

SERFF Tracking Number: SYMT-127866507 State: Arkansas
Filing Company: Symetra Life Insurance Company State Tracking Number: 50407
Company Tracking Number: LGC-10018
TOI: H17G Group Health - Prescription Drug Sub-TOI: H17G.000 Health - Prescription Drug
Product Name: Select Benefits
Project Name/Number: Outpatient Prescription Drug Indemnity Policy/LGC-10018

Filing at a Glance

Company: Symetra Life Insurance Company

Product Name: Select Benefits

TOI: H17G Group Health - Prescription Drug

Sub-TOI: H17G.000 Health - Prescription Drug

Filing Type: Form

SERFF Tr Num: SYMT-127866507 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 50407

Co Tr Num: LGC-10018

Authors: Mary Ellen Mckendry, Jen
Franklin

Date Submitted: 12/06/2011

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 12/07/2011

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: Outpatient Prescription Drug Indemnity Policy

Project Number: LGC-10018

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer, Association, Trust

Filing Status Changed: 12/07/2011

State Status Changed: 12/07/2011

Created By: Jen Franklin

Corresponding Filing Tracking Number: LGC-10018

Filing Description:

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Overall Rate Impact:

Deemer Date:

Submitted By: Jen Franklin

Arkansas Department of Insurance

Symetra Life Insurance Company, NAIC#: 1129-68608

SERFF Tracking Number: SYMT-127866507 State: Arkansas
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Re: Select Benefits Group Outpatient Prescription Drug Indemnity Policy and Certificate
Policy LGC-10018P-AR 10/11
Certificate LGC-10018C-AR 10/11
Employer Application LGC-9096AR 12/11
Memorandum of Variable Text VAR10018GEN- 10/11

Enclosed please find copies of the above-referenced forms hereby submitted for filing and approval. Variable information is indicated by brackets []. This is a new form and has not been filed before in Arkansas. This form does not replace any form currently filed with your department. The forms are submitted in final printed form. Also enclosed are the Employer Application LGC-9096AR 12/11 and Memorandum of Variable Text VAR10018GEN- 10/11.

The policy form will be issued on a direct issue basis to groups defined as eligible under Arkansas state insurance law.

The Policy pays a pre-selected fixed dollar amount for each qualifying prescription. It provides benefits for both generic and brand name prescription drugs. It has no pre-existing condition limitations.

With regard to marketing information, this Policy will be offered on a contributory or non-contributory basis, where the insured may be required to contribute none, all, or a portion of the premium. Coverage will be marketed through agent/broker solicitation.

We trust that with all this information you will be able to approve this filing. We hope to make these forms effective upon your approval. Should you have any question, please contact me at 1-800-426-7784 X68835, or my direct line at 425-256-8835. My email address is maryellen.mckendry@symetra.com.

Sincerely,

Mary Ellen McKendry
Senior Contract Analyst
Benefits Division, Compliance

SERFF Tracking Number: SYMT-127866507 State: Arkansas
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Company and Contact

Filing Contact Information

Mary Ellen McKendry, Contract Analyst maryellen.mckendry@symetra.com
 777 108th Avenue N.E., Suite 1200 425-256-8835 [Phone]
 Bellevue, WA 98004

Filing Company Information

Symetra Life Insurance Company	CoCode: 68608	State of Domicile: Washington
777 108th Ave NE, Suite 1200	Group Code: 1129	Company Type: Insurance
Bellevue, WA 98004-5135	Group Name:	State ID Number:
(800) 796-3872 ext. [Phone]	FEIN Number: 91-0742147	

Filing Fees

Fee Required? Yes
 Fee Amount: \$150.00
 Retaliatory? No
 Fee Explanation: 1 policy = \$50.00
 1 certificate = \$50.00
 1 application = \$50.00
 Total= \$150.00

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Symetra Life Insurance Company	\$150.00	12/06/2011	54298291

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/07/2011	12/07/2011

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Project Name/Number: Outpatient Prescription Drug Indemnity Policy/LGC-10018

Disposition

Disposition Date: 12/07/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: SYMT-127866507 State: Arkansas
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	No
Supporting Document	Application	Approved-Closed	No
Supporting Document	Transmittal	Approved-Closed	No
Supporting Document	Fee schedule	Approved-Closed	No
Supporting Document	Variability	Approved-Closed	No
Form	Outpatient Prescription Drug Indemnity Policy	Approved-Closed	No
Form	Outpatient Prescription Drug Indemnity Certificate	Approved-Closed	No
Form	Employer Application	Approved-Closed	No

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Form Schedule

Lead Form Number: LGC-10018

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	LGC-10018P-AR	Policy/Contract	Outpatient Prescription Drug Indemnity Policy Certificate	Initial			AR-Indemnity Rx LGC-10018P-AR 10-11.pdf
Approved-Closed	LGC-10018C-AR	Certificate	Outpatient Prescription Drug Indemnity Certificate	Initial			AR-Indemnity Rx LGC-10018 1C-AR 10-11.pdf
Approved-Closed	LGC-9096AR	Application/Enrollment Form	Employer Application	Initial			AR-LGC-9096 12-11App .pdf

SELECT BENEFITS

**OUTPATIENT
PRESCRIPTION DRUG INDEMNITY POLICY**

POLICY SPECIFICATIONS

THIS IS A FIXED INDEMNITY PRESCRIPTION DRUG POLICY

Policyholder:

Policy Number:

Policy Effective Date:

Premium Due Date:

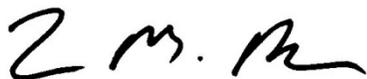
Policy Anniversary:

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

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 Executive Vice President, executed this **Policy** as of this **Policy Effective Date** and caused it to be duly countersigned at Bellevue, Washington.



Thomas Marra,
President



Michael Fry
Executive Vice President

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INTRODUCTION

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

- a. The **Policyholder** section
- b. The **Certificateholder** section

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

The **Policyholder** will be responsible for giving the **Certificateholder** section to the covered **Certificateholder**.

Whenever **We** use the terms “**You or Your**” in the **Policyholder** section, **We** mean the **Policyholder**.

Whenever **We** use the terms “**You, Your or Yourself**” in the **Certificateholder** section, **We** mean the **Certificateholder** and/or **Certificateholder’s Dependents**.

Whenever **We** use the terms “**We, Us or Our**” in the **Policyholder** or **Certificateholder** section, **We** mean Symetra Life Insurance Company (“Symetra”).

SELECT BENEFITS

**OUTPATIENT
PRESCRIPTION DRUG INDEMNITY POLICY**

[POLICYHOLDER NAME]

[POLICY NUMBER]

POLICYHOLDER SECTION

NOTICE TO BUYER

This is a limited benefit, fixed indemnity policy. This Policy provides a fixed benefit amount in the event the Insured fills a qualifying prescription. This Policy does NOT provide comprehensive coverage.

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SCHEDULE OF PREMIUM RATES

[Policyholder: XXXXXXXX]
[Policy Number: XXXXXXXX]
[Effective Date XX-XX-XXXX]

[

Coverage

Rate

Monthly

1

ASSOCIATED ENTITIES

[Policyholder: XXXXXXXX]
[Policy Number: XXXXXXXX]
[Effective Date XX-XX-XXXX]

Page 1 of 1

Insurance is extended to the **Policyholder'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]

POLICYHOLDER PROVISIONS

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 to the **Policyholder**, is hereby amended to conform to the minimum requirements of such statutes, unless otherwise forbidden by the laws of the state where the **Certificateholder** 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 **Certificateholders** or to continue coverage of terminated **Certificateholders**.

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 3 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 the officers of the **Policyholder**. 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 **Certificateholder** or **Dependent**. No agent has the authority to change this **Policy** or to waive any of its provisions.

Entire Contract

This **Policy** form, the Certificate of Coverage, the attached Application of the **Policyholder**, and all **Amendments, Endorsements** or **Riders** form the entire contract, and to the extent required by state law the applications, if any, of the **Insured** persons.

POLICYHOLDER PROVISIONS ♦ Continued

Statements Not Warranties

In the absence of fraud, all statements made by **You** 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 instrument signed by **You** or the **Insured**.

Pronouns

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

Records of the Policyholder

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:

- a. For nonpayment of **Premium**; or
- b. For fraudulent misstatements by **You**.

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 **Policyholder's** Application. The initial **Rate** guarantee period will be shown on the **Policyholder's** Application.

POLICYHOLDER 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** administrative office].

Grace Period

After **You** pay the first **Premium** due, **You** have a grace period thereafter of 31 days in which to pay the **Premium** during which coverage will continue in force. If **You** do not pay the **Premium** by the 31st day, the **Policy** will automatically terminate. If **You** give **Us** advanced written notice of an earlier termination date, the **Policy** will terminate on the earlier date, provided however, that **Premium** is due for each day the **Policy** is in force.

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** when:

- a. A change in the **Benefits** occurs which affects risk;
- b. A division, subsidiary or associated company is added or deleted;
- c. The number of **Certificateholders** changes by [25%] or more; or
- d. A new law or change in existing law is enacted which applies to the **Policy**.

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, so long as no **Claims** related to the reason for the adjustment have been paid during the period for which the refund has been requested.

Termination by the Policyholder

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

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 as communicated in writing; 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.

POLICYHOLDER PROVISIONS ♦ Continued

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.

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.

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**,

SELECT BENEFITS

**OUTPATIENT
PRESCRIPTION DRUG INDEMNITY POLICY**

[POLICY NUMBER]

CERTIFICATEHOLDER SECTION

NOTICE TO BUYER

This is a limited benefit, fixed indemnity policy. This Policy provides a fixed benefit amount in the event the Insured fills a qualifying prescription. This Policy does NOT provide comprehensive coverage

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INTRODUCTION

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

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 **Certificateholder** section replaces all others previously issued.

INTRODUCTION

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

If we at Symetra Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1804
1-800-852-5494



PART 1. ~ TABLE OF CONTENTS

[Policyholder: XXXXXXXX]
[Policy Number: XXXXXXXX]
[Effective Date XX-XX-XXXX]

[

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]

THIS IS A FIXED INDEMNITY PRESCRIPTION DRUG POLICY

PART 2. ~ SUMMARY OF BENEFITS

Policyholder:

Policy Number:

Policyholder Effective Date:

Policy Anniversary:

Eligible Classes of Certificateholders

[All eligible **Certificateholders** of the **Policyholder** who are defined as follows:]

Class	Description
[Determined by the Policyholder]	

Hourly Certificateholders

Benefit amounts are based on:

The following Levels and the amount of coverage selected by the **Policyholder** 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 as reported by the **Policyholder**.

Service Waiting Period

[The first of the month following the date of employment or as determined by the **Policyholder**]

Certificateholder and Dependent Benefits

Outpatient Prescription Drug Indemnity Benefit

Benefit [Brand Name: [\$0 - \$200] per **Prescription**
Number of **Prescriptions** per **Insured** per **Calendar Year** [4- 24]]

[Generic [\$0- \$200] per **Prescription**
Number of **Prescriptions** per **Insured** per **Calendar Year** [4 -24]]

[From time to time **We** may offer or provide to **You** noninsurance benefits and services. In addition, **We** may arrange for third party service providers to give access to **You** to discounted goods and services. While **We** have arranged for this access, the third party service providers are liable to **You** for the provision of such goods and/or services. **We** are not responsible for the provision of such goods and/or services nor are **We** liable for the failure of the provision of the same. Further, **We** are not liable to **You** for the negligent provision of such goods and/or services by third party service providers.]

PART 3. ~ DEFINITIONS

<i>Amendment</i>	a document that modifies this Policy , and becomes part of this Policy , also known as an Endorsement or Rider .
<i>Benefit</i>	the fixed benefit amount payable by Us to a claimant under this Policy .
<i>Calendar Year</i>	the period from January 1 through December 31 of the same year.
<i>Certificateholder</i>	<ol style="list-style-type: none">a person who is employed by, and paid by, the Policyholder; ora person who is employed by, and paid by an association acting in the capacity of the master Policyholder or the Insured of a member company of an association; ora person who is eligible for coverage under this Policy as a worker including one who is under exclusive contract with an employer [or individual/owner proprietor] and is enrolled, and for whom Premium is paid.
<i>Claim</i>	is a request for payment of a fixed benefit amount for a qualifying Prescription .
<i>Confined/Confinement</i>	an inpatient in a Hospital or other health care facility.
<i>Contract Year</i>	a period of one year commencing on the Policyholder's Effective Date of Coverage and ending at 12:00 midnight on the last day of the one-year period.
<i>Dependent</i>	<p>the following persons:</p> <ol style="list-style-type: none">Your spouse, as defined by state law [or Your same or opposite sex domestic partner as permitted or required to be recognized as a dependent under state or federal law;]Your child who is under 26 years of age (Limiting Age); orYour child, who is incapable of self-support due to Developmental Disability or physical disability, provided the condition occurs prior to age 26. <p>Your 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.</p>
<i>Developmental Disability</i>	<p>a disability attributable to:</p> <ol style="list-style-type: none">mental retardation, cerebral palsy, epilepsy, autism, or another neurological condition closely related to mental retardation; orfrom a condition that requires treatment similar to that required for mentally retarded individuals which disability originates before such individual attains the Limiting Age, which has continued or can be expected to continue indefinitely, and which constitutes a substantial handicap to such individual.

DEFINITIONS ♦ Continued

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 a Policyholder and for any eligible Certificateholders and Dependents .
Endorsement	a document that modifies this Policy , and becomes part of this Policy , also known as an Amendment or Rider .
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.
Hours of Work Credit	the hours worked by You for whom contributions have been made on Your behalf by the Policyholder .
Insured	a person who is eligible for coverage under this Policy as a Certificateholder or as a Dependent , is enrolled, and for whom Premium is paid.
Outpatient	an individual who receives health care services where he is not admitted to a Hospital or other health care facility.
Physician	a duly licensed member of a medical profession who: a. has a Medical Doctor or Doctor of Osteopathy degree; b. is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and c. provides medical services which are within the scope of his license or certificate. This also includes a health professional who: a. is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices; b. provides medical services which are within the scope of his or her license or certificate;

DEFINITIONS ♦ Continued

- c. under applicable insurance law is considered a "physician" for purposes of this coverage;
- d. has the medical training and clinical expertise suitable to treat your condition;
- e. specializes in psychiatry; and
- f. is not **You** or related to **You**.

<i>Policy</i>	the Outpatient Prescription Drug Indemnity Policy of which this Certificate forms a part that is issued to the Policyholder .
<i>Policy Anniversary</i>	the date twelve months after the date of the Policyholder's Effective Date of Coverage under this Policy , or as indicated on the Policy Specification page.
<i>Policyholder</i>	the entity named on the Application and the Summary of Benefits , who has applied for coverage under the Policy .
<i>Premium</i>	the dollar amount shown on the Schedule of Premium Rates page and amount paid by the Policyholder and/or You to keep the Policy in force.
<i>Prescription</i>	a Physician's written order for drugs and medicines, and any valid refill of that order.
<i>Proof of Loss</i>	Written evidence, meaning a claim form or other reasonable evidence of the Claim , that You must furnish to Us before the fixed benefit amount may be paid to You under this Policy .
<i>Provider</i>	a pharmacy, which is an establishment where prescription drugs are legally dispensed. Pharmacy includes a retail, specialty and mail order pharmacy.
<i>Rate</i>	the pricing factor upon which the Policyholder's and/or Your Premium is based.
<i>Reinstatement</i>	the resumption of coverage, which has lapsed under this Policy .
<i>Renewal</i>	continuance of coverage under this Policy beyond its original term by Our acceptance of the Premium for a new Policy term.
<i>Rider</i>	a document that modifies this Policy , and becomes part of this Policy , also known as an Endorsement or Amendment .
<i>Service Waiting Period</i>	the length of time, as specified in the Summary of Benefits , You must wait from Your date of employment or application for coverage, until Your coverage is effective.
<i>Summary of Benefits</i>	are the pages of this Policy , which list the Benefits selected by the Policyholder and You .

PART 4. ~ CERTIFICATEHOLDER ELIGIBILITY

Eligible Certificateholders - Hours of Work Credit

Each **Certificateholder** of a **Policyholder** 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 **Policyholder**;
- 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 **Policyholder**.

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.

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.

Late Enrollment

If **You** fail to enroll **Yourself** [or **Your** eligible **Dependents**] within 31 days of **Your** [or **Your** eligible **Dependent's** original eligibility date, then **You** [or **Your** eligible **Dependent**] will not be eligible to enroll for coverage under this **Policy** until the **Policyholder's** next open enrollment, if any. In the case of no open enrollment, late enrollment will be at the discretion of the **Policyholder**.

CERTIFICATEHOLDER ELIGIBILITY ♦ Continued

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 **Certificateholder**.

PART 5.~ DEPENDENT ELIGIBILITY

Dependent coverage and the benefit amounts stated only apply if included on Your Summary of Benefits

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**; and
- c. The **Dependent** is not covered as a **Certificateholder** under this **Policy**.

If **You** and **Your** spouse or domestic partner are covered under this **Policy** as **Certificateholders**, either, but not both, may elect to cover children who are eligible **Dependents**. No person can be insured as both a **Dependent** and a **Certificateholder** under this **Policy**.

Date a Dependent is Eligible for Coverage

A **Dependent** is eligible for coverage under this **Policy** on the later of:

- a. The date **You** become eligible for **Certificateholder** coverage; or
- b. The date **You** acquire **Your** first **Dependent**, including the date of birth of a newborn or the date of placement of an adopted child; 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** by submitting an enrollment form with the **Dependent** box checked 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**.

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.

If **You** had elected **Dependent** coverage before the birth or adoption of a child, **Dependent** coverage will be provided from the moment of birth or adoption of such child.

DEPENDENT ELIGIBILITY ♦ Continued

If **You** did not elect **Dependent** coverage before the birth or adoption of a child, **Dependent** coverage will be provided for the first 60 days following the birth or adoption of such child. Coverage will continue beyond the 60 day period for that child, if:

- a. **You** notify **Us** in writing of the birth or adoption of such child; and
- b. **You** authorize the **Policyholder** to make the required payroll deductions toward the cost of **Your Dependent** coverage within 90 days of the date of birth or adoption.

With respect to an adopted child, the **Policy** will provide coverage for any minor under the charge, care, and control of the **Insured** whom the **Insured** has filed a petition to adopt. Coverage shall begin on the date of the filing of a petition for adoption if the **Insured** applies for coverage within sixty (60) days after the filing of the petition for adoption. However, coverage shall begin from the moment of birth if the petition for adoption and application for coverage is filed within sixty (60) days after the birth of the minor.

We require **You** to notify **Us** of additional **Dependents** to assure accurate **Claims** handling. If a **Dependent** 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.”

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 the **Policyholder'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 the **Policyholder'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 the qualifying **Prescription** is filled.

Change in Amounts of Coverage

Once **You** have made **Your Benefit** elections for a given year, **You** cannot change those elections until the **Policyholder's** next open enrollment. Increases in the amount of **Certificateholder** 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 the **Policyholder's** normal place of business.

Decreases in the amount of **Certificateholder** 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 the **Policyholder'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 the **Policyholder's** coverage ceases under this **Policy**; or
- c. The last day of the month in which the first of the following occurs:
 - i. **You** membership in an eligible class ceases;
 - ii. **You** employment with the **Policyholder** ceases; to the extent applicable;
 - iii. **You** or the **Policyholder** cease **Premium** payments for **Your** coverage;
 - iv. **You** are pensioned or retired, as defined by the **Policyholder**;
 - v. The date **You** begin active duty in the armed forces.

In addition, if **You** are classified as an hourly **Certificateholder**, **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 the **Policyholder**.

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** and child **Premium Rates** of this **Policy**, coverage and the child **Premium Rates** 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** 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" provisions for exceptions to 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 the **Policyholder** during the continuation period.

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

Your Coverage

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

<u>Cause of Absence</u>	<u>Period in which Employment is Deemed to Continue</u>	<u>Coverage</u>
Illness or injury	6 months	Prescription Drug benefit
Temporary Lay-Off	2 months	Prescription Drug benefit
Leave of Absence	2 months	Prescription Drug benefit

Upon written request from the **Policyholder**, **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 ~ OUTPATIENT PRESCRIPTION DRUG INDEMNITY BENEFIT

Dependent coverage and the benefit amounts stated only apply if included on Your Summary of Benefits.

The pre-selected fixed dollar amount, as shown in the **Summary of Benefits** will be paid to **You**, while **You** are covered under this **Policy**. **We** will pay to **You** the specified **Benefit** for each qualifying **Prescription** as specified on the **Summary of Benefits**.

To qualify for payment of a **Benefit**, **Prescriptions** must be:

- a. Ordered by a **Physician**; and
- b. Dispensed by a licensed pharmacist or **Physician**.

Covered Prescriptions

Prescriptions for the following are covered under this **Policy**:

- a. Legend drugs - has the legend "Caution: federal law prohibits dispensing without a **Prescription**;"
- b. Drugs dispensed in disposable pre-filled needles/syringes;
- c. Compound drugs - at least one ingredient must contain a legend drug;
- d. Any other drug, which under federal or applicable state law, may only be dispensed by a licensed pharmacist or **Physician**;
- e. Oral contraceptives;
- f. Tretinoin - all dosage forms (e.g., Retin-A) for individuals through age 26;
- g. Disposable blood/urine glucose/acetone testing agents (i.e., Chemstrips®, Acetest® tablets, and Clinitest® tablets);
- h. Growth hormones; and
- i. Pre-natal prescription vitamins.

Prescription Exclusions and Limitations

The following **Prescriptions** are excluded from coverage under this **Benefit**:

- a. **Prescriptions** for drugs administered while **Confined** as an inpatient in any health care facility;
- b. Prescriptions for drugs for which the **Insured** has no legal obligation to pay;
- c. **Prescriptions** received after Termination of Coverage;
- d. **Prescriptions** for drugs, which are available without a **Prescription**;
- e. Therapeutic devices or appliances including support garments, or other non-medical substances, regardless of their intended use;
- f. Immunization agents, biological sera, blood or blood plasma including the administration thereof;
- g. Charges for the administration or injection of any drug;
- h. Any **Prescription** which the Federal Food and Drug Administration has determined to be contraindicated;

OUTPATIENT PRESCRIPTION DRUG INDEMNITY BENEFIT ♦ Continued

- i. Any **Prescription** not approved by the Federal Food and Drug Administration for a particular indication, unless such drug is recognized as effective for treatment of such indication:
 - i. In one of the standard reference compendia;
 - ii. In the majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia; or
 - iii. by the Federal Secretary of Health and Human Services.
- j. **Prescriptions** for infertility drugs;
- k. **Prescriptions** for drugs which are consumed or administered at the place where they are dispensed;
- l. Any **Prescription** that is dispensed by a hospital, skilled nursing facility, rest home, or any other institution capable of dispensing drugs;
- m. **Prescription** drugs that can be obtained without charge under local, state, or federal programs, including Workers' Compensation, except Medicaid;
- n. **Prescription** drugs dispensed more than one year following the date of **Prescription**;
- o. Refills of any **Prescription** in excess of the number specified by the **Physician**
- p. Any quantity of drugs, which exceeds a 34-day supply or 100 unit or doses, whichever is greater, when taken in accordance with the directions of the prescribing **Physician**;
- q. Anorectics (any **Prescription** drugs used for the purpose of weight loss);
- r. **Prescriptions** for dietary supplements;
- s. **Prescriptions** for immunosuppressants;
- t. **Prescriptions** for minoxidil (Rogaine®) for the treatment of alopecia;
- u. **Prescriptions** for vitamins, singly or in combination,
- v. **Prescriptions** for smoking deterrent medications or any other smoking cessation aids, all dosage forms (e.g., Nicorette®, Nicoderm®, etc.);
- w. **Prescriptions** for fluoride supplements;
- x. **Prescriptions** for minerals; and
- y. **Prescriptions** for hematinics.

PART 10 ~ CLAIM PROVISIONS

Notice of Claim

When **You** fill a qualifying **Prescription**, **You** must present **Your** ID card to receive **Benefits**. If **You** do not receive a **Benefit** when **You** fill the **Prescription**, **You** must file a **Claim** for **Benefits**. **You** must provide notice of **Claim** to **Us** within 20 days after the date **You** fill a **Prescription**. If such notice is not furnished within that 20-day period, a **Claim** will still be considered for payment and will not be denied 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** satisfactory to **Us** within the time set forth in the **Proof of Loss** provision.

Proof of Loss

Written **Proof of Loss** must be given to **Us** within 90 days after the date of loss.

CLAIM PROVISIONS ♦ Continued

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.

This one-year period will not apply when **You** are legally incapable of submitting proof. **Proof of Loss** satisfactory to **Us** is required before payment of **Benefits**.

Time Payment of Claims

When **We** receive all information needed to make a determination on the **Claim**, **We** will pay **Benefits** promptly and within the time period required by law.

Payment of Benefits

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

- a. **You**; or
- b. **Your** legally appointed guardian if **You** are not legally able to accept such **Benefits**.

PART 11 ~ RIGHT TO APPEAL A DENIED CLAIM

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 [**Us** at **Our** administrative office]:

**[Select Benefit Administrators
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.

Important Appeal Deadline

Failure to comply within the 180 day deadline may cause **You** to forfeit any right to any further review of an adverse decision under these procedures or in a court of law.

Your written appeal should state the reasons that **You** feel **Your Claim** should not have been denied. It should include any additional facts and/or documents that **You** feel support **Your Claim**. **You** may also ask additional questions or make comments and **You** may review pertinent documents.

Notification of Adverse Benefit Decision

We will review and make a decision regarding **Your** appeal within a reasonable period but no later than 30 days after it is submitted and **We** will notify **You** in writing of **Our** decision. If the decision remains the same, a denial, **We** will specify the reason for the denial and upon request, specify the **Policy** provisions, protocol or guideline relied upon which the decision is based.

If **Your** coverage is governed by the Employee Retirement Income Security Act, known as "ERISA" (that is, most employment-related health coverage, other than that which is provided by governmental entities or churches), **You** have a right to file a lawsuit under Section 502(a) of ERISA to recover benefits due **You** at any point after completion of an appeal. **You** may have other legal rights and remedies available under state or federal law.

Claims Fiduciary

We are designated as the **Claims** fiduciary for **Benefits** provided under the **Policy**. **We** have the discretionary authority to determine **Your** eligibility for **Benefits** and to construe the terms of the **Policy** to make a **Benefits** determination.

Preemption of State Law

If applicable state law requires **Us** to take action on a **Claim** or appeal in a shorter timeframe, the shorter period will apply.

PART 12. ~ EXTENSION OF COVERAGE BENEFIT

Extension of Coverage applies to the Prescription Drug Benefit shown in the **Summary of Benefits** of this **Policy**,

You and **Your Dependents** may qualify to temporarily extend the **Benefits** provided in 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 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 a **Certificateholder**, **You** may choose Extension of Coverage for **Yourself** if **You** lose **Your** coverage for any of the following reasons (qualifying event):

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

Covered **Dependent** children of a **Certificateholder** may continue coverage if they cease to qualify as **Dependents** under this **Policy**. **You** or **Your Dependent** is responsible for notifying the **Policyholder** when certain qualifying events occur. These events include divorce or legal separation and ceasing to qualify as a **Dependent** under this **Policy**.

The **Policyholder** must be notified within 60 days of the later of:

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

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

- a. The date **You** lose coverage due to the qualifying event; or
- b. The date the **Policyholder** informed **You** that **You** may choose Extension of Coverage.

If **You** do not choose Extension of Coverage, **Your** coverage with the **Policyholder** will end. If **You** choose Extension of Coverage, it will be identical to the coverage **You** and/or **Your Dependents** had immediately prior to the date coverage ended.

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 **Your** 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 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 the **Policyholder** 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 BENEFIT ♦ Continued

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

- a. The **Policyholder** no longer provides coverage to any **Certificateholders**;
- b. **You** do not pay the **Premium** for **Your** Extension of Coverage on time;
- c. **You** become covered under another policy that does not include a preexisting condition exclusion or limitation on preexisting conditions that **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 **Policyholder**.

SYMETRA[®]

FINANCIAL

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

APPLICATION Select Benefits

[Mail to:
Select Benefit Administrators
P.O. Box 440
(overnight deliveries to: 118 3rd Street East)
Ashland, WI 54806
P 1-800-497-3699
F (715) 682-5919]

Directions:

1. Complete this form in its entirety.
2. Attach the Select Benefits Plan Summary chosen by the Policyholder to the back of this sheet.

NOTE: All incomplete applications will not be accepted, and will be returned to the Agent/Broker.

Policyholder (Legal Name) _____ Administrative Contact _____
Street Address _____ Title _____
City _____ State _____ Zip _____ Phone _____ Fax) _____
Mailing Address _____ Email _____
City _____ State _____ Zip _____ Requested Effective Date _____

SIC Code _____ Number of Full-Time [Certificateholders] _____ Number of Eligible [Certificateholders] _____

Would you like an annual open enrollment period at renewal? Yes No

Waiting Period for Plan Eligibility

First of the month following: Date of hire 30 days of employment 60 days of employment 90 days of employment
 Other _____

Eligible Classes of [Certificateholders]: Full-time Part-time Hourly Temporary Other _____

Policyholder Contribution (please specify % or dollar amount) _____ Hourly or _____ Monthly

Policy Selection: Indemnity (Medical) Indemnity Outpatient Prescription Drug Accident Critical Illness Other _____

Plan(s) Selected _____ As named on this quote/ proposal matrix: _____

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.

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 policy is not intended to replace major medical coverage.
4. All necessary administrative information concerning all Certificateholders shall be subject to the provisions of the policy and shall be furnished to Symetra by the Policyholder.
5. All benefits shall be in accordance with those agreed to by Symetra.

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

Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefits or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison

Policyholder's Application and Certification:

By checking this box, I am indicating that 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.

No person to be covered for Critical Illness may be covered by any Title XIX program, designated as Medicaid or any similar name.

Signed by _____ Title _____ Date _____

Servicing Agent's Certification:

By checking this box, I am indicating 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 Policyholder is financially sound.

By checking this box, I am further indicating 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 Signature _____

Agent Name (Print) _____ Date _____

Address _____ Agent License Number _____

City _____ State _____ Zip _____ Tax ID Number _____

Phone _____ Fax _____ Writing Number _____

Email _____

SERFF Tracking Number: SYMT-127866507 State: Arkansas
 Filing Company: Symetra Life Insurance Company State Tracking Number: 50407
 Company Tracking Number: LGC-10018
 TOI: H17G Group Health - Prescription Drug Sub-TOI: H17G.000 Health - Prescription Drug
 Product Name: Select Benefits
 Project Name/Number: Outpatient Prescription Drug Indemnity Policy/LGC-10018

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	12/07/2011
Comments:		
Attachment: Readability Certification.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	12/07/2011
Comments:		
Attachment: AR-LGC-9096 12-11App .pdf		

	Item Status:	Status Date:
Satisfied - Item: Transmittal	Approved-Closed	12/07/2011
Comments:		
Attachment: industry_rates_09_life_trans.pdf		

	Item Status:	Status Date:
Satisfied - Item: Fee schedule	Approved-Closed	12/07/2011
Comments:		
Attachment: fee.pdf		

	Item Status:	Status Date:
Satisfied - Item: Variability	Approved-Closed	12/07/2011
Comments:		

SERFF Tracking Number: SYMT-127866507 *State:* Arkansas
Filing Company: Symetra Life Insurance Company *State Tracking Number:* 50407
Company Tracking Number: LGC-10018
TOI: H17G Group Health - Prescription Drug *Sub-TOI:* H17G.000 Health - Prescription Drug
Product Name: Select Benefits
Project Name/Number: Outpatient Prescription Drug Indemnity Policy/LGC-10018

Attachment:

VARIABILITY.pdf

READABILITY CERTIFICATION

I hereby certify on behalf of Symetra Life Insurance Company that the attached form meets the reading ease score established in the Arkansas Policy Language Simplification Act 23-86-203. The combined Flesh score is 40.5 .



Michael Fry
Executive Vice President
Symetra Life Insurance Company

SYMETRA[®]

FINANCIAL

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

APPLICATION Select Benefits

[Mail to:
Select Benefit Administrators
P.O. Box 440
(overnight deliveries to: 118 3rd Street East)
Ashland, WI 54806
P 1-800-497-3699
F (715) 682-5919]

Directions:

1. Complete this form in its entirety.
2. Attach the Select Benefits Plan Summary chosen by the Policyholder to the back of this sheet.

NOTE: All incomplete applications will not be accepted, and will be returned to the Agent/Broker.

Policyholder (Legal Name) _____ Administrative Contact _____
Street Address _____ Title _____
City _____ State _____ Zip _____ Phone _____ Fax) _____
Mailing Address _____ Email _____
City _____ State _____ Zip _____ Requested Effective Date _____

SIC Code _____ Number of Full-Time [Certificateholders] _____ Number of Eligible [Certificateholders] _____

Would you like an annual open enrollment period at renewal? Yes No

Waiting Period for Plan Eligibility

First of the month following: Date of hire 30 days of employment 60 days of employment 90 days of employment
 Other _____

Eligible Classes of [Certificateholders]: Full-time Part-time Hourly Temporary Other _____

Policyholder Contribution (please specify % or dollar amount) _____ Hourly or _____ Monthly

Policy Selection: Indemnity (Medical) Indemnity Outpatient Prescription Drug Accident Critical Illness Other _____

Plan(s) Selected _____ As named on this quote/ proposal matrix: _____

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.

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 policy is not intended to replace major medical coverage.
4. All necessary administrative information concerning all Certificateholders shall be subject to the provisions of the policy and shall be furnished to Symetra by the Policyholder.
5. All benefits shall be in accordance with those agreed to by Symetra.

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

Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefits or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison

Policyholder's Application and Certification:

By checking this box, I am indicating that 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.

No person to be covered for Critical Illness may be covered by any Title XIX program, designated as Medicaid or any similar name.

Signed by _____ Title _____ Date _____

Servicing Agent's Certification:

By checking this box, I am indicating 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 Policyholder is financially sound.

By checking this box, I am further indicating 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 Signature _____

Agent Name (Print) _____ Date _____

Address _____ Agent License Number _____

City _____ State _____ Zip _____ Tax ID Number _____

Phone _____ Fax _____ Writing Number _____

Email _____

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas
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2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	Symetra Life Insurance 777 108 th Ave NE, Suite 1200 Bellevue, WA 98004	WA	L&H	1129	68608	91-0742147	

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	Mary Ellen McKendry 777 108 th Ave NE, Suite 1200 Bellevue, WA 98004	425-256-8835	425-256-5321	maryellen.mckendry@symetra.com

5.	Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6.	Company Tracking Number	LGC-10018
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7.	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission Previous file # _____
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8.	Market	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise <input type="checkbox"/> Small <input checked="" type="checkbox"/> Large <input type="checkbox"/> Small and Large <input checked="" type="checkbox"/> Employer <input checked="" type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input checked="" type="checkbox"/> Trust <input type="checkbox"/> Other: _____
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9.	Type of Insurance (TOI)	H17G Group Health – Prescription Drug
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10.	Sub-Type of Insurance (Sub-TOI)	H17G.000 Health – Prescription Drug
------------	--	-------------------------------------

11.	Submitted Documents	<input checked="" type="checkbox"/> FORMS <input checked="" type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input checked="" type="checkbox"/> Certificate <input checked="" type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other <u>Rates</u> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate <input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____ <u>SUPPORTING DOCUMENTATION</u> <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreements <input type="checkbox"/> Statement of Variability <input checked="" type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other _____
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12.	Filing Submission Date	12/6/11
13.	Filing Fee (If required)	Amount <u> \$50 </u> Check Date <u> </u>
		Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No Check Number <u> </u>
14.	Date of Domiciliary Approval	
15.	Filing Description:	
	Group Outpatient Prescription Drug Indemnity Policy	

16.	Certification (If required)
I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas_____.	
Print Name	<u> Michael Fry </u> Title <u> Executive Vice President </u>
Signature	<u>  </u> Date: <u> 12/6/11 </u>

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	LGC-10018
This filing corresponds to rate filing company tracking number	

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Select Benefits Group Outpatient Prescription Drug Indemnity Policy	LGC-10018P-AR 10/11	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	LGC-9072AR 11/05
02	Select Benefits Group Outpatient Prescription Drug Indemnity Certificate	LGC-10018C-AR 10/11	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03	Memorandum of Variable Text	VAR10018GEN 10/11	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04	Employer Application	LGC-9096AR 12/11	<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

LH FFA-1

18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number				
This filing corresponds to form filing company tracking number				
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing		%		
	Document Name Description	Affected Form Numbers		Previous State Filing Number
01			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	

LH RFA-1

ARKANSAS INSURANCE DEPARTMENT

400 University Tower Building
1123 South University Avenue
Little Rock, Arkansas 72204

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: Symetra Life Insurance

Company NAIC Code: 1129-68608

Company Contact Person & Telephone #: Mary Ellen McKendry 425-256-8835

INSURANCE DEPARTMENT USE ONLY		
ANALYST: _____	AMOUNT: \$ _____	ROUTE SLIP: _____

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LINE OF BUSINESS, UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Life and/or Disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing

* 3 x \$50 = \$150

**Retaliatory _____

Life and/or Disability - Filing and review of each rate filing or loss ratio guarantee filing, per each insurer.

* _____ x \$50 = \$ _____

**Retaliatory _____

Life and/or Disability Policy, Contract or Annuity Forms: Filing and review of each certificate, rider, endorsement or application if each is filed separately from the basic form.

* _____ x \$20 = _____

**Retaliatory _____

Life and/or Disability: Filing and review of Insurer's advertisements, per advertisement, per each insurer.

* _____ x \$25 = _____

**Retaliatory _____

AMEND CERTIFICATE OF AUTHORITY

Review and processing of information to amend an Insurer's Certificate of Authority.

* _____ x \$400 = _____

Filing to amend Certificate of Authority.

*** _____ x \$100 = _____

MEMORANDUM OF VARIABLE TEXT
GROUP OUTPATIENT PRESCRIPTION DRUG INDEMNITY POLICY LGC-10018P AND
CERTIFICATE LGC-10018C 10/11,

POLICY

- Page i, brackets are around Policyholder so the Policyholder's name may be inserted; brackets are around Policy Number so the Policy Number may be inserted; brackets are around Policy Effective Date so the Policy's Effective Date may be entered; brackets are around Premium Due Date so that the Policy's Premium Due Date may be entered; brackets are around Policy Anniversary so that the Policy's Anniversary date may be entered.
- Page iii, brackets are around Policyholder so the Policyholder's name may be inserted; brackets are around Policy Number so the Policy Number may be inserted.
- Page iv, brackets are around Policyholder so the Policyholder's name may be inserted; brackets are around Policy Number so the Policy Number may be inserted; brackets are around Policy Effective Date so the Policy's Effective Date may be entered; brackets are around Coverage, Rate, Monthly so the employer chosen coverage may be inserted and the corresponding rate and rate payment mode may be inserted.
- Page v, brackets are around Policyholder so the Policyholder's name may be inserted; brackets are around Policy Number so the Policy Number may be inserted; brackets are around Policy Effective Date so the Policy's Effective Date may be entered; bracket are around name so that the name of a company division or subsidiary may be inserted; brackets are around effective date so that the effective date of the division or subsidiary may be inserted; brackets are around termination date so that when a division or subsidiary terminates coverage that date may be insert.

CERTIFICATE

- Page 1, brackets are around Policy Number so the Policy Number may be inserted.
- Page 3, brackets are around Policyholder so the Policyholder's name may be inserted; brackets are around Policy Number so the Policy Number may be inserted; brackets are around Policy Effective Date so the Policy's Effective Date may be entered.
- Page 5, Summary of Benefits - brackets are after Policyholder so the Policyholder's name may be inserted; brackets are after Policy Number so the Policy Number may be inserted; brackets are after Policyholder Effective Date so the Policyholder's Effective Date may be entered; brackets are after Policy Anniversary so that the Policy's Anniversary date may be entered.
- Page 5, Eligible Classes - is not defined under the terms of the policy. It is at the discretion of the employer. The selections made by the employer are those that are within the confines of state law, to the extent they are applicable.
- Page 5, Hourly Certificateholders, the levels are bracketed so the employer may choose the number of hours they want in each level.
- Page 5, Service Waiting Period - is not defined under the terms of the policy. It is at the discretion of the employer. The selections made by the employer are those that are within the confines of state law, to the extent they are applicable.
- Page 5, Certificateholder and Dependent Benefit –

Generic Number of Prescriptions per Insured per Calendar year [4, 5, 6, 7, 8, 9 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24].

Benefit Amount per prescription \$[0, 10, 15, 20, 25, 30, 35, 40, 45, 50, 55, 60, 65, 70, 75, 80, 85, 90, 95, 100, 105, 110, 115, 120, 125, 130, 135, 140, 145, 150, 160, 165, 170, 175, 180, 185, 190, 195, 200]

Brand Number of Prescriptions per Insured per Calendar year [4, 5, 6, 7, 8, 9 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24].

Benefit Amount per prescription \$[0, 10, 15, 20, 25, 30, 35, 40, 45, 50, 55, 60, 65, 70, 75, 80, 85, 90, 95, 100, 105, 110, 115, 120, 125, 130, 135, 140, 145, 150, 160, 165, 170, 175, 180, 185, 190, 195, 200]

- Page 5, last paragraph is bracketed so that the paragraph may be in or out depending on whether non-insurance benefits and services are available.
- Page 6, definition of dependent bullet a., has a bracket so the employer may include or exclude domestic partners.

EMPLOYER APPLICATION LGC-9096 12/11

- Mail to is bracketed so alternate TPA's can receive enrollment.
- Certificateholder is bracketed and the choices are interchangeable and the options are "Certificateholder", "Organization", "Union", "Entity", "Worker", "Association", "Firm", "1099 Contractors", "Member of the Association", "Employees of Members of the Association", "Participating Organization" or the specific entity may be named. In some instances, words such as "the", "Your" and "an" precede the term. These words may be deleted or changed to appropriately correspond to the substituted term (Example: "Your Employer" could be changed to "the Association"). Additionally, in some instances the term is used in the possessive form or plural form. When substituted for an alternate term, the alternate term will also be used in the possessive form or plural form (Example: "the Employer's" could be changed to "the Association's"; "the Employers" could be changed to "the Organizations"). If the first letter of the term is not capitalized then the replacement term will not be capitalized.

VARIABILITY:

- Logo may change.
- Address and/or phone numbers may change if home office is moved. Any change in the home office address and/or phone numbers will be submitted to the Department in an informational filing prior to use.