date **You** die there is:

a. No named **Beneficiary**; or
b. No living named **Beneficiary**

We may, at **Our** option, pay any **Benefits** due under this **Policy** to the following surviving relatives of **Yours**:

a. **Your** Spouse;
b. **Your** Children; or
c. **Your** parents; or
d. **Your** siblings; or
e. **Your** estate

Any payment made in good faith fully discharges **Us** to the extent of that payment. Failure to honor an **Assignment** to a **Provider** due to inadvertent error will not subject **Us** to double payment.

Physical Examination and Autopsy

We, at **Our** own expense, will have the right to have **You** examined as often as **We** may reasonably require while a **Claim** is pending, and to require an autopsy in the case of death, unless it is forbidden by law.

PART 27. ~ RIGHT TO APPEAL A DENIED CLAIM

The Select Benefits plan has a procedure for appealing **Claim** decisions. If **You** disagree with a decision on a **Claim**, **You** or **Your** representative may, within 180 days of receiving an initial denial notice (or within the stated time period above if **You** receive no response regarding **Your Claim**) submit a written request to:

Select Benefit Administrators of America
118 Third Street East
P.O. Box 440
Ashland, WI 54806
1-800-497-3699

a. Include comments and questions in writing.
b. Review documents that apply to **Your Claim**.

If **Your** written request for review is not received within 180 days of receiving a denial notice, **You** will forfeit **Your** right to an appeal.

PART 28. ~ EXTENSION OF COVERAGE BENEFIT

Extension of Coverage applies to all **Benefits** shown in the **Summary of Benefits** of this **Policy**, with the exception that Extension of Coverage shall not apply to **[Employee]** Life, **Dependent** Life, Accidental Death & Dismemberment, or Non-Occupational Disability Income Weekly benefits whether or not shown on the **Summary of Benefits**.

You and **Your Dependents** may qualify to temporarily extend the medical, dental, and vision **Benefits** of this **Policy** at group rates (Extension of Coverage) in certain situations where coverage would otherwise end.

You may choose Extension of Coverage for **Yourself** and any covered **Dependent** if **You** lose **Your** group medical, dental, and vision coverage because of a reduction in hours or termination of employment (for reasons other than gross misconduct). If **You** are a covered spouse, or **Dependent** child of an **[Employee]**, **You** may choose Extension of Coverage for **Yourself** if **You** lose group medical, dental, and vision coverage for any of the following reasons (qualifying event):

a. **Your** spouse dies;
b. **Your** spouse's or **Your** parent's employment ends (for reasons other than gross misconduct), or his hours are reduced;
c. **You** or **Your** parents divorce or legally separate;
d. **Your** spouse, or parent becomes entitled to Medicare; or

Covered **Dependent** children of an **[Employee]** may continue coverage if they cease to qualify as **Dependents** under the group medical, dental, and vision plan. **You** or **Your Dependent** are responsible for notifying **Your [Employer]** when certain qualifying events occur. These events include divorce or legal separation and ceasing to qualify as a **Dependent** under the group plan.

Your [Employer] must be notified within 60 days of the later of:

a. The event; or
b. The date coverage would end because of the event.

You have 60 days to elect Extension of Coverage from the later of:

a. The date **You** lose coverage due to the event; or
b. The date **Your [Employer]** informed **You** that **You** may choose Extension of Coverage.

If **You** do not choose Extension of Coverage, **Your** group medical, dental, and vision coverage with **Your [Employer]** will end. If **You** choose Extension of Coverage, it will be identical to the medical, dental, and vision coverage **You** and/or **Your Dependents** had immediately prior to the date coverage ended. **[Employee]** Life insurance, Accidental Death & Dismemberment insurance, Non-Occupational Disability Income Weekly benefit, and **Dependent** Life insurance are not included in this Extension of Coverage benefit.

If **You** elect Extension of Coverage, **You** must pay the full cost of coverage each month. **You** have the option to continue coverage for **Yourself** and/or **Your** covered **Dependents** for 18 months if **You** lose group medical, dental, and vision coverage due to termination of employment or a reduction in hours. A longer coverage period may be available in case of disability. If the Social Security Administration determines that **You** or a covered **Dependent** is disabled within the first 60 days of Extension of Coverage following termination of employment, coverage for the disabled person and all covered **Dependents** may be extended for an additional 11 months up to

EXTENSION OF COVERAGE BENEFIT◈ Continued

a total of 29 months. This same 11-month extension is provided to a disabled child if the child is born or placed for adoption during the Extension of Coverage period and the child is determined to be disabled within the first 60 days of Extension of Coverage. In order to qualify for coverage extension, **You** must notify **Your [Employer]** before the end of the 18-month Extension of Coverage period and provide a copy of the Social Security disability determination letter within 60 days of the determination date. If, during the 18-month Extension of Coverage period, *another* qualifying event takes place, coverage may be extended for up to 36 months for covered **Dependents**. In no case will the total Extension of Coverage period exceed 36 months.

Extension of Coverage may be terminated for any of the following reasons:

a. **Your [Employer]** no longer provides group medical, dental, and vision coverage to any **[Employees]**;
b. **You** do not pay the **Premium** for **Your** Extension of Coverage on time;
c. **You** become covered under another group medical, dental, and vision plan that does not include a preexisting condition exclusion or limitations on preexisting conditions you may have after the date of your Extension of Coverage election;
d. **You** become entitled to Medicare after the date of **Your** Extension of Coverage election; or
e. The person whose Social Security disability enabled the extended coverage is determined to have recovered.

If **You** have any questions about Extension of Coverage, contact the **Your [Employer].**

PART 29. ~ EXCLUSIONS AND LIMITATIONS

In addition to the Exclusions and Limitations listed in the Benefit sections, this section applies to all Benefits payable under this Policy.

Benefits will not be paid for the cost of services or supplies:

a. For which there is no legal obligation to pay;
b. Received after Termination of Coverage, except as provided under this **Policy**;
c. Which are not **Medically Necessary**;
d. Which are not furnished or prescribed by a **Doctor**;
e. For **Experimental** or **Investigational** treatment, procedures for research purposes, or practices when not generally recognized as accepted medical practices, denial will not be based solely on the fact that the person was a participant in a clinical trial;
f. That are not approved or accepted as essential to the treatment of an **Injury** or **Illness** by any of the following:

  i. The American Medical Association;
  ii. The U.S. Surgeon General;
  iii. Department of Public Health; or
  iv. The National Institute of Health.

g. Related to r dental care done to beautify an **Insured** without medical or dental indication of **Injury** or **Illness;**
h. Related to cosmetic surgery to beautify an **Insured,** except for all stages of reconstructive breast surgery on the diseased breast as a result of a mastectomy as well as any surgical procedure on the non-diseased breast necessary to establish symmetry between the 2 breasts. Surgical procedure performed on a non-diseased breast to establish symmetry with

the diseased breast must occur with 5 years of the date the reconstructive breast surgery was performed on a diseased breast;

i. For reversal procedures in connection with previous male or female sterilization;
j. In the nature of educational or vocational testing or training;
k. For **Outpatient** food, food supplements, or vitamins;
l. For radial keratotomies;
m. For physical therapy, occupational therapy, or speech therapy;
n. In connection with treatment of male or female infertility, in vitro and in vivo fertilization of an ovum, or artificial insemination;
o. For **Durable Medical Equipment;**
p. For **Custodial Care;**
q. For surgical anesthesia;
r. For **Ancillary Hospital Services** or supplies in connection with surgery or other **Illness,** except as stated in the **Summary of Benefits**;
s. Related to smoking cessation;
t. For the treatment of the following:

   i. **Codependency**;
   ii. Social, occupational, or religious maladjustments;
   iii. **Compulsive Gambling**; or
   iv. Chronic marital or family problems when not related to the primary focus of treatment that must be a diagnosable **Mental Disorder**.

t. For the treatment of obesity, weight reduction, or dietetic control, except for morbid obesity or disease etiology;
u. For the following, except as specifically stated in the **Summary of Benefits** section of this **Policy**:

   i. For dental treatment and oral surgery;
   ii. For treatment of **Mental Disorders**;
   iii. For treatment of **Substance Abuse Disorders**;
   iv. For refractions, eyeglasses, or hearing aids or their fitting; or
   v. For routine physicals or general health exams, routine immunizations and vaccinations.

v. For treatment of **Temporomandibular Joint Dysfunction** (**TMJ)** pain syndrome, orofacial, or myofascial syndrome whether medical or dental in scope;
w. For an **Injury** or **Illness** caused wholly or partly, directly or indirectly by:

   i. Declared or undeclared war or act of war;
   ii. Committing or attempting to commit an assault or felony;
   iii. Inciting or taking part in any form of public violence; or
   iv. Intentionally self-inflicted **Injury**, while sane or insane.

x. Any **Illness** or **Injury** covered by any **Worker's Compensation** Act or similar law.

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SELECT BENEFIT ADMINISTRATORS OF AMERICA (SBAA)

Address and Contact Information

Select Benefit Administrators of America
PO Box 440 **or**
118 Third Street East (for overnight deliveries)
Ashland, WI 54806

Customer Service: 1-800-497-3699 **Local**: (715) 682-5990 **Fax**: (715) 682-5919

ID Cards and Certificate Fulfillment Packets

Once SBAA receives enrollment forms, fulfillment packets consisting of ID cards and certificates are printed and mailed to the policyholder who will then distribute these items to covered certificateholders. (There is a single card for both medical and prescription claims.)

If you need enrollment materials for new hires that begin after the initial enrollment period, contact SBAA. You will then receive what you need, at no additional charge.

Online Enrollment

SBAA is pleased to offer online enrollment and account access for policyholders and certificateholders. With the enrollment site, www.selectbenefitonline.net, policyholders can easily access their company plan to review and approve enrollment applications. They can also update certificateholder information.

Certificateholders can use this site to enroll in the plan as an alternative to using a paper application. They can also go online and check the status of a claim or verify their eligibility.

If you are interested in using the Select Benefits online enrollment site, talk with someone at SBAA or your Symetra Financial representative.

Open Enrollment

Policyholders will often decide to have an open enrollment period prior to their policy's effective date and at renewal. They should work with their agent or broker to notify SBAA in writing of the dates planned for the open enrollment, as well as gain their agent's assistance in coordinating the meetings and enrollment material.

Evidence of Insurability for Late Entrants

If certificateholders or their dependents do not enroll within 31 days of their eligibility, they are required to show "evidence of insurability" for life and disability income benefits. SBAA provides *Proof of Good Health* and *Authorization for Release of Medical Information* forms which the certificateholders or their dependents need to complete and sign. The policyholder attaches completed forms to the certificateholder's enrollment form and sends it to SBAA. Late entrants' coverage becomes effective the first day of the month following SBAA approval of the application.

Enrollment and *Proof of Good Health* forms are mailed to:

Select Benefit Administrators of America
Attention: Eligibility Department
PO Box 440 **or**
118 Third Street East (for overnight deliveries)
Ashland, WI 54806

Monthly Billing Procedures

Bills are printed and mailed on the 15th of each month, and premium is due by the 1st. Groups that have a monthly rate will be sent a standard list bill each month. **Policyholders need to pay as billed.**

If a certificateholder terminates during the billed month, policyholders mark the change with a single line through the certificateholder's name and write the termination date next to the name. Terminations are considered effective by SBAA on the 1st of the month, and are not allowed at any other time during the month. Policyholders may fax the termination notice to SBAA at (715) 682-5919. The notice needs to include the certificateholder's name, group number and termination date.

Policyholders cannot make any changes to the amount due. Terminations show up on the following month's bill as a retroactive termination so that policyholders receive credit on that bill. Any retroactive additions appear with the premium due. If notice of an addition or termination is received prior to the 14th of the month, the policyholder will see this change on the next month's bill. If changes come in after the 14th, they will be reflected on the subsequent bill.

If policyholders are interested in making premium payments through wire transfer, they can contact the Billing Department at 1-800-497-3699.

Hourly Plan Billing Procedures

To determine benefits for hourly plans, the previous month's hours are used. For example, hours worked in January determine the level of coverage for February.

Policyholders are required to complete an *Hours and Contribution Report* for all certificateholders participating in the plan. (SBAA can provide a sample report.) Each certificateholder, the group number and the total hours worked for the reported month must be listed on the report. The total hours reported times the hourly rate is the premium remitted.

SBAA is flexible about how reporting information is submitted. SBAA can help policyholders set up their desired format and assist with transmission, security and ease of use. For support, please call the IT Department at 1-800-497-3699.

The completed *Hours and Contribution Report* can be faxed to (715) 682-5919 or sent by e-mail. (Please call SBAA for an e-mail address.) Premium may be sent by mail or wire transfer. If sending premium through wire transfer, please contact the Billing Department for assistance. In accordance with HIPAA privacy rules, any information that includes the electronic transmission of protected health information ("EPHI") must be encrypted. Note: Premium must be remitted by the 10th of each month.

It is important for SBAA to receive the *Hours and Contribution Report* as early in the month as possible. Because previous month's hours determine current month's coverage, current hours are critical when quoting benefit levels to certificateholders.

If SBAA does not receive hours and contribution information for a certificateholder, he or she will be terminated from the plan. If hours are received within 90 days of termination, the certificateholder will be reinstated effective for the month SBAA receives hours and contribution. If it is beyond 90 days, the certificateholder must complete a new enrollment form since the individual is treated as a new certificateholder.

Medical Claim Processing

When going to a medical provider, a certificateholder should present the Select Benefits ID card. If the provider accepts an assignment of benefits, this allows the provider to bill SBAA directly and saves the certificateholder time. SBAA can process the claim and pay the provider directly. The provider is under no obligation to accept an assignment. Certificateholders receive an *Explanation of Benefits* ("EOB") in the mail showing what was paid and the balance not covered by their plan. If they need to see a provider before receiving an ID card, covered certificateholders can call 1-800-497-3699 and a customer service representative can assist them.

If a certificateholder has a provider who will not submit insurance information, the certificateholder needs to obtain an itemized bill from his or her provider listing dates of service, procedure and diagnosis codes. SBAA cannot process a claim without CPT/procedure codes and ICD9/diagnosis codes. Certificateholders should ask for *Health Care Financing Administration (HCFA)* claim forms from the doctor's office and *UB92* forms if seen at a hospital. (However, SBAA also accepts the standard claim forms used by most providers. Symetra can also provide the certificateholder with a standard claim form, LG-12058.) The certificateholder can then send completed forms to SBAA to be paid directly. Neither a provider's billing statement with a remaining balance, nor another insurer's EOB, is acceptable documentation to process the claim.

Claims should be mailed or faxed to:

Select Benefit Administrators of America
Attention: Claims Department
PO Box 440 **or**
118 Third Street East (for overnight deliveries)
Ashland, WI 54806
Fax: (715) 682-5919

Occasionally, a certificateholder has a provider who does not honor Select Benefits ID cards. In this situation, the certificateholder can have the provider call SBAA customer service at 1-800-497-3699 to verify coverage.

The following disability income and life insurance claim information only pertains to group policies that include such benefits.

Disability Income Claims

SBAA provides *Disability Income Claim* forms that policyholders can use when they have a certificateholder that is out of work due to a covered nonwork-related illness or injury.

When a claim is filed, it is important that policyholders inform SBAA of premium payment/deduction information. SBAA needs to know if premium is collected on a pretax or after-tax basis, and what portion of premium the policyholder pays. This information is important to determine whether or not the benefit is taxable since SBAA deducts and reports the certificateholder-paid (or withheld) portion of taxes from the disability income payment. This information will be sent to policyholders whenever they have a certificateholder receiving disability income benefits.

All Social Security, Medicare (FICA) and FIT withholdings are deposited directly to the IRS as required by Public Law 97-123. This law requires policyholders to report and deposit an equal amount with the IRS for the required withholdings to Social Security and Medicare (FICA).

SBAA is not required by law to prepare W-2 forms that policyholders must use to report Social Security, Medicare and FIT withholdings. It is important that policyholders keep this information to assist them in preparing W-2s at the end of the year. Policyholders may prepare a supplemental W-2 form that addresses only sick pay benefits, or sick pay benefit information may be included on regular W-2 forms.

For questions about disability income issues, policyholders can contact SBAA customer service at 1-800-497-3699.

Life Insurance Claims

If a certificateholder, or dependent of a certificateholder, dies while covered under the group policy's life insurance benefit, please contact a Life Claims representative at 1-800-497-3699 for assistance.

Life Insurance Conversion Option

If a certificateholder terminates and wishes to exercise his or her right to convert the life insurance coverage under the group policy to an individual policy, the certificateholder needs to complete a *Conversion Information Request* form. This form is included in the policyholder's welcome kit or can be requested from SBAA.

Prescription Drug Claims

The current prescription drug policy benefits are administered by RESTAT.

Policies with Co-Pays

If a policyholder elects a prescription co-pay plan, the pharmacy benefit can be accessed with the same Select Benefits ID card used for filing medical claims. When filling a prescription, the certificateholder takes this card to a participating pharmacy that processes it at point of service.

Along with their ID card, certificateholders receive information about the pharmacy mail-in option. For more details, certificateholders can call SBAA. SBAA staff has access to RESTAT online information.

Certificateholders who do not receive their ID cards and pay for their prescriptions out-of-pocket can mail in their receipt for reimbursement.

Requests for reimbursement are sent to:

RESTAT
Patient Reimbursement
PO Box 758
West Bend, WI 53095-0758

Note: This applies only to the co-pay plans, not the discount plan. All manual reimbursements on prescriptions take 30-45 days to process.

Pharmacy Discount

To access the pharmacy discount, certificateholders must go to a participating pharmacy. The discount will vary due to formulas used to calculate the discount. Neither SBAA nor RESTAT will process discount reimbursements.

Continuation of Benefits

If coverage terminates because of qualifying events as defined in the contract, the certificateholder has the option to continue coverage under the group policy. The certificateholder's coverage ends when the policyholder notifies SBAA of the termination. Continuation of benefits commences when the certificateholder completes the form required to elect this option and remits the required first and subsequent premium payments to SBAA. The policyholder does not need to track these benefits. SBAA will automatically administer these benefits unless the employer informs SBAA otherwise, in writing.

Survivor Benefit

If a certificateholder dies while covered under Select Benefits, all covered dependents will be extended benefits (other than Dependent Life) without premium payments for up to two years after the certificateholder's death. The policyholder's group policy must remain in force and the covered dependent(s) must meet the coverage requirements in the policy. SBAA can work with policyholder groups to help surviving dependents use their benefits.

Select Benefit Administrators of America is a division of Employee Benefit Consultants, Inc., a Symetra company.

SYMETRA®
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Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004
www.symetra.com

Select Benefits is insured by Symetra Life Insurance Company and is not available in all U.S. states or any U.S. territories.

SYMETRA SELECT BENEFITS
STEPS TO ENROLLMENT SUCCESS

Symetra Life Insurance Company offers a variety of enrollment support, including national and regional enrollment coordinators for groups with 50 or more eligible lives. But whether you're enrolling one-on-one or hosting a meeting for several hundred, following these simple steps can help deliver the results you want.

1 **Finalize Plan Design**
- Establish the effective date of coverage

2 **Identify Enrollment Logistics**
- Number of locations
- Number of employees at each location
- Open enrollment dates - for each location
- Payroll dates
- End date for open enrollment
- Date payroll stuffers to be inserted with paychecks

3 **Determine Enrollment Methods**
- Online
- Paper

4 **Order and Distribute Enrollment Materials**
- Enrollment kits

Kit orders must be received at least 10 business days prior to the enrollment date. Send requests to your regional group manager (RGM) or, for groups with 50 or more lives, your enrollment coordinator.
- Employee and manager letters
- Stuffers
- Posters

These items can be ordered from our Web site, www.symetra.com/selectbenefits, by calling 1-800-706-0700, sending email to invest@symetra.com or by working with your RGM or enrollment coordinator.

5 **Enroll**
- One-on-one meetings
- Group meetings
- Managers' meetings
- First payroll deduction

Education and communication are key components in helping employees make informed decisions about their benefits. Symetra has resources to ensure you have a successful enrollment; so please contact us for support.

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Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004
www.symetra.com

Symetra Select Benefits is insured by Symetra Life Insurance Company, 777 108th Avenue NE, Suite 1200, Bellevue, WA 98004, and is not available in all U.S. states or any U.S. territory.

BROKER OR AGENT USE ONLY

Click here to clear page

SYMETRA FINANCIAL

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004-5135
1-800-796-3872
TTY/TDD 1-800-833-6388

Select Benefits Case Transmittal Sheet

Agents/Advisors: Please fill out and forward to Select Benefit Administrators of America (SBAA) along with a copy of the employer's plan matrix and *completed* application. (Complete means all fields are filled in and boxes checked.)

Coverage may be delayed if these steps are not followed correctly. An incomplete application will be sent back to you.

Application Checklist

☐ The *Plan Selected* field notes which plan(s) from the matrix is being offered. For example, if the matrix shows four plans and the employer is only choosing Plan 1, "Plan 1" should be noted in that space.

☐ The employer signed and dated the application.

☐ The writing agent signed and dated the application.

☐ Any premium checks are made out to Select Benefit Administrators of America.

Enrollment Checklist

Date enrollment begins _____/_____/_____

Number of days to complete enrollment _____

Are there multiple locations? ☐ Yes ☐ No

Will there be group employee meetings prior to enrollment? ☐ Yes ☐ No

Date of first payroll deduction _____/_____/_____
Payroll deductions must be complete prior to the effective date.

Enrollment method(s) to be used (check all that apply).
Requests must be received at least 10 business days prior to the enrollment date.
SBAA will contact you once the enrollment method(s) is ready.

☐ Group meetings ☐ Online ☐ Live person call center ☐ Integrated voice response call center

☐ Paper enrollment forms
Completed enrollment forms must be received by SBAA at least 10 business days prior to the *requested* effective date.

Do you want plan-specific enrollment books?
☐ Yes Complete the Enrollment Booklet Order Form (LGS-5878).

☐ No Notify SBAA where general use enrollment packets need to be mailed. (Available in English or Spanish.)

☐ Fax or mail the plan matrix along with this completed case transmittal sheet and application to:
Select Benefit Administrators of America
Fax: (715) 682-5919
PO Box 440 (or 118 Third St. E. for overnight deliveries)
Ashland, WI 54806
sbaa@selectbenefit.net

For questions about enrollment or administration, contact SBAA at 1-800-497-3699 or sbaa@selectbenefit.net, Monday through Friday, 6:30 a.m. to 5 p.m. CT. For sales support, call your Symetra Financial sales representative.

SYMETRA FINANCIAL

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004

APPLICATION

Select Benefit Administrators of America

Policyholder (Legal Name)_____ Administrative Contact _____

Street Address _____ Title _____

City _____ State TN Zip _____ Telephone (____)_____ Fax (____)_____

Mailing Address _____ Requested Effective Date _____

City _____ State _____ Zip _____ Nature of Business _____

Number of Full-Time Employees:_____ ***Number of Eligible Employees:*** _____

Waiting Period for Plan Eligibility_____

Eligible Classes of Employees:_____

Open Enrollment Period at Renewal? ☐ ***Yes*** ☐ ***No***

Plan Selected: Medical/RX/Accident ***Employer Contribution*** _____ *(hourly)* ***or*** _____ *(monthly)*

Directions:

1. Complete this form in its entirety.
2. Attach the plan matrix chosen by the Employer to the back of this sheet.

Note: All Applications not fully completed will not be accepted and will be returned to the Agent/Broker.

Conditions:

1. This Application is subject to acceptance by Symetra Life Insurance Company.
2. The initial rate guarantee will be for 12 months following the effective date.
3. This plan is not intended to replace major medical coverage.
4. All necessary administrative information concerning all covered persons shall be subject to the provisions of the policy and shall be furnished to Symetra by the Employer.
5. All benefits shall be in accordance with those agreed to by Symetra.

Deposit:

A deposit of $_____ is hereby submitted to apply to the first premium payment due under the policy, if issued. Coverage is subject to Symetra Home Office approval and nothing contained herein shall be binding until approved. The deposit will be returned in full if coverage is not issued. Payment of a premium after delivery of the policy shall constitute acceptance of the terms and conditions.

Please read the following notice that we are required by law to give to you.

Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Employer's Application and Certification:

I agree that all statements and answers recorded on this Application are true and complete to the best of my knowledge and belief, and shall form a part of any policy issued.

Signed by _____ Title _____ Date _____

Servicing Agent's Certification:

I hereby certify that:

a) All information set forth above is correct to the best of my knowledge;
b) I have complied fully with the underwriting guidelines;
c) I have explained this Application and the proposed insurance plan in detail to the applicant; and
d) To the best of my knowledge, the above Employer is financially sound.

I further certify that all agents involved in the presentation of this account

a) are licensed by Symetra Life Insurance Company; or
b) have submitted the necessary paperwork to become a licensed agent through Symetra Life Insurance Company.

Agency:_____

Agent Name (Print) _____ Signature _____ Date _____

Address _____ Agent License Number _____

City _____ State ____ Zip _____ Tax ID Number_____

Telephone (____)_____ Fax (____)_____ Stat. Number _____

SYMETRA®
FINANCIAL

SELECT BENEFITS ENROLLMENT FORM

[Mail completed forms to:
Select Benefit Administrators of America
118 3rd Street East or PO Box 440
Ashland, WI 54806
1-800-497-3699]

This Election for Coverage Cannot Be Processed Unless all Questions Are Answered and the Form Is Signed and Dated.

PART I - TO BE COMPLETED BY THE CERTIFICATEHOLDER

Certificateholder's Name (Last, First, Middle)			Social Security #	Date of Birth / /
Certificateholder's Home Address	City	State	Zip Code	Home Phone #
Sex ☐M ☐F	Policyholder's Name		Date of Hire	

DEPENDENT INFORMATION - Complete if you Are Applying for Family Coverage

No person can be insured under this policy as both a Certificateholder and a dependent, or as a dependent of more than one Certificateholder. Please complete the following information for each family member you wish to cover.

Dependent Name (Last, First, Middle)	Sex	Date of Birth	Relationship to Certificateholder	Full-Time Student
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

BENEFICIARY DESIGNATION - Complete if Your Policy has a Life Insurance Benefit

PRIMARY (P) - The person(s) you want to receive the life insurance benefit if you die. If more than one primary beneficiary is named, and a specific percentage is not designated, each receives an equal share of the benefit.
CONTINGENT (C) - The person(s) you want to receive the life insurance benefit if you die and no primary beneficiary is alive on that date. If more than one contingent beneficiary is named, and a specific percentage is not designated, each receives an equal share of the benefits.
NOTE: The Group Policyholder may not be named as a Beneficiary.

BENEFICIARY DESIGNATION

Full Name & Address	Date of Birth	Relationship	Primary (P) Contingent (C)	% of Benefit

YES, I DO WANT THIS COVERAGE

- I elect coverage for insurance for which I am eligible under the terms of the group policy, or policies, issued to the policyholder by Symetra Life Insurance Company.
- I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance. **(Not applicable if the Policyholder pays 100% of the required contribution.)**
- I designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death.
- All information submitted by me on this form is true and complete to the best of my knowledge and belief.

Certificateholder Signature _____ Date Signed _____

A Change in Enrollment Status Form must be completed for any changes such as marriage/divorce, name change, beneficiary change, birth or adoption of a child. <u>This new form must be dated and signed.</u>

PART II - TO BE FILLED OUT BY THE POLICYHOLDER

☐ New Certificateholder ☐ Late Entrant Enrollee ☐ Open Enrollment Effective Date of Coverage ____/____/____

Case Number _____

Select Benefits
Declination of Group Insurance

I have been given the opportunity to enroll in the Select Benefits group insurance plan provided by my employer. I have decided ***not*** to elect this coverage.

I understand that if I decide to enroll in this insurance plan at a later date, satisfactory proof of insurability may be required.

_____ _____

Employee signature Date signed

Click here to clear form.

SYMETRA FINANCIAL

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004-5135
1-800-426-7784

SELECT BENEFITS
Claim Form for Policy Benefits

When seeing a provider, you have two options for filing a claim.

Option 1: Provider Submission – The more common way to submit a claim for benefits to Symetra is to present your Select Benefits ID card to your provider. Ask your provider to assign your benefits at the time of service and to bill the policy administrator, Select Benefit Administrators of America directly.

Note: The provider is under no obligation to accept an assignment.

Option 2: Certificateholder Submission – If you paid your provider at the time of service, you may submit a claim via this form. Simply complete the following information.

Name of Insured: _____

Date of Birth: _____ Group Number: _____

Patient Name: _____ Relationship to Insured: _____

- Attach a copy of your itemized receipt for services, or claim form given to you by your provider (doctor's office, clinic, hospital or similar). *Please note – an Explanation of Benefits from another insurance plan is not an acceptable form of receipt for services.*
- Verify that the following information is shown on the attached receipt or form:
  - ✓ Patient name
  - ✓ Provider name, address and identification number
  - ✓ Diagnosis or ICD-9 code(s) [description of your medical condition]
  - ✓ Procedure or CPT or revenue codes [indicates the services rendered]
  - ✓ Charges
  - ✓ Date(s) of service
- Mail or fax to:

  Select Benefit Administrators of America
  Attention: Claims Department
  P.O. Box 440
  Ashland, WI 54806

  Fax: (715) 682-5919
  Phone: 1-800-497-3699

Benefits are subject to eligibility at the time of service and subject to any plan limitations that may apply.
Benefits can only be determined after receipt of a claim; this is not a guarantee of payment.