Idaho AGC HEALTH PLAN

Dear Broker: October 15, 2020

Enclosed is your Idaho AGC Health Plan renewal packet for the 2021 plan year, effective January 1, 2021, through December 31, 2021. The following benefit changes were approved by the Idaho AGC Health Plan Board of Trustees.

2021 Benefit Changes

The enclosed Plan Updates documents outline the changes effective January 1, 2021.

Renewal documents to return to Idaho AGC:

1. **2021 Renewal Rate Sheet:** Select plan, sign, and date. Groups with 11 or more enrolled employees may offer up to two plans. Groups with 51 or more enrolled employees may offer up to three plans. If more than one plan is selected then a Plan Selection Form will be provided for all current and future employee elections.
2. **Detailed Group Headcount List:** A list of employees enrolled in the plan as of August 2020 is provided. Please update to reflect your current list of employees and their enrollment status (enrolled, waived, probationary).
3. **Annual Renewal Agreement**: Complete all sections; including signatures from your broker and an officer of the company.
4. **SBC Attestation form:** Complete and sign form.
5. **Waiver Form:** Please have all employees listed as waiving coverage on Detailed Group Headcount List (#2 above) complete a waiver form. Do not use this form to terminate an employee.

Renewal documents to distribute to all employees:

1. **Plan Updates**: Distribute to employees 30 days prior to January 1, 2021, as required by law.
2. **Summary of Benefits and Coverage (SBC):** Distribute to employees at least 30 days prior to January 1, 2021, as required by law. The SBC Distribution Notice is provided for your guidance.
3. **Glossary of Health Coverage and Medical Terms:** Distribute to employees with the SBC as required by law.
4. **2021 Benefit Highlight Sheet:** Please distribute the appropriate Benefit Highlight Sheet to all employees.
5. **Forms:** Please distribute as needed for appropriate benefits and submit them by **November 23, 2020**.

Your broker of record received an identical copy of the enclosed 2021 renewal packet and should be contacting you to coordinate the completion of your 2021 group renewal elections. Please ensure your broker receives a copy of all signed documents. **The completed renewal documents must be returned to our office on or before November 13, 2020, *even if you are not making any changes to your current plan*.**

January invoices will be sent mid-December and will reflect your 2021 plan enrollment with applicable rates. Please review this invoice to verify all enrollees are correctly enrolled with the accurate rate and notify our office of any discrepancies.

Thank you for your continued support of the Idaho AGC Health Plan. We wish you a healthy and successful 2021!

Sincerely,

Ginger Sinclair
Sr. Health Plan Director

Employer Renewal Agreement, Forms, and Reference Materials

IDAHO AGC SELF-FUNDED HEALTH PLAN

For Renewing Group Use Only

Annual Renewal Agreement for Plan Year January 1 – December 31, 2021

Idaho AGC Self-Funded Benefit Trust

The Idaho AGC Self-Funded Health Plan includes medical, dental and vision benefits are provided by the Idaho AGC Self-Funded Benefit Trust. The medical, dental and vision plans are not insurance. The Idaho AGC Self-Funded Benefit Trust does not participate in the state guaranty association. The Idaho Self-Funded Benefit Trust is mandated by the Idaho Department of Insurance to provide an annual audit and review certification by an independent third party accredited actuary.

Name of Business:____

DBA, (if Applicable):________________________________**SIC**_________________**EIN**_________________

Group Administrator Name:____________________________ **Email:** _________________________________

CENSUS: Total Number of Employees (*all employees, including those not covered on the Idaho AGC Self-Funded Health Plan)* listed on SUTA. Put each employee in only <u>ONE</u> category (4th quarter will be an estimate).

1ST Quarter F/T_______, P/T______, Seasonal______, Leased______, Union______, Total EE's_______

2nd Quarter F/T_______, P/T______, Seasonal______, Leased______, Union______, Total EE's_______

3rd Quarter F/T_______, P/T______, Seasonal______, Leased______, Union______, Total EE's_______

4th Quarter F/T_______, P/T______, Seasonal______, Leased______, Union______, Total EE's_______

The Idaho AGC Self-Funded Health Plan is a **<u>group</u>** plan. To qualify as a group an employer must have a minimum of two full-time employees. An eligible employee is one that has completed their probationary period and is actively working 30 or more hours per week.

Employer groups are subject to audits throughout the policy year.

Employee Participation Requirements

You must extend participation in the Plan to 100% of your eligible employees. An eligible employee is one that has completed their probationary period and works 30 or more hours per week.

At least 75% of all eligible employees must participate in the Idaho AGC Health Plan (the plan) or waive coverage due to enrollment in another qualified health plan. Failure to comply with this requirement may result in termination of coverage from the plan for all employees. Compliance is mandatory throughout the policy year, termination can result mid-year.

Based on the above statement:

A) Total number of employees in your company: ______________

B) Total number of employees in your company eligible for coverage under The Idaho AGC Self-Funded Health Plan: ______________

C) Total number of employees covered on the Idaho AGC Self-Funded Health Plan: ______________

D) Total number of employees waiving with other qualified medical coverage: ______________

E) Total number of employees waiving without other qualified medical coverage: ______________

F) Participation percentage (C+ D) ÷B = % of participation: ______________

Example: A group has 13 employees, 12 are eligible, 10 are covered on the Idaho AGC Self-Funded Health Plan, 2 are waiving for other qualified medical coverage. To find the percentage take 10 + 2 ÷12 = 100%. The group has 100% of Its' eligible employees covered on the plan and is in compliance with the participation requirement of this plan.

COBRA

An employee is subject to COBRA during the current calendar year if the employer employed 20 or more employees (part-time are counted as fractional) or more than 50% of its typical business days in the preceding calendar year. This number is based on the total number of employees not the number of employees covered on the Self-Funded health plan. Part-time employees are expressed as a fraction. Employers that do not qualify (do not have 20 or more employees on more than 50% of its typical business days in the preceding calendar year) must mark "NO".

Based on the above statement you are subject to COBRA? Yes______ No______

Probationary Periods

Please complete each classification of employee, if nothing is filled in the blank, 0 days of probation will be given to that classification of employee. Coverage is effective the first of the month following the completion of the probationary period. Due to Federal Health Care Reform mandates all regular employees must have the same probationary period and probationary periods cannot exceed 60 days plus the days to the first of the next month when coverage starts. Please give only one probationary period for regular employees and one for re-hire, if different.

All Regular Employees __________ Rehired Employees___________

Contributions

The minimum employer contribution is 50% of the employee rate. The Group agrees to make the following employer contribution toward employee and their dependent contributions

__________% per employee per month **OR** $__________per employee per month

__________% per dependent per month $__________per dependent per month

Affirmation

I affirm the answers given are complete and correct. I understand the Idaho AGC Self-Funded Health Plan will rely on each answer in making certain determinations including, but not limited to, eligibility for employees and their dependents, COBRA eligibility and group participation compliancy. If there is any material statements or omissions The Idaho AGC Self-Funded Health Plan or contracted carrier, may within 24 months of coverage, take any other legal action by law.

I have reviewed all answers in this Annual Renewal Agreement and acknowledge and agree that all of the terms and conditions outlined in the previously signed Participation Agreement, except as changed by this Annual Renewal Agreement, continue to apply. Regardless of whether an independent producer or other person has completed the answers for me, I verify that all answers are true and complete.

__________ I agree to the terms and conditions of this Annual Renewal Agreement.
Initial

Employer Group

Signature of Officer:____ **Date:**_____________________

Printed Name:_____________________________________ **Title:**_____________________________________

Company Name:____

Broker / Agency

Broker Signature:____ **Date:**_____________________

Agency Name:____

PLEASE FORWARD A COPY OF YOUR RENEWAL TO YOUR BROKER FOR REVIEW

Idaho AGC
HEALTH PLAN

Summary of Benefits and Coverage Attestation

Company Information

Please complete the information below.

Company

Address | City, State | Zip Code

Email Address | Phone

Employer Attestation

I attest that the (company) employer will distribute to all its employees, dependents, retirees and COBRA eligible if applicable or otherwise provide access, to the applicable Summary of Benefits and Coverage(s) (SBC) in a timely manner and in accordance with the requirements of the Patient Protection and Affordable Care Act (PPACA) and its implementing regulations. I attest that I am authorized to submit this documentation on behalf of the company/employer listed above for the purpose of illustrating compliance with PPACA standards.

First Name (Print) | Middle Initial | Last Name

Title

Signature | Date

IMPORTANT NOTICE REGARDING A NEW FEDERAL LAW
Action Required

Summary of Benefits and Coverage (SBC) Information
For renewing AGC groups

Dear Group Administrator:

Enclosed is your renewal for the Idaho AGC Health Plan, administered by Blue Cross of Idaho.

Federal law requires health insurance providers to give members access to information to help them understand and evaluate their health insurance plans. These materials include two key pieces:

1. Summary of Benefits and Coverage (SBC) outlining the specific plan benefit information
2. Uniform Glossary terms commonly used in health insurance.

You can view and print the SBCs for your group's current coverage option(s) and the Uniform Glossary on the Blue Cross of Idaho website at bcidaho.com/employers.

Please distribute these items to your employees and other plan participants.

If you have questions about the SBC, need language assistance or would like a paper copy free of charge, please refer to the Customer Service number on the back of your Blue Cross of Idaho ID cards or call 1-800-627-1188. You can also visit the Blue Cross of Idaho website at ***bcidaho.com/SBC*** for more information.

IMPORTANT NOTICE REGARDING A NEW FEDERAL LAW
Additional Action Required

Summary of Benefits and Coverage (SBC) Information
for AGC groups making benefit changes at renewal

Dear Group Administrator:

We have received your renewal for the Idaho AGC Health Plan, administered by Blue Cross of Idaho.

We have ordered an updated SBC that reflects your benefit changes that will be effective January 1, 2021.

Federal law requires health insurance providers to give members access to information to help them understand and evaluate their health insurance plans. These materials include two key pieces:

1. Summary of Benefits and Coverage (SBC) outlining the specific plan benefit information
2. Uniform Glossary terms commonly used in health insurance.

You can view and print the SBCs for your group's changed coverage option(s) and the Uniform Glossary on the Blue Cross of Idaho website at bcidaho.com/employers within 7 days.

Please distribute these items to your employees and other plan participants.

If you have questions about the SBC, need language assistance or would like a paper copy free of charge, please refer to the Customer Service number on the back of your Blue Cross of Idaho ID cards or call 1-800-627-1188. You can also visit the Blue Cross of Idaho website at ***bcidaho.com/SBC*** for more information.

Idaho AGC
HEALTH PLAN

Employee's Waiver of Health Care Coverage

If you decline to enroll either yourself or your eligible family members in the health care coverage offered by your employer, we ask that you complete this form. **Qualified late enrollees who decline coverage may not reapply for coverage until their employer's policy renewal date or experience a qualifying event.**

I certify that I have been informed of the availability of coverage under my employer's health benefit plan, but I choose not to enroll *(please check all that apply and list each eligible family member's name)*:

☐ myself ______________________________ ☐ my eligible child(ren): ____________________________________

☐ my spouse ______________________________ ____________________________________

I have chosen to decline health care coverage at this time because:

☐ I and/or my dependents have other group or individual coverage with (*name of insurance company*) ________________________

through (*insured's name and relationship*) ____

☐ Other reason(s) to waive coverage (please specify): ____

I understand that if, at this time, I decline coverage offered by my employer for myself or my eligible family members, and then choose to apply for coverage later, the plan may exclude coverage, except in the following instances:

1. The individual meets each of the following:

    a. The individual(s) lost coverage as a result of termination of employment or eligibility, the involuntary termination as a result of a qualifying event.
    b. The employer stops contributing towards your or your dependents' other coverage; and
    c. The individual request submits a enrollment application within 30 days after termination or qualifying event.

2. A court has ordered that coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within 30 days after issuance of the court order; or

3. If an individual seeks to enroll a dependent(s) during the first sixty (60) days of eligibility, the coverage of the dependent(s) shall become effective:

    a. in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received after the application is received;
    b. in the case of a dependent's birth, as of the date of such birth; or
    c. in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

______________________________ ______________________________
Please print name *Name of group*

______________________________ ______________________________
Social Security number *Group number*

______________________________ ______________________________
Employee's signature *Date* *Group administrator's signature* *Date*

Benefit Summary

GENERAL BENEFIT PLAN SUMMARY

Idaho AGC Self-Funded Benefit Trust

Group Number: 1680

Contract Effective Date: 01/01/2021

Benefit Overview	PPO	Premier	Non-Participating
Per Person Deductible Excluding Diagnostic and Preventive services per benefit year	$50	$50	$50
Family Deductible Excluding Diagnostic and Preventive services per benefit year	$150	$150	$150
Maximum Benefit Per eligible person per benefit year	$1,000	$1,000	$1,000
Services	**You pay the % below**		
Preventive & Diagnostic Services Examinations, X-rays, teeth cleaning	0%	20%	20%
Basic Services Fillings, root canals, extractions, oral surgery	20%	20%	20%
Major Services Crowns, implants, onlays, bridges, dentures Late enrollee waiting period is 24 months	50%	50%	50%

PARTICIPATING AND NON-PARTICIPATING DENTISTS

If the dentist is a PPO or Premier participating dentist, Delta Dental will base payment on the lesser of the Submitted Amount or the Contract Fee. Delta Dental will send payment to the participating dentist and the subscriber will be responsible for any co-payment and/or any non-covered services.

If the dentist is a non-participating dentist, Delta Dental will base payment on the lesser of the Submitted Amount or Delta Dental's non-participating dentist Fee. It is the subscriber's responsibility to make full payment to the non-participating Dentist. For dental services rendered by an out-of-state dentist, Delta Dental will base payment on the lesser of the Submitted Amount or the Contract Fee in that area, if the out-of-state dentist is a participating dentist with a Delta Dental plan in the state in which the service is rendered.

Delta Dental of Idaho
555 E Parkcenter Blvd
Boise, ID 83706

Customer Service
(208) 489-3580
(800) 356-7586

Benefits and Limitations

Class I Preventive and Diagnostic Services
Examinations twice per year.
Cleanings twice per year (restricts against periodontal maintenance within the same time period).
Fluoride once every 12 months for dependent children under age 19.
Full mouth series or panoramic X-rays once every 5 years.
Bitewing X-rays once every 12 months.
Class II Basic Services
Periodontal maintenance once every 6 months (restricts against basic cleaning within the same time period).
Scaling and root planing covered once per quadrant every 24 months. Periodontal surgery is payable once per quadrant in any 3 year period.
Fillings restricted to same tooth/surface once every 24 months.
Class III Major Restorative Services
Crowns, build-ups, stainless steel crowns, onlays, or bridges on same tooth once every 7 years.
Porcelain, porcelain substrate, and cast restorations are not payable for children less than 16 years.
Partials, or dentures 1 time per arch every 7 years, eligible for partials at age 16.
Implants
Implants are a covered benefit per tooth with a maximum lifetime benefit of $900.
Dependents
Eligible children must be under age 26.

GENERAL PLAN INFORMATION

1. Optional treatment: If the subscriber or eligible dependent selects a more expensive service than is customarily provided. For example, if teeth can be restored satisfactorily with amalgam or composite material, the cost of inlays, onlays and crowns are not covered and the cost difference between the covered and the non -covered procedure is to be borne by the patient.
2. Payment provisions: The following guidelines will be used to determine the date on which a service shall be paid:
   a. Full dentures or partial dentures: On the date the final impression is taken.
   b. Fixed bridges, crowns, and onlays: On the date the tooth or teeth are prepared.
   c. Root canal therapy: On the date the root canal is initiated.
3. Processing Policies may limit benefits. Processing Policies applied to a claim are noted on the Explanation of Benefits (EOB).
4. Predeterminations: If your dental treatment involves services of $300 or greater, it is advisable to ask your dentist to submit

a predetermination of benefits. A statement will be sent to you and your dentist estimating the amount of Delta Dental payment obligation and the amount that you will owe. These estimates will be subject to your continuing eligibility in the plan and the group contract remaining in effect. If claims for other completed dental services are received and processed prior to the completion date of the proposed treatment, this may reduce Delta Dental's estimated payment for the proposed treatment and increase your obligation to the dentist. Predeterminations are valid for ninety (90) days from the date issued by Delta Dental.

WHAT SERVICES ARE NOT COVERED?

No payment will be made by Delta Dental and all charges for the following services will be the responsibility of the subscriber:

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Benefits or services that are available from any government agency, political subdivision, community agency, foundation, or similar entity. This provision does not apply to any programs provided under Title XIX Social Security Act, i.e., Medicaid.
2. Services for cosmetic surgery, or dentistry for aesthetic reasons.
3. Services or appliances started before an individual became eligible under the contract.
4. Prescription drugs, pre-medications and/or relative analgesia. General anesthesia and/or intravenous sedation other than for covered oral surgery. Charges for hospitalization, laboratory tests, and examinations and any additional fees charged by the dentist for hospital treatment.
5. Preventive control programs, including home care items.
6. Charges for failure to keep a scheduled visit with the dentist.
7. Repair, relines, or adjustments of occlusal guards.
8. Charges for completion of forms. A participating dentist may not make these charges to a subscriber or eligible dependent.
9. Prosthodontic services (Class III benefits), unless specified as a covered service in the Benefit Summary.
10. Orthodontic services (Class IV benefits), unless specified as a covered service in the Benefit Summary.
11. Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances.
12. Services for which no valid dental need can be demonstrated, that are specialized techniques, or that are experimental in nature as determined by the standards of generally accepted dental practice.
13. Appliances, surgical procedures, and restorations for increasing vertical dimension; for restoring occlusion; for replacing tooth structure loss resulting from attrition, abrasion, or erosion. If orthodontic benefits have been selected under this contract, this exclusion will not apply to the orthodontic services.
14. Treatment by other than a dentist, except for services performed by a licensed dental hygienist or denturist within the scope of his or her license.
15. Processing Policies may limit benefits. Processing Policies applied to a claim are noted on the Explanation of Benefits (EOB).
16. Services or supplies for which no charge is made, or for which the patient is not legally obligated to pay. This includes services or supplies furnished by a dentist who is related to the patient by blood or who is related to the patient by blood or marriage and who ordinarily dwells in the patient's household, the dentist providing service to him/her self, or services which would not have a charge in the absence of Delta Dental coverage.
17. Services or supplies received as a result of defect, or injury due to an act of war, declared or undeclared.
18. Services that are covered under a hospital, surgical/medical, or prescription drug program.
19. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
20. Myofunctional therapy.
21. Delta Dental is not obligated to pay claims received more than 12 months after the date of service.
22. Nutritional counseling, tobacco counseling and oral hygiene instruction are not covered benefits except for participants in Delta Dental's Health through Oral Wellness® (HOW®) program.

Your VSP Vision Benefits Summary

IDAHO AGC SELF-FUNDED BENEFIT TRUST and VSP provide you with an affordable eye care plan.

VSP Provider Network: VSP Choice

Benefit	Description	Copay	Frequency
Your Coverage with a VSP Provider			
WellVision Exam	• Focuses on your eyes and overall wellness • Please check if your Costco optometrist is a participating retail provider	$10	Every 12 months
Prescription Glasses		$20	See frame and lenses
Frame	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance • $80 Costco® frame allowance	Included in Prescription Glasses	Every 24 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every 12 months
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$55 $95 - $105 $150 - $175	Every 12 months
Contacts (instead of glasses)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

Your Coverage with Out-of-Network Providers

Get the most out of your benefits and greater savings with a VSP network doctor. Your coverage with out-of-network providers will be less or you'll receive a lower level of benefits. Visit **vsp.com** for plan details.

Exam .... up to $45	Lined Bifocal Lenses .... up to $50	Progressive Lenses .... up to $50
Frame .... up to $70	Lined Trifocal Lenses .... up to $65	Contacts .... up to $105
Single Vision Lenses .... up to $30		

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

Contact us. **800.877.7195 | vsp.com**

1. Brands/Promotion subject to change.
2. Savings based on network doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details.
3. Blueocean Market Intelligence National Vision Plan Member Research, 2014

©2017 Vision Service Plan. All rights reserved.
VSP, VSP Vision care for life, eyeconic.com, and WellVision Exam are registered trademarks, and "Life is better in focus." is a trademark of Vision Service Plan. Flexon is a registered trademark of Marchon Eyewear, Inc. All other company names and brands are trademarks or registered trademarks of their respective owners.

2021 Plan Changes and
New SAHA and MVN CCO Benefit Options

PLAN UPDATES

To Your
Group Plan

Please Read Carefully

This *Plan Update* is a summary of the Idaho AGC Health Plan changes that were approved by the Trustees of the Idaho AGC Self-Funded Benefit Trust effective on January 1, 2021. We encourage you to review this carefully. For reference, the words and terms capitalized in this document are defined in the Plan.

Two Coordinated Care (CCO) plan options added. Employers have the option of a Coordinated Care Organization (CCO) plan for your medical coverage. A CCO plan offers high-quality care at a lower cost. Unlike a PPO Plan, Participants must select a Primary Care Physician (PCP) from the CCO network of physicians to receive the in-network benefits. Please see the attached CCO Flyers for additional details.

For Southwest Idaho: Saint Alphonsus Health Alliance (SAHA).
This network has more than 2,600 providers across Ada, Boise, Canyon, Elmore, Gem, Owyhee, Payette, Valley, and Washington counties. This network includes 20 hospitals and surgery centers, 39 urgent care centers, and providers in the Saint Alphonsus Health System.
Find a full list of providers at *bcidaho.com/saintalphonsus*

For Eastern Idaho: Mountain View Network (MVN)
Eastern Idaho residents can take part in the Mountain View Network (MVN). MVN has more than 400 providers in many hospitals and surgery centers. You can find MVN providers in Bingham, Bonneville, Butte, Clark, Custer, Fremont, Jefferson, Lemhi, Madison, and Teton counties.
Providers are found in the Mountain View Network throughout Eastern Idaho:

- Mountain View Hospital, Idaho Falls
- Idaho Falls Community Hospital, Idaho Falls
- Skyline Surgery Center, Pocatello
- MVH Parkway Surgery Center, Blackfoot
- Blackfoot Medical Center, Blackfoot
- Shelley Family Medical Center, Shelley
- Altenburg Joint Replacement Surgery, Idaho Falls and Pocatello
- Prescription Center, Idaho Falls
- Madison Memorial Hospital, Rexburg
- Teton Cancer Institute – Idaho Falls and Rexburg
- Pain and Spine Specialists of Idaho – Idaho Falls, Rexburg, Blackfoot, and Pocatello
- Creekside Surgical Center, Idaho Falls
- Portneuf Medical Center, Pocatello

Find a full list of providers at *bcidaho.com/mvn*

The medical in-network out-of-pocket is $8,500 for an individual and $17,000 for a family. The out-of-network out-of-pocket limit **is** $17,000 for an individual and $34,000 for a family for all Plans except the $3,000 High Deductible Health Plan which has no changes.

A weight management program is now available at no cost to qualified participants. To find out if you qualify, contact our program partner, Naturally Slim by email at ***support@naturallyslim.com*** or by phone at 855-999-7549.

Palliative care services are now covered as well. Please see your plan for a description of covered services and the cost-sharing amount.

Telehealth virtual care services are available for any covered outpatient services. Please see the benefits outline for details of those services.

Medical food is now covered for inborn errors of metabolism when a provider has diagnosed inadequate nutritional intake. Please see your plan for what is covered.

Therapeutic shoes and inserts are now covered for participants with diabetes. Please see your plan for what is covered.

Prior Authorization (PA)
The complete list of services that require PA has been added to your plan.

Major Medical Benefits
The **skilled nursing facility** benefit language has been clarified. If a stay in a skilled nursing facility crosses from one benefit period to the next, the benefit limit will still start over with the new period, but the participant does not have to be discharged first.

Definitions for medical food, palliative care, and telehealth virtual care services have been added.

Connected Care for Groups

The Idaho AGC is always looking for ways to bring your employees access to the care they need at a price you and your employees can both afford. The Blue Cross of Idaho ConnectedCare Plans helps you save money and time while improving the results of their care.

The Saint Alphonsus Health Alliance (SAHA) is a Plan option available to employers in Southwest Idaho. The Mountain View Network (MVN) in Eastern Idaho. The attached information includes a list of all Idaho Counties where SAHA and MVN is available.

What makes ConnectedCare Different from a PPO Plan?

- A Primary Care Physician (PCP) – employees must be selected a PCP from the list of available providers in the network for his or her care. Employees with dependents may select a different PCP for their family members. If a PCP is not selected during the open enrollment period, a PCP will be assigned to you. You can contact Blue Cross of Idaho to request a PCP change at any time.

  SAHA or MVN Provider Lookup Links:
  Mountain View Providers: www.bcidaho.com/mvn
  Saint Alphonsus Providers: www.bcidaho.com/saha

- **What if a provider type is needed (specialty) that is not available in the CCO network?** The PCP can request a referral to a specialist out of the network and have it covered as in-network if there is a gap in the network.

- **Out of State Students:** A gap in care authorization can be put in place for the student based on their location. These can last a year in our system and have to be updated annually.

  Out of State Travel: Urgent and Emergent Services are covered at in-network benefit. Out of network providers are reimbursed at the PPO reimbursement level. This can lead to balance billing only when the out of network provider will not accept the reimbursement threshold that is distributed. Services rendered out of state that are not urgent or emergent are considered out of network.

  Blue Cross of Idaho ID Card - a SAHA or MVN ID will be issued to all participants electing the CCO Plan. The card includes the network name and the PCP. Examples of the ID cards are shown below:

Blue Cross of Idaho | Idaho AGC HEALTH PLAN

Enrollee Name / Number
John Smith
QGM123456789

Coverage For:
John Smith
Primary Care Provider (PCP)
Sample PCP

Group Number 10012345
RXBIN 020123 RXPCN IRXCOMM
RXGRP RXBCID
Provider Network MVN

Medical POS
Dental DPPO
Vision Yes

Blue Cross of Idaho | Idaho AGC HEALTH PLAN

Enrollee Name / Number
John Smith
QGM123456789

Coverage For:
John Smith
Primary Care Provider (PCP)
Sample PCP

Group Number 10012345
RXBIN 020123 RXPCN IRXCOMM
RXGRP RXBCID
Provider Network SAHA

Medical POS
Dental DPPO
Vision Yes

Blue Cross of Idaho

Idaho AGC HEALTH PLAN

COORDINATED CARE ORGANIZATION OPTIONS

As an AGC member, you now have the option of a Coordinated Care Organization (CCO) plan for your medical coverage. A CCO plan offers you high-quality care at a lower cost with no referral needed to see an in-network specialist.

Why pick a CCO plan?

CCO plans help you keep your out-of-pocket costs low while you get quality care.

With a CCO plan, you'll get to choose a primary care provider (PCP) who will not only care for you but also create a healthcare plan and guide you to the right care at the right time. You don't need a referral to see an in-network specialist. If you need specialty care that can't be found in the network, Blue Cross of Idaho and the network will help you get the care you need from an out-of-network provider through a referral.

What do I need to know about a CCO plan?

- **You'll want a PCP.** Your PCP can be a family practice, internal medicine, pediatrician, OB-GYN or general practice provider. Your PCP will send you to a specialist for care if needed and help you save money by avoiding services you don't need.
- **You don't need a referral to see a specialist.** If you need to see an in-network specialist, you don't have to get a referral from your PCP.
- **Learn about your network.** Before you get care, make sure your provider, urgent care or hospital is in your network. (Learn how to find in-network providers for each network on the next page.)
- **Plan ahead when you're traveling.** When traveling within Idaho, you will need a referral from your PCP for non-emergency services. When traveling out of state, avoid balance billing – being charged for the difference between the allowed amount covered by your benefits and the cost of services from an out-of-network provider – by searching for in-network, out-of-state providers if you expect to need non-emergency care. Find out-of-state providers by visiting ***bcidaho.com/findaprovider*** and selecting ***TRAD*** (Traditional Provider Network) from the drop-down menu at the top of the search area (be sure to search as a guest).

© 2020 by Blue Cross of Idaho, an independent licensee of the Blue Cross and Blue Shield Association

For Southwest Idaho: Saint Alphonsus Health Alliance

If you live in Southwest Idaho, you can benefit from the Saint Alphonsus Health Alliance (SAHA). SAHA has more than 2,600 providers across Ada, Boise, Canyon, Elmore, Gem, Owyhee, Payette, Valley and Washington counties. This network includes 20 hospitals and surgery centers, 39 urgent care centers, and providers in the Saint Alphonsus Health System.

Find a full list of providers at ***bcidaho.com/saintalphonsus***.

Providers are found in the SAHA network throughout Southwest Idaho and Eastern Oregon:

- Saint Alphonsus Regional Medical Center, Boise
- Saint Alphonsus Medical Center, Nampa
- West Valley Medical Center, Caldwell
- Cascade Medical Center, Cascade
- Valor Health, Emmett
- Saint Alphonsus Medical Center – Ontario and Baker City, Oregon

For Eastern Idaho: Mountain View Network

Mountain View Network

Eastern Idaho residents can take part in the Mountain View Network (MVN). MVN has more than 400 providers in many of hospitals and surgery centers. You can find MVN providers in Bingham, Bonneville, Butte, Clark, Custer, Fremont, Jefferson, Lemhi, Madison and Teton counties.

Find a full list of providers at ***bcidaho.com/mvn***.

Providers are found in the Mountain View Network throughout Eastern Idaho:

- Mountain View Hospital, Idaho Falls
- Idaho Falls Community Hospital, Idaho Falls
- Skyline Surgery Center, Pocatello
- MVH Parkway Surgery Center, Blackfoot
- Blackfoot Medical Center, Blackfoot
- Shelley Family Medical Center, Shelley
- Altenburg Joint Replacement Surgery, Idaho Falls and Pocatello
- Prescription Center, Idaho Falls
- Madison Memorial Hospital, Rexburg
- Teton Cancer Institute – Idaho Falls and Rexburg
- Pain and Spine Specialists of Idaho – Idaho Falls, Rexburg, Blackfoot and Pocatello
- Creekside Surgical Center, Idaho Falls
- Portneuf Medical Center, Pocatello

Blue Cross of Idaho

Coordinated Care Organization (CCO) FAQs

Do CCO plan members have to pick a primary care provider (PCP)?

Yes, CCO plan members are required to select a PCP. Our CCO plans are designed to create a lasting relationship between the PCP and a member.

What kind of providers can be PCPs?

Member can select an in-network general practitioner, family practitioner, internist, pediatrician or OB/GYN as a PCP.

Is a PCP referral required to see a specialist? Or can CCO plan members see any in-network specialist without a referral?

Yes, a PCP referral is required to receive covered services from a specialist at the in-network benefit level. Seeing a specialist without a referral could result in higher out-of-pocket costs.

If members need care right away, where can they go?

When they need care right away, members can visit any emergency room (ER) or urgent care facility. To avoid any extra costs that may be billed by an out-of-network hospital or clinic, members should learn which ERs or urgent care clinics are in network. If members need to visit a specialist for more care after the ER or urgent care visit, the PCP must submit a referral.

What if members travel outside Idaho and need emergency care?

Members can visit any ER or urgent care facility when they need care right away. If the facility contracts with their local Blue Cross Blue Shield plan, services will be covered as in network through BlueCard and will not be subject to balance billing.

After the ER or urgent care visit, if members need to visit a specialist – including an out-of-state and/or out-of-network specialist – for more care, they need a PCP referral that's approved by Blue Cross of Idaho for their care to be billed as in network. Non-emergency care outside Idaho or from an out-of-network provider without a PCP referral will be billed as out of network.

If members have dependents living outside of Idaho, how can they get care?

Members enrolled in a CCO network should contact the Blue Cross of Idaho Customer Service Department. They will help make an out-of-area dependent referral.

What if CCO plan members need services from a type of specialist who is NOT available in their network?

Our CCO plans require a gap-in-network referral and authorization for services provided outside of the network in order to be billed as in network. This referral must be submitted by the in-network PCP and is reviewed by Blue Cross of Idaho. When a gap-in-network referral to a specific provider or facility is authorized by Blue Cross of Idaho, the services will be billed as in network. When a gap-in-network referral is not obtained or is not authorized by Blue Cross of Idaho, the services will be billed as out of network.

© 2019 by Blue Cross of Idaho, an independent licensee of the Blue Cross and Blue Shield Association

How does the referral process work?

When members need care from a specialist, the PCP will submit a referral based on the type of service needed. The Blue Cross of Idaho Customer Service Department can assist members with any referral questions.

How long does it take to get a referral approved?

A referral to an in-network specialist is approved immediately. If a referral to an out-of-network specialist is required, the process can take up to 14 days.

Is there a difference between ConnectedCare plans and CCO plans?

ConnectedCare is the name of the Blue Cross of Idaho product. CCO have become the general ways to refer to the plans and organizations. They are largely interchangeable when referring to options in the market.

Primary Care Physician Selection Form

Your health insurance program requires that you select a Primary Care Physician (PCP) for yourself and for each covered member of your family. Each member of your family may choose a different PCP or you may all share the same one. To make a selection:

- Review the Provider Directory online at ***bcidaho.com***. It shows which doctors are accepting new patients and which ones have practice limitations. (A practice limitation is when a doctor accepts only certain types of patients, such as children under the age of 12 or women over the age of 18.)
- Choose a doctor that is accepting new patients and make sure that you fit within any practice limitations.
- Call the doctor's office and confirm that he or she is still accepting new patients.
- Complete this form by filling in your name, your Blue Cross of Idaho identification number, your social security number, the name of the company you work for and the name of the PCP you have selected for yourself and for each covered member of your family. Be sure to note whether or not the selected PCP has seen or treated the member previously.

If you decide later that you want to change your PCP, just call our Customer Services Department and let us know. The change will be effective the first of the following month.

Your Name: ______________________________

BCI Identification Number #: ______________ Your Social Security #: ______________

Your Employer's Name: ______________________________

Member's Name *(first, middle initial, last)*	Name of PCP *(first & last)*	Has this member ever seen this doctor?
		❒ Yes ❒ No
		❒ Yes ❒ No
		❒ Yes ❒ No
		❒ Yes ❒ No
		❒ Yes ❒ No
		❒ Yes ❒ No
		❒ Yes ❒ No

Please return this form to: Enrollment & Billing Department, P.O. Box 7408, Boise, ID 83707-1408 or just call our Customer Services Department at (208) 331-7347 or 1-800-627-1188. We can take this information over the phone, if you prefer.

Remember: to make the most of your benefits, your PCP should provide or coordinate most of your medical care.

(208) 345-4550 • www.bcidaho.com
3000 E. Pine Avenue, Meridian, ID 83642-5995
P.O. Box 7408, Boise, ID 83707-1408

© 2012 Blue Cross of Idaho is an Independent Licensee of the Blue Cross and Blue Shield Association

Employee Open Enrollment Forms

Idaho AGC HEALTH PLAN

Employee Enrollment & Change Forms
2021 Plan Year

Open enrollment is a one-time opportunity for employees to make changes to their Idaho AGC Health Plan enrollment for themselves and eligible dependents without a qualifying event. This includes new enrollments, enrollment tier changes, and waiver or cancellation of coverage. Please submit all forms to our office on or before November 23, 2020, by email to healthplanteam@idahoagc.org.

Medical (Dental & Vision) Plan Forms

- **Idaho AGC Health Plan Large Group Application (Form No. ID AGC LG 9-18):** Use this form when employees are enrolling themselves or adding dependents to their medical (dental & vision) enrollment. Complete pages 1, 2, and sign and date page 4. No need to complete page 3.
- **Idaho AGC Waiver form:** Use this form for employees' declining medical (dental & vision) coverage.
- **Idaho AGC Cancellation Form**: Use this form for active employees and/or dependents that are currently enrolled, but wish to cancel their medical (dental & vision) coverage.
- **Plan Selection Form**: This form will be provided to applicable groups offering more than one plan.

CCO MVN and SAHA Primary Care Physician (PCP) Forms (Use when the the MVN or SAHA option is offered)

- **Primary Care Physician Selection Form:** Use this form when employees select the Primary Care Physician from the MVN or SAHA list of covered providers. Employees with enrolled dependents may select a different PCP from the list of covered providers if he/she chooses to do this. For example, the employee may select a General Practitioner while the child(ren) may select a Pediatrician.
- **Group Use Primary Care Physician Form:** Employers may use this form in place of or in addition to the Primary Care Selection Form noted above to designate which PCP an employee and dependents have selected.

Life Insurance/Short-Term Disability (STD)/Accident Plan Forms

- **Symetra Group Life Insurance and Disability Income Insurance Enrollment Form:**
  - Use this form when employees are enrolling, changing, or terminating basic life/AD&D, supplemental life, basic or buy-up STD.
  - Reminder: Minimum annual income for $200 STD buy-up is $26,000 and $400 STD buy-up is $43,333.
- **Symetra Group Life Insurance and Disability Income Insurance LIFE ONLY Enrollment Form:**
  - Use this form when employees are waiving or canceling medical coverage and only enrolling in basic life/AD&D and supplemental life for employees or dependents. Life Only enrollees are not eligible for basic or buy-up STD.
- **Symetra Group Accident Enrollment Form:**
  - Use this form when employees are enrolling in, changing, or terminating accident benefits.
- **Symetra Evidence of Insurability (EOI) Form:**
  - Use this form when employees are enrolling in or increasing their supplemental life insurance for themselves and/or dependents more than one increment or buying up STD. Please note the following regarding the EOI process:
    - Employees can enroll in $25,000 or increase their current coverage by one increment of $25,000 up to a maximum of $100,000 without completing (EOI) at open enrollment.
    - Spouses can enroll in $5,000 or increase their coverage by $5,000, not to exceed 50% of the employee's supplemental life enrollment without completing EOI at open enrollment.

- Children can enroll in $2,000 supplemental life if the employee is enrolled in any supplemental life insurance amount without EOI at open enrollment.
- Employees must complete EOI if enrolling in or increasing their buy-up STD at open enrollment.
- EOI is not required when enrolling or changing accident coverage at open enrollment.

Termination of Employment

- Send an email to healthplanteam@idahoagc.org with the employee name, last 4 digits of their social security number, termination date, and current address to remove a terminated employee from all benefit plans.

GROUP INFORMATION

TO BE COMPLETED BY GROUP ADMINISTRATOR
Group Number_____________ Effective Date ____________ Subgroup _______ Class______

IDAHO AGC HEALTH PLAN LARGE GROUP APPLICATION

Please type or print legibly in black ink and complete all applicable sections.

SECTION 1 EMPLOYER/EMPLOYMENT INFORMATION

1. Name of Employer			2. Phone Number ( )
3. Address	4. City	5. State	6. Zip Code
7. Occupation	8. Hours Worked Per Week	9. Date You Started Work *(mm/dd/yyyy)*	

SECTION 2 APPLICANT INFORMATION (Employee)

1. **Legal** First Name, Middle Name, Last Name *(and suffix, if applicable)*			
2. Mailing Address *(Street, Route, P.O. Box)*			
3. City	4. State	5. Zip Code	6.County
7. Preferred **Daytime** Phone Number ( )	8. Email Address		9. Marital Status ❑ Single ❑ Married ❑Other
10.Gender ❑ Male ❑ Female	11. Social Security Number **(required)**		12. Date of Birth *(mm/dd/yyyy)*
13.Height	14.Weight		

If you wish to waive coverage for you and/or any dependents at this time, please complete Section 3 – Waiver of Coverage. If you wish to enroll yourself and/or your dependents, please complete all sections except Section 3.

SECTION 3 WAIVER OF COVERAGE *(To be completed only if coverage is declined or refused by an eligible employee or dependents.)*

1. I decline coverage for:

Self (name) ____ Dependent (name)________________________________

Spouse (name) ____ Dependent (name)________________________________

Dependent (name) _______________________________________ Dependent (name)________________________________

2. Reason for declining coverage (check all that apply):

❑ I and/or my dependents currently have other qualifying medical coverage with (name of carrier) ________________________________ ____ through:

❑ My other employer ❑ My spouse's employer ❑ Individual policy ❑ Medicare ❑ Medicaid

❑ Tricare ❑ Indian Health Services **OR**

❑ Other reason for declining coverage (please explain): ____

SIGNATURE TO WAIVE**

I have decided to waive coverage as indicated above. I have been given the opportunity to apply for group coverage by the employer. Should I decide to apply for this coverage in the future, I realize and agree any coverage may be subject to additional probationary waiting periods.

****Signature** ____ **Date** _____________________________
(sign only if waiving coverage) *mm/dd/yyyy*

Notice of enrollment rights: If you are declining enrollment for you or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 60 days after the marriage, birth, adoption or placement for adoption.

FOR OFFICE USE ONLY Electronic System ID

SECTION 4 ENROLLMENT INFORMATION (check all that apply)

1. Are you: ❑ A new applicant ❑ Adding dependents ❑ Enrolling during your employer's open enrollment
2. If you are enrolling ***outside*** of your employer's open enrollment or adding dependents, please mark the appropriate reason below and provide the date of the event (mm/dd/yyyy) ___________________________

   (documentation may be required) ❑ Marriage ❑ Divorce ❑ Birth ❑ Adoption

   ❑ Involuntary loss of ***employer*** coverage* ❑ Involuntary loss of ***individual*** coverage*
   *Provide name of carrier ____

   ❑ Involuntary loss of Medicaid

   ❑ Court order *(copy of court order required)* ❑ Other _____________________________________

3. Type of enrollment:

	HEALTH	DENTAL	VISION
Self Only	❑	❑	❑
Self and spouse	❑	❑	❑
Self, spouse & dependents	❑	❑	❑
Self & one dependent	❑	❑	❑
Self & two or more dependents	❑	❑	❑

4. Current employment status:
   ❑ Actively at work ❑ Retiree ❑ COBRA participant ❑ Disability ❑ Other

SECTION 5

DEPENDENT INFORMATION (List all eligible dependents you wish to enroll, including any child who is under the age of 26; or who is medically certified as disabled and dependent on parent for support (copy certification required). If you have more dependents to include, make a copy of this page and attach.)

Dependent's Name (first, initial, last)	Social Security Number	Relationship (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yyyy)	Height	Weight	Gender
Dependent 1						❑ Male ❑ Female
Dependent 2						❑ Male ❑ Female
Dependent 3						❑ Male ❑ Female
Dependent 4						❑ Male ❑ Female
Dependent 5						❑ Male ❑ Female
Dependent 6						❑ Male ❑ Female

SECTION 6 OTHER COVERAGE INFORMATION

(Please complete the section below if you have other coverage that will remain in effect. If you have more policies to include, make a copy of this page and attach.)

Other Policy

1. Other Insurance Carrier Information: Insurance Carrier Name, Policy Number, Phone Number

2. Policy Holder Name

3. Names of Covered Members

4. Types of Coverage *(check all that apply)*
   ❑ Group ❑ Medical
   ❑ Individual ❑ Dental
   ❑ Medicare ❑ Vision

5. Coverage Start Date *mm/dd/yyyy*

6. Is this coverage terminating?
   ❑ Yes (complete #7)

7. Coverage End Date *mm/dd/yyyy*

8. Are you or any dependent listed on this application covered on Medicare or have received Social Security Disability or Worker's Compensation payments or are now eligible to receive such payments?
   ❑ **No**
   ❑ **Yes** If yes, give person's name, type of Coverage, and reason for entitlement: ___________________________________ _________

FOR OFFICE USE ONLY Electronic System ID

SECTION 7

HEALTH STATEMENT

(Complete this health statement if you apply for coverage for yourself or a family member after the original eligibility period.)

1. Have you or any family member listed on this application ever been advised to have any surgical operation(s) that you or any family member have not yet had?
   ❑ **YES** ❑ **NO**

2. Do you or any family member listed on this application suffer from any chronic or recurring ailments, illnesses or other departures from good health, regardless of whether a physician or other health care professional has been consulted?
   ❑ **YES** ❑ **NO**

3. During the past 12 months, have you or any family member listed on this application received a prescription for medication from a physician or taken any prescribed medication?
   ❑ **YES** ❑ **NO**

4. Are you or any family member listed on this application now pregnant?
   ❑**YES** ❑ **NO** If pregnant, what is the anticipated delivery date?

5. Have you or any family member listed on this application ever been refused or issued restricted health insurance coverage?
   ❑ **YES** ❑ **NO**

6. Have you or any family member listed on this application been hospitalized during the last 5 years?
   ❑ **YES** ❑ **NO**

7. Within the past two years, have you or any member of your family been treated for back/joint disorder?
   ❑ **YES** ❑ **NO**

8. Have you or any family member listed on this application ever had, been told he or she had, been counseled or treated for any of the following: alcohol/drug use or abuse, cancer, heart problem/disorder, diabetes, digestive disorder, immune disorder, renal/kidney disease, strokes, mental or nervous disorders or respiratory disorders?
   ❑ **YES** ❑ **NO**

If you checked YES to any question above, please provide details below *(please use extra paper if necessary)*:

Item No.	Person Affected	Mo./ Year	Name of Disease, Symptom or Condition – Include Type of Treatment	Name of Hospital and Number of Days	Date Last Treated	Was Recovery Complete?	Drugs – Include Type or Name, Dosage, Strength and Duration	Name of Physician

9. Has any person listed on this application used a tobacco product on average four or more times a week within no longer than the past six months (anyone age 18 or older)? ❑ No ❑ Yes **If yes**, list names below:

______________________________ ______________________________

______________________________ ______________________________

10. Are you or any of your dependents listed on this application currently disabled? ❑ No❑ Yes

Name of disabled person ______________________ Physician's name and phone ______________________

Date of disability ______________________ Physician's address ______________________

Nature of disability ______________________

FOR OFFICE USE ONLY Electronic System ID

SECTION 8 AFFIRMATION

I affirm the answers in this "Idaho AGC Health Plan Large Group Application" are complete and correct. I am providing these answers as part of the application procedure required by the Idaho AGC Health Plan to enroll in its coverage. I understand that the Idaho AGC Health Plan will rely on each answer in making its determination to extend coverage and to determine the type of coverage offered. I understand if I have made any misstatement or omission in this application, the Idaho AGC Health Plan may take any action available by law, including but not limited to, retroactive adjustment of contributions or claims. Further, I understand that any fraud or intentional misrepresentation of material fact on the part of the employer is cause for retroactive termination of coverage by the Idaho AGC Health Plan and/or other action available by law. I will promptly inform the Idaho AGC Health Plan in writing if anything happens before my coverage takes effect that makes an answer on this application incomplete or incorrect. Following receipt of a fully-executed application, coverage will be in force as of the effective date determined by the Idaho AGC Health Plan under applicable law.

SECTION 9 STATEMENT OF UNDERSTANDING

By signing this application, I represent that all my answers are complete and accurate and that I understand and agree to the following conditions:

- No independent producer, agent or employee of the Idaho AGC Health Plan, or of my employer, can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- The Idaho AGC Health Plan may terminate or rescind an employer's group coverage for any intentional misrepresentation omission of fact by, concerning, or on behalf of any applicant by the employer that was or would have been material to the Idaho AGC Health Plan's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim.
- As proof of status of employment, I authorize my employer to release to the Idaho AGC Health Plan appropriate documents, including but not limited to W-2 Wage and Tax Statements and other wage and tax summaries or forms.
- Coverage for me and any eligible persons named on this application will begin on the effective date pursuant to the terms of the plan/ contract.
- I agree to abide by the terms of the group's master policy/member certificate, which sets forth all of the terms and conditions of my coverage. No agent or other person can change the terms of the master contract, any of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of the Idaho AGC Health Plan.
- I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.

SECTION 10 ACKNOWLEDGMENT

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the enrollment form) for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.

Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- A clinic, hospital, long-term care or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies or;
- An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

This acknowledgment does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

Signature of Employee ______________________________ Date *(mm/dd/yyyy)* ______________

Signature of Spouse ______________________________ Date *(mm/dd/yyyy)* ______________
(if applying for coverage)

FOR OFFICE USE ONLY Electronic System ID

Idaho AGC HEALTH PLAN

Employee's Waiver of Health Care Coverage

If you decline to enroll either yourself or your eligible family members in the health care coverage offered by your employer, we ask that you complete this form. **Qualified late enrollees who decline coverage may not reapply for coverage until their employer's policy renewal date or experience a qualifying event.**

I certify that I have been informed of the availability of coverage under my employer's health benefit plan, but I choose not to enroll *(please check all that apply and list each eligible family member's name)*:

☐ myself ______________________________ ☐ my eligible child(ren): ____________________________________

☐ my spouse ______________________________ ____________________________________

I have chosen to decline health care coverage at this time because:

☐ I and/or my dependents have other group or individual coverage with (*name of insurance company*) ________________________

through (*insured's name and relationship*) ____

☐ Other reason(s) to waive coverage (please specify): ____

I understand that if, at this time, I decline coverage offered by my employer for myself or my eligible family members, and then choose to apply for coverage later, the plan may exclude coverage, except in the following instances:

1. The individual meets each of the following:

   a. The individual(s) lost coverage as a result of termination of employment or eligibility, the involuntary termination as a result of a qualifying event.
   b. The employer stops contributing towards your or your dependents' other coverage; and
   c. The individual request submits a enrollment application within 30 days after termination or qualifying event.

2. A court has ordered that coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within 30 days after issuance of the court order; or

3. If an individual seeks to enroll a dependent(s) during the first sixty (60) days of eligibility, the coverage of the dependent(s) shall become effective:

   a. in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received after the application is received;
   b. in the case of a dependent's birth, as of the date of such birth; or
   c. in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

______________________________ ______________________________
Please print name *Name of group*

______________________________ ______________________________
Social Security number *Group number*

______________________________ ______________________________
Employee's signature *Date* *Group administrator's signature* *Date*

Idaho AGC
HEALTH PLAN

CANCELLATION REQUEST - EMPLOYEE/DEPENDENT

(To be used by the employee when removing self or dependents while remaining an **active** employee)

Employer Name: ______________________________________ Group Number:______________________

Employee Name: ______________________________________ SSN: ________________________________

I, ____, request that the following persons be cancelled
(Employee Name)

from the Idaho AGC Health Plan on the last day of the month of ________________, 20________ at Midnight.
(Month) (Year)

Reason for cancellation (required):____

____

____

(Divorce: provide the date the divorce is final. If requested cancellation date is prior to divorce finalization the spouse being cancelled must sign).

Individuals cancelling coverage:

1.____________________________________ SSN: xxx-xx-___________________

2.____________________________________ SSN: xxx-xx-___________________

3.____________________________________ SSN: xxx-xx-___________________

4.____________________________________ SSN: xxx-xx-___________________

5.____________________________________ SSN: xxx-xx-___________________

6.____________________________________ SSN: xxx-xx-___________________

Employee Signature:______________________________________ Date: ____________________________

Spouse Signature:______________________________________ Date: _____________________________

SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: Benefits Division | PO Box 34690 | Seattle, WA 98124-1690
Phone 1-800-426-7784 | Fax 1-866-348-0058 | TTY/TDD 1-800-833-6388

GROUP LIFE INSURANCE AND DISABILITY INCOME INSURANCE ENROLLMENT

TO BE COMPLETED BY THE POLICYHOLDER

Policy Number 01-018070-00 / Idaho AGC Health Benefit Plan

Employer/Policyholder Name ____________________

Street Address ____________ City Boise State ID Zip Code 83702

Employee Occupation/Job Title ____________________

Employee Date of Employment ____________________

Effective Date of Coverage ____________________

☐ Full Time Employee ☐ Part Time Employee

$____________/ ☐ HR ☐ WK ☐ MO ☐ YR
Basic Earnings

Social Security Number ____________________

Reason for Enrolling ____________________

I. EMPLOYEE/ENROLLEE INFORMATION

Name ____________________ Sex ☐ M ☐ F

Street Address ____________ City ____________ State ____ Zip Code ____

Home Telephone Number ____________ Date of Birth ____________ Marital Status ____________

II. BENEFITS (Please check if you wish to enroll)

	Y	No	Indicate the benefit amount
Employee Life	X		$25,000 Flat Amount – Employer Paid
Employee AD&D	X		$25,000 Flat Amount – Employer Paid
Basic Spouse Life	X		$5,000 Flat Amount – Employer Paid
Basic Child Life	X		$5,000 Flat Amount – Employer Paid
Core Short-Term Disability Income Insurance	X		$125 Flat Amount – Employer Paid
*Employee Supplemental Life (Select one)			$25,000 or $50,000 or $75,000 or $100,000
Dependents who are Confined will be subject to a Deferred Effective Date – see your Certificate for details.			
Dependent Supplemental Life			
**Spouse[2]			$ ____________ (In $5,000 Increments)
Child[2]			$2,000 Flat Amount
Buy Up Short-Term Disability Income Insurance			
➢ Option 1			$325 Flat Amount includes Basic
➢ Option 2			$525 Flat Amount includes Basic

*New hires -> For Employee Supplemental Life, employee may elect in increment of $25,000 up to a maximum of $100,000 without evidence of insurability.

-> **For Dependent Spouse Supplemental Life coverage, employee may elect in increments of $5,000, up to a maximum of $50,000; not to exceed 50% of the Employee Supplemental Life benefit amount.

*During annual modified open enrollment –> For Employee Supplemental Life, employee may increase the current coverage by one increment without Evidence of Insurability.

->** For Dependent Spouse Supplemental Life coverage, employee may increase the current coverage by one increment without Evidence of Insurability

[2] ***List Dependents' names and birthdates (use another page if needed).***

Name	Relationship	Date of Birth	Name	Relationship	Date of Birth

III. BENEFICIARY DESIGNATION

Primary Beneficiary: The person or persons you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

Contingent Beneficiary: The person or persons you want to receive the life insurance benefit if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

	NAME	ADDRESS	DATE OF BIRTH	RELATIONSHIP	% OF BENEFIT
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

IV. SELECTION/WAIVER OF GROUP INSURANCE *(Only check one box below, and sign.)*

☐ I, the undersigned, elect the insurance coverage which I selected above and 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, the undersigned, hereby waive my right at this time to elect the insurance coverage which I did not select above. I understand that if I do not enroll within 31 days of the date I am first eligible, that I will not be able to obtain coverage in the future without submitting satisfactory evidence of insurability (proof of good health) to Symetra Life Insurance Company for approval. I also understand that Symetra Life Insurance Company will have the right to refuse my request for insurance.

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 to the best of my knowledge and belief is true and complete.

Enrollee/Employee Signature _______________________ Date Signed _______________________

Group Benefits are insured by Symetra Life Insurance Company.

Symetra® is a registered service mark of Symetra Life Insurance Company.

SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: Benefits Division | PO Box 34690 | Seattle, WA 98124-1690
Phone 1-800-426-7784 | Fax 1-866-348-0058 | TTY/TDD 1-800-833-6388

Life Only Enrollments

GROUP LIFE INSURANCE AND DISABILITY INCOME INSURANCE ENROLLMENT

TO BE COMPLETED BY THE POLICYHOLDER

Policy Number 01-018070-00 / Idaho AGC Health Benefit Plan

Employer/Policyholder Name ____________________

Street Address ____________ City Boise State ID Zip Code 83702

Employee Occupation/Job Title ____________ Employee Date of Employment ____________

Effective Date of Coverage ____________ ☐ Full Time Employee ☐ Part Time Employee

$____________/ ☐ HR ☐ WK ☐ MO ☐ YR
Basic Earnings

Social Security Number ____________

Reason for Enrolling ____________

I. EMPLOYEE/ENROLLEE INFORMATION

Name ____________ Sex ☐ M ☐ F

Street Address ____________ City ____________ State ____________ Zip Code ____________

Home Telephone Number ____________ Date of Birth ____________ Marital Status ____________

II. BENEFITS (Please check if you wish to enroll)

	Y	No	Indicate the benefit amount
Employee Life	X		$25,000 Flat Amount – Employer Paid
Employee AD&D	X		$25,000 Flat Amount – Employer Paid
Basic Spouse Life	X		$5,000 Flat Amount – Employer Paid
Basic Child Life	X		$5,000 Flat Amount – Employer Paid
Core Short-Term Disability Income Insurance		X	$125 Flat Amount – Employer Paid
*Employee Supplemental Life (Select one)			$25,000 or $50,000 or $75,000 or $100,000
Dependents who are Confined will be subject to a Deferred Effective Date – see your Certificate for details.			
Dependent Supplemental Life			
**Spouse[2]			$ ____________ (In $5,000 Increments)
Child[2]			$2,000 Flat Amount
Buy Up Short-Term Disability Income Insurance			
➤ Option 1		X	$325 Flat Amount includes Basic
➤ Option 2		X	$525 Flat Amount includes Basic

*New hires -> For Employee Supplemental Life, employee may elect in increment of $25,000 up to a maximum of $100,000 without evidence of insurability.

-> **For Dependent Spouse Supplemental Life coverage, employee may elect in increments of $5,000, up to a maximum of $50,000; not to exceed 50% of the Employee Supplemental Life benefit amount.

*During annual modified open enrollment –> For Employee Supplemental Life, employee may increase the current coverage by one increment without Evidence of Insurability.

->** For Dependent Spouse Supplemental Life coverage, employee may increase the current coverage by one increment without Evidence of Insurability

[2] ***List Dependents' names and birthdates (use another page if needed).***

Name	Relationship	Date of Birth	Name	Relationship	Date of Birth

III. BENEFICIARY DESIGNATION

Primary Beneficiary: The person or persons you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

Contingent Beneficiary: The person or persons you want to receive the life insurance benefit if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

	NAME	ADDRESS	DATE OF BIRTH	RELATIONSHIP	% OF BENEFIT
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

IV. SELECTION/WAIVER OF GROUP INSURANCE *(Only check one box below, and sign.)*

☐ I, the undersigned, elect the insurance coverage which I selected above and 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, the undersigned, hereby waive my right at this time to elect the insurance coverage which I did not select above. I understand that if I do not enroll within 31 days of the date I am first eligible, that I will not be able to obtain coverage in the future without submitting satisfactory evidence of insurability (proof of good health) to Symetra Life Insurance Company for approval. I also understand that Symetra Life Insurance Company will have the right to refuse my request for insurance.

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 to the best of my knowledge and belief is true and complete.

______________________________ Enrollee/Employee Signature

______________________________ Date Signed

Group Benefits are insured by Symetra Life Insurance Company.

Symetra® is a registered service mark of Symetra Life Insurance Company.

SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135

Mailing Address: Select Benefit Administrators
PO Box 440 | Ashland, WI 54806
Overnight deliveries to: 118 3rd Street East | Ashland, WI 54806
Phone 1-800-497-3699 | Fax (715) 682-5919

ACCIDENT BENEFIT

ENROLLMENT/CHANGE REQUEST
For Select Benefits Group Insurance

Group Information (To be Completed by Employer)

Group name	Effective date for action requested	Group number

☐ Newly-Eligible Request ☐ Subsequent Enrollment Period ☐ Special Enrollment Request

Reason____

Authorized Representative signature (required)	Date

Name (printed)	Title

Your Information (To be completed by individual requesting coverage)

Name	Social Security number

Date of birth	Date of hire	Gender	Home phone	Work phone
		☐ M ☐ F		

Job title / occupation	I am actively working	Average number of hours worked per week
	☐ Yes ☐ No	

Home address	City	State	Zip

Email address	Marital Status
	☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Separated ☐ Widowed

Action Requested

☐ Enroll in the coverage for insurance as selected below.
☐ Change (add, increase, decrease, terminate) my current coverage, as shown below.
☐ Update information about me, my dependents and/or beneficiaries.
☐ Terminate all current coverage.

Coverage

Accident

Option_______________________________
Identify coverage option

☐ Self
☐ Self plus spouse
☐ Self plus child(ren)
☐ Self plus family
☐ Decline

Symetra® is a registered service mark of Symetra Life Insurance Company.
Select Benefit Administrators is an administrative division of Symetra Life Insurance Company, 777 108th Ave NE, Suite 1200, Bellevue, WA 98004-5135.

Dependent Information *(Complete to add, change or terminate coverage for dependents. List additional dependents on a separate sheet and attach to this form.)*

No person can be insured under any policy as both a certificateholder and a dependent, or as a dependent of more than one certificateholder. The effective date of coverage for a dependent who is confined may be delayed.

Name

Date of birth	Gender	Full-time student	Relationship
	☐ M ☐ F	☐ Yes ☐ No	

Home address (if different than your address) City State Zip

☐ Add
☐ Change
☐ Terminate
Coverage: ☐ Accident

Name

Date of birth	Gender	Full-time student	Relationship
	☐ M ☐ F	☐ Yes ☐ No	

Home address (if different than your address) City State Zip

☐ Add
☐ Change
☐ Terminate
Coverage: ☐ Accident

Name

Date of birth	Gender	Full-time student	Relationship
	☐ M ☐ F	☐ Yes ☐ No	

Home address (if different than your address) City State Zip

☐ Add
☐ Change
☐ Terminate
Coverage: ☐ Accident

Signatures *(Sign and date **only one option** below. Retain a copy for yourself. Provide the original to your insured group's representative.)*

Authorization *(If you are enrolling in, changing or updating coverage)*

☐ I, the undersigned, elect the insurance coverage which I selected above and for which I am eligible under the terms of the group policy (or policies) insured by Symetra Life Insurance Company. I authorize the deduction from my earnings for any contribution I am required to make toward the cost of this insurance. I further understand that I may not be able to make any changes to my elected coverage until the next enrollment period.

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 to the best of my knowledge and belief is true and complete.

This form replaces all Enrollment/Change Request forms previously submitted.

Enrollee/Employee signature	Date

Waiver *(If you are declining or terminating all coverage.)*

☐ I, the undersigned, hereby waive my right at this time to elect the insurance coverage which I did not select above. I understand that if I do not enroll within 30 days of the date I am first eligible, that I may have to wait to obtain coverage until the next enrollment period.

Further, I understand that I may not be able to obtain coverage for life insurance, disability, or critical illness benefits in the future without submitting satisfactory evidence of insurability to Symetra Life Insurance Company for approval. I also understand that Symetra Life Insurance Company will have the right to refuse my request for insurance.

Reason: ☐ I already have insurance ☐ Other________________________________

All information submitted by me on this form to the best of my knowledge and belief is true and complete.

This form replaces all Enrollment/Change Request forms previously submitted.

Enrollee/Employee signature	Date

SYMETRA®
RETIREMENT | BENEFITS | LIFE

Evidence of Insurability for Group Coverage Applicants Residing in Idaho

Instructions

Employer/Policyholder Please complete Page 2 and provide to the employee/applicant to complete.

Employee/Applicant Please complete page 3, sign and date page 4 and an "Authorization for Release of Medical Information" form. If applying for spouse coverage, have your spouse complete page 6, sign and date page 7 and an "Authorization for Release of Medical Information" form. Return to Symetra for processing.

Two copies of the 'Authorization for Release of Medical Information' form are included in the back of this packet. One for you and one for your spouse, if applicable.

Completed forms can be mailed or faxed to: Symetra Life Insurance Company PO Box 34690 Seattle, WA 98124-1690 Fax: 1-866-348-0058	Comments

Symetra® is a registered service mark of Symetra Life Insurance Company.

SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
Benefits Division
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: PO Box 34690 | Seattle, WA 98124-1690
Phone 1-800-426-7784 | TTY/TDD 1-800-833-6388
Fax completed forms to: 1-866-348-0058

EVIDENCE OF INSURABILITY FOR GROUP COVERAGE

Policyholders: Completely fill out Sections 1 – 3 and forward to the applicant to complete, sign and return to Symetra.

Section 1: Group Plan Details *(to be completed by Policyholder)*

Company name (policyholder)	Policy number
Division or associated company (if applicable)	
Company mailing address (street, city, state, zip code)	
Benefits contact name (first, last)	
Benefits contact email address	Benefits contact phone (include area code)

Section 2: Applicant Details *(to be completed by Policyholder)*

Name of applicant	Date of hire (mm/dd/yyyy)
Class	Basic Annual Earnings*

*As described in the group policy

Section 3: Coverages Requested *(to be completed by Policyholder)* ***Check all that apply***

Coverage (Check all that apply)	Current amount of coverage (including GI** amount)	Additional coverage requested	Total coverage amount
(Example for Life Policies)	$25,000	$100,000	$125,000
☐ Applicant: Basic Life			
☐ Applicant: Supplemental or Voluntary Life			
☐ Spouse: Basic Life			
☐ Spouse: Supplemental or Voluntary Life			
☐ Child: Basic Life			
☐ Child: Supplemental or Voluntary Life			

Coverage	Yes	No
☐ Applicant: Short Term Disability	☐ Yes	☐ No
☐ Applicant: Voluntary Short Term Disability	☐ Yes	☐ No
☐ Applicant: Long Term Disability	☐ Yes	☐ No
☐ Applicant: Voluntary Long Term Disability	☐ Yes	☐ No

**Guarantee Issue (GI) is the maximum amount of coverage defined by the group policy that does not require evidence of insurability.

Section 4: Applicant Information *(to be completed by applicant)*

Applicant name (first, last)				Gender ☐ Male ☐ Female
Applicant address (street, city, state, zip code)				
Date of birth	Height	Weight	Driver License number	Email address
State of birth	Day phone (include area code)	Evening phone (include area code)		

How may we best contact you?
Symetra offers secure e-mail for the quickest turnaround time ☐ Mail ☐ Email ☐ Day phone ☐ Evening phone

Full name, address and phone of your personal physician

Section 5: Applicant Health Information *(to be completed by applicant)*

The following health questions must be answered fully and truthfully to the best of your knowledge and belief. If any misstatements or omissions are made, they may be the basis for later rescission of your insurance coverage. Rescission voids your coverage and claims will not be paid.

1. Are you pregnant? ☐ Yes ☐ No **If yes, please give details in the Health Information Section including due date.**
2. In the past ten years, or as indicated below, have you been treated for, or been diagnosed with by a member of the medical profession as having any of the following conditions? **If yes, please check the box and provide details in Section 6.**
   - a) ☐ Heart Disease or Disorder
   - b) ☐ Bipolar Disorder, Major Depressive Disorder, or Schizophrenia
   - c) ☐ Alcoholism and/or Drug Use
   - d) ☐ Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection/Disease, or tested Positive to the AIDS virus (HIV)
   - e) ☐ Stroke, Paralysis
   - f) ☐ Multiple Sclerosis, ALS (Lou Gehrig's Disease)
   - g) ☐ Type I/Insulin-Dependent Diabetes
   - h) ☐ Grand Mal Epilepsy or Generalized Seizures
   - i) ☐ Hepatitis B or C
   - j) ☐ Cirrhosis of the liver
3. In the past ten years, or as indicated below, have you been treated for, or been diagnosed with by a member of the medical profession as having any of the following conditions? **If yes, please check the box and provide details in Section 6.**
   - k) ☐ Non-Insulin Dependent/ Type II Diabetes
   - l) ☐ Mental & Nervous Disorder; Depression/Anxiety
   - m) ☐ Brain or Central Nervous System disorder; Parkinsonism, Absence Seizures/Petit Mal Epilepsy
   - n) ☐ Liver Disorder
   - o) ☐ Kidney Disorder
   - p) ☐ Blood Disorder
   - q) ☐ Stomach, Abdominal, Intestinal Disorder
   - r) ☐ Bone, Joint, Connective Tissue Disorder
   - s) ☐ Cancer, Tumors
   - t) ☐ Gland Disorder
   - u) ☐ Lungs, Respiratory Disorder
4. Have you consulted, been advised or been examined by any healthcare provider for any other medical reason within the last ten years, or as indicated above? ☐ Yes ☐ No
   If yes, please indicate condition and provide details in the Health Information Section.

Section 6: Applicant Health Information *(to be completed by the applicable person)*

Question # or Letter	Details of Yes answers	Onset Mo. Yr.	Duration	Degree of recovery	Name/address/phone of attending physician

Please list all your medications

Medication	Dosage/Frequency	What condition is treated with this medication?	Onset Mo. Yr.

By signing below, 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. I also agree that I have read and understand the fraud warning on the following page which applies to me.

Signature of applicant	Date
Print name	

Remember to complete an "Authorization for Release of Medical Information" form to send to Symetra with this package.

Applicant's copy

Disclosure Notice to Applicants for Insurance

This brief description of our underwriting process is designed to help you to understand how an application for insurance is handled, the type and sources of information we may collect about you, the circumstances under which we may disclose that information to others and your right to learn the nature and substance of that information upon written request. Your medical history and current physical condition, which is obtained from various sources, are factors, which are considered in determining your insurability.

Sources of Information:

Your application, including the medical history, is a primary source of information in the evaluation process. We may also ask for a report from your doctor, hospital, pharmacy, pharmacy benefit manager or another insurance company. When we do so, we use the authorization form you sign with your application. It is sometimes necessary that we ask you to take a physical examination or other special tests such as an electrocardiogram and/or blood test.

Disclosure to Others:

Personal information obtained about you during the underwriting process is confidential and will not be disclosed to other persons or organizations without your written authorization except to the extent necessary for the conduct of our business. Examples of situations where we share information about you are as follows:

1. The agent may retain a copy of your application. If reinsurance is required, the reinsurance company would have access to our application file.
2. We may release information to another life insurance company to whom you have applied for life or health insurance or to whom you have submitted a claim for benefits, if you have authorized them to obtain this information.
3. We would disclose information to government regulatory officials, law enforcement authorities and others where required by law.

Disclosure to You:

If an adverse underwriting decision is made, we will notify you of the reason(s) for that decision and the source of the information upon which our action is based. Medical record information, however, will be given only to a licensed physician of your choice.*

Symetra Life Insurance Company respects your right to the privacy of your personal information. This notice is provided to you to help you understand that information, which is obtained, is treated in a confidential manner. You have a right of access and correction with respect to all personal information collected. Upon written request, we will provide you with a more detailed description of our information practices and your rights of access and correction.

**For residents of Louisiana and Massachusetts only:*

Medical record information will be given to a medical professional designated by you and licensed to provide the kind of medical care in question or, if you prefer, to you directly. Mental health record information will be given directly to you only with the approval or the professional who has treatment responsibility for the condition in question.

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

For all states not named: 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.

AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AR, LA, RI, WV: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit 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.

AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA: For your protection California law requires the following to appear hereon: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DE: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DC: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

ME: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

NH: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NM: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NY: The following applies to health insurance only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TN, VA, WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TX: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Section 7: Spouse or Domestic Partner or Civil Union Partner Information

(to be completed by the Spouse or Domestic Partner or Civil Union Partner (if applicable))

Spouse/Domestic Partner name (first, last)	Gender ☐ Male ☐ Female

Address (street, city, state, zip code)

Date of birth	Height	Weight	Drivers license number	Email address

State of birth	Day phone (include area code)	Evening phone (include area code)

How may we best contact you?
Symetra offers secure e-mail for the quickest turnaround time ☐ Mail ☐ Email ☐ Day phone ☐ Evening phone

Full name, address and phone of your personal physician

Section 8: Spouse or Domestic Partner or Civil Union Partner Health Information *(to be completed by the applicable person)*

The following health questions must be answered fully and truthfully to the best of your knowledge and belief. If any misstatements or omissions are made, they may be the basis for later rescission of your insurance coverage. Rescission voids your coverage and claims will not be paid.

1. Are you pregnant? ☐ Yes ☐ No **If yes, please give details in the Health Information Section including due date.**
2. In the past ten years, or as indicated below, have you been treated for, or been diagnosed with by a member of the medical profession as having any of the following conditions? **If yes, please check the box and provide details in Section 9.**
   - a) ☐ Heart Disease or Disorder
   - b) ☐ Bipolar Disorder, Major Depressive Disorder, or Schizophrenia
   - c) ☐ Alcoholism and/or Drug Use
   - d) ☐ Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection/Disease, or tested Positive to the AIDS virus (HIV)
   - e) ☐ Stroke, Paralysis
   - f) ☐ Multiple Sclerosis, ALS (Lou Gehrig's Disease)
   - g) ☐ Type I/Insulin-Dependent Diabetes
   - h) ☐ Grand Mal Epilepsy or Generalized Seizures
   - i) ☐ Hepatitis B or C
   - j) ☐ Cirrhosis of the liver
3. In the past ten years, or as indicated below, have you been treated for, or been diagnosed with by a member of the medical profession as having any of the following conditions? **If yes, please check the box and provide details in Section 9.**
   - k) ☐ Non-Insulin Dependent/ Type II Diabetes
   - l) ☐ Mental & Nervous Disorder; Depression/Anxiety
   - m) ☐ Brain or Central Nervous System disorder; Parkinsonism, Absence Seizures/Petit Mal Epilepsy
   - n) ☐ Liver Disorder
   - o) ☐ Kidney Disorder
   - p) ☐ Blood Disorder
   - q) ☐ Stomach, Abdominal, Intestinal Disorder
   - r) ☐ Bone, Joint, Connective Tissue Disorder
   - s) ☐ Cancer, Tumors
   - t) ☐ Gland Disorder
   - u) ☐ Lungs, Respiratory Disorder
4. Have you consulted, been advised or been examined by any healthcare provider for any other medical reason within the last ten years, or as indicated above? ☐ Yes ☐ No
   If yes, please indicate condition and provide details in the Health Information Section.

Section 9: Spouse/Domestic Partner/Civil Union Partner Health Information *(to be completed by the applicable person)*

Question # or Letter	Details of Yes answers	Onset Mo. Yr.	Duration	Degree of recovery	Name/address/phone of attending physician

Please list all your medications

Medication	Dosage/Frequency	What condition is treated with this medication?	Onset Mo. Yr.

By signing below, 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. I also agree that I have read and understand the fraud warning on the following page which applies to me.

Signature of Spouse/Domestic Partner (if applicable)	Date
Print name	

Remember to complete an "Authorization for Release of Medical Information" form to send to Symetra with this package.

Applicant's copy

Disclosure Notice to Applicants for Insurance

This brief description of our underwriting process is designed to help you to understand how an application for insurance is handled, the type and sources of information we may collect about you, the circumstances under which we may disclose that information to others and your right to learn the nature and substance of that information upon written request. Your medical history and current physical condition, which is obtained from various sources, are factors, which are considered in determining your insurability.

Sources of Information:

Your application, including the medical history, is a primary source of information in the evaluation process. We may also ask for a report from your doctor, hospital, pharmacy, pharmacy benefit manager or another insurance company. When we do so, we use the authorization form you sign with your application. It is sometimes necessary that we ask you to take a physical examination or other special tests such as an electrocardiogram and/or blood test.

Disclosure to Others:

Personal information obtained about you during the underwriting process is confidential and will not be disclosed to other persons or organizations without your written authorization except to the extent necessary for the conduct of our business. Examples of situations where we share information about you are as follows:

1. The agent may retain a copy of your application. If reinsurance is required, the reinsurance company would have access to our application file.
2. We may release information to another life insurance company to whom you have applied for life or health insurance or to whom you have submitted a claim for benefits, if you have authorized them to obtain this information.
3. We would disclose information to government regulatory officials, law enforcement authorities and others where required by law.

Disclosure to You:

If an adverse underwriting decision is made, we will notify you of the reason(s) for that decision and the source of the information upon which our action is based. Medical record information, however, will be given only to a licensed physician of your choice.*

Symetra Life Insurance Company respects your right to the privacy of your personal information. This notice is provided to you to help you understand that information, which is obtained, is treated in a confidential manner. You have a right of access and correction with respect to all personal information collected. Upon written request, we will provide you with a more detailed description of our information practices and your rights of access and correction.

**For residents of Louisiana and Massachusetts only:*

Medical record information will be given to a medical professional designated by you and licensed to provide the kind of medical care in question or, if you prefer, to you directly. Mental health record information will be given directly to you only with the approval or the professional who has treatment responsibility for the condition in question.

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

For all states not named: 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.

AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AR, LA, RI, WV: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit 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.

AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA: For your protection California law requires the following to appear hereon: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DE: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DC: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

ME: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

NH: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NM: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NY: The following applies to health insurance only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TN, VA, WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TX: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

SYMETRA®
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
PO Box 34690 | Seattle, WA 98124-1690
Phone: 1-800-426-7784 | Fax: 1-866-348-0058 | TTY/TDD 1-800-833-6388

Note: We will accept an authorization form preferred by your provider's office in place of this authorization form.

SYMETRA LIFE INSURANCE COMPANY
Authorization for Release of Medical Information

Group Life Policy Number: __________________________

Name of insured/patient (please type or print): ____ Date of birth: _________________

I authorize any physician, health care professional, hospital, clinic, medical facility, laboratory, pharmacy or pharmacy benefit manager, other health care provider, insurance company, or government agency that has provided treatment, services, or payment to me or on my behalf ("My Providers") to disclose my entire medical record, medications prescribed, prescription history, and any other protected health information concerning me to Symetra Life Insurance Company, its employees, agents, or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness, excluding psychotherapy notes, and the use of alcohol, drugs, and tobacco.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Symetra Life Insurance Company may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; 3) obtain reinsurance; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Symetra Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Symetra Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers have already relied on this Authorization to disclose information about me or to the extent that Symetra Life Insurance Company has a legal right to contest a claim under an insurance policy. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Symetra Life Insurance Company except as authorized by me or as required by law.

This Authorization complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

I understand that if I refuse to sign this authorization to release my complete medical record, Symetra Life Insurance Company may not be able to process my application, continue my coverage, or make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

____ _________________________

Signature of Insured/Patient or Personal Representative Date

____

Description of Personal Representative's Authority or Relationship to Patient

Symetra® is a registered service mark of Symetra Life Insurance Company.

SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
PO Box 34690 | Seattle, WA 98124-1690
Phone: 1-800-426-7784 | Fax: 1-866-348-0058 | TTY/TDD 1-800-833-6388

Note: We will accept an authorization form preferred by your provider's office in place of this authorization form.

SYMETRA LIFE INSURANCE COMPANY
Authorization for Release of Medical Information

Group Life Policy Number: __________________________

Name of insured/patient (please type or print): ____ Date of birth: _________________

I authorize any physician, health care professional, hospital, clinic, medical facility, laboratory, pharmacy or pharmacy benefit manager, other health care provider, insurance company, or government agency that has provided treatment, services, or payment to me or on my behalf ("My Providers") to disclose my entire medical record, medications prescribed, prescription history, and any other protected health information concerning me to Symetra Life Insurance Company, its employees, agents, or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness, excluding psychotherapy notes, and the use of alcohol, drugs, and tobacco.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Symetra Life Insurance Company may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; 3) obtain reinsurance; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Symetra Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Symetra Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers have already relied on this Authorization to disclose information about me or to the extent that Symetra Life Insurance Company has a legal right to contest a claim under an insurance policy. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Symetra Life Insurance Company except as authorized by me or as required by law.

This Authorization complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

I understand that if I refuse to sign this authorization to release my complete medical record, Symetra Life Insurance Company may not be able to process my application, continue my coverage, or make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

____ _____________________________

Signature of Insured/Patient or Personal Representative | Date

____

Description of Personal Representative's Authority or Relationship to Patient

Symetra® is a registered service mark of Symetra Life Insurance Company.

Symetra Life, Short-Term Disability, and Accident Rates and Benefit Summaries

Group Life Insurance

Basic Life and Accidental Death & Dismemberment

SUMMARY OF BENEFITS

Class 1

Sponsored By:	**Idaho AGC Health Benefit Plan**
Effective Date:	**January 1, 2020**
Policy Number:	**01-018070-00**

The information in this summary may be replaced by any subsequently issued summary or policy amendment.

Employee	**Life Benefit**
Amount	$25,000
Minimum Amount	$25,000
Maximum Amount	$25,000
Guarantee Issue	$25,000

Employee	**AD&D Benefit**
Amount	$25,000
Minimum Amount	$25,000
Maximum Amount	$25,000

Spouse	**Dependent Life Benefit**
Spouse Amount	$5,000
Maximum Amount	$5,000
Guarantee Issue	$5,000

Child	**Dependent Life Benefit**
Child Amount	15 day(s) to 26 year(s): $5,000

Benefit Reduction	**Employee**
Current Benefit Amount Reduced By	35% at age 70 15% at age 75 20% at age 80

Eligibility

All active full-time employees eligible for medical coverage working a minimum of 30 hours per week and their eligible dependents.

Symetra® is a registered service mark of Symetra Life Insurance Company.

Additional Benefit Details	
Accelerated Death Benefit	If an employee has been diagnosed as terminally ill, Symetra Life Insurance Company may pay a portion of the death benefit in advance to the employee. Please refer to your employee certificate for additional information.
Conversion	A conversion benefit is available that allows you to convert your group coverage to an individual policy if certain conditions apply. Please refer to your employee certificate for additional information.
Portability	This coverage may be continued at group rates upon termination of employment. Certain restrictions apply. Please refer to your employee certificate for additional information.
Waiver of Premium	With proof of disability, Symetra Life Insurance Company will waive Life Insurance premiums for an employee that becomes disabled. Certain restrictions apply. Please refer to your employee certificate for additional information.
AD&D Riders	Includes Seat Belt, Airbag, Repatriation, Child Education, Day Care, Rehabilitation, Spouse Education, Adaptive Home and Vehicle, Critical Burn, Therapeutic Counseling, Felonious Assault and Coma benefits. Please refer to your employee certificate for additional information.

Value Added Services	
Beneficiary Companion	Support services for beneficiaries who have experienced a loss.
Travel Assist	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.
Identity Theft Protection	Help is just a phone call away wherever employees travel, including lost wallet protection, translation service and emergency cash.

Contact Information for Claims

Phone: 1-877-377-6773
Fax: 1-877-737-3650

Symetra Life Insurance Company
Life and Absence Management Center
P.O. Box 1230
Enfield, CT 06083-1230

Symetra® is a registered service mark of Symetra Life Insurance Company.

This summary provides only a brief description of the Life Insurance coverage insured by Symetra Life Insurance Company under the LGC-13000 8/06 series Group Life Insurance policy. For a complete description, including all definitions, exclusions, limitations, and reductions in coverage, as well as information on termination of benefits, please contact your benefit administrator or refer to the Group Insurance Certificate you will receive when you become insured. Coverage will be offered under Group Policy number 01-018070-00. All benefits are subject to the terms and conditions of the Group Policy. If there is a difference between the information in this summary and the information contained in the Group Insurance Certificate, the terms of the Group Insurance Certificate will prevail. The terms of coverage may change over time; always refer to your current Group Insurance Certificate for information regarding your insurance benefits.

Insured by Symetra Life Insurance Company

Symetra® is a registered service mark of Symetra Life Insurance Company.

Group Life Insurance — Supplemental Life

SUMMARY OF BENEFITS — Class 1

Sponsored By: **Idaho AGC Health Benefit Plan**
Effective Date: **January 1, 2020**
Policy Number: **01-018070-00**

The information in this summary may be replaced by any subsequently issued summary or policy amendment.

Employee	**Life Benefit**
Amount	Increments of $25,000
Minimum Amount	$25,000
Maximum Amount	$100,000
Guarantee Issue	$100,000

Spouse	**Life Benefit**
Spouse Amount	Increments of $5,000
Minimum Amount	$5,000
Maximum Amount	$50,000 not to exceed 50% of Supplemental Employee Coverage
Guarantee Issue	$50,000

Child	**Life Benefit**
Child Amount	15 day(s) to 26 year(s): $2,000

Benefit Reduction	**Employee**
No Reductions	

Benefit Reduction	**Spouse**
	Benefits Terminate at Age 70

Eligibility	
	All active full-time employees eligible for medical coverage working a minimum of 30 hours per week and their eligible dependents.

Symetra® is a registered service mark of Symetra Life Insurance Company.

Evidence of Insurability	
New Hires:	Enroll within 31 days after becoming eligible under The Policy without Evidence of insurability.
Annual Enrollment:	During annual enrollment, employee may enroll or elect one increment of $25,000 for employee and one increment of $5,000 for spouse without Evidence of Insurability. Evidence of Insurability is required for any election during annual enrollment over one increment of $25,000 for employee and one increment of $5,000 for spouse.

Additional Benefit Details	
Accelerated Death Benefit	If an employee has been diagnosed as terminally ill, Symetra Life Insurance Company may pay a portion of the death benefit in advance to the employee. Please refer to your employee certificate for additional information.
Conversion	A conversion benefit is available that allows you to convert your group coverage to an individual policy if certain conditions apply. Please refer to your employee certificate for additional information.
Portability	This coverage may be continued at group rates upon termination of employment. Certain restrictions apply. Please refer to your employee certificate for additional information.
Waiver of Premium	With proof of disability, Symetra Life Insurance Company will waive Life Insurance premiums for an employee that becomes disabled. Certain restrictions apply. Please refer to your employee certificate for additional information.

Contact Information for Claims

Phone: 1-877-377-6773
Fax: 1-877-737-3650

Symetra Life Insurance Company
Life and Absence Management Center
P.O. Box 1230
Enfield, CT 06083-1230

Symetra® is a registered service mark of Symetra Life Insurance Company.

Rates for Supplemental Life coverage

Monthly Employee and Spouse* Supplemental Life Rates per $1,000 of coverage

AGE	RATE
Under 25	$0.067
25 - 29	$0.070
30 - 34	$0.094
35 - 39	$0.119
40 - 44	$0.142
45 - 49	$0.211
50 - 54	$0.351
55 - 59	$0.625
60 - 64	$0.878
65 - 69	$1.616
70 - 74	$2.617
75 - 100	$2.617

***Supplemental Spouse Life Rates are based on Spouse's Age**

Monthly Child Supplemental Life Rate per Family Unit of coverage is $0.40

Calculating Your Cost

Supplemental Employee Life:	(volume)	x	(rate)	/1,000 =	$ Monthly Cost
Supplemental Spouse Life:	(volume)	x	(rate)	/1,000 =	$ Monthly Cost

This summary provides only a brief description of the Life Insurance coverage insured by Symetra Life Insurance Company under the LGC-13000 8/06 series Group Life Insurance policy. For a complete description, including all definitions, exclusions, limitations, and reductions in coverage, as well as information on termination of benefits, please contact your benefit administrator or refer to the Group Insurance Certificate you will receive when you become insured. Coverage will be offered under Group Policy number 01-018070-00. All benefits are subject to the terms and conditions of the Group Policy. If there is a difference between the information in this summary and the information contained in the Group Insurance Certificate, the terms of the Group Insurance Certificate will prevail. The terms of coverage may change over time; always refer to your current Group Insurance Certificate for information regarding your insurance benefits.

Insured by Symetra Life Insurance Company

Symetra® is a registered service mark of Symetra Life Insurance Company.

Group Disability Insurance **Short Term Disability**

SUMMARY OF BENEFITS Class 1

Sponsored By: **Idaho AGC Health Benefit Plan**
Effective Date: **January 1, 2020**
Policy Number: **01-018070-00**

The information in this summary may be replaced by any subsequently issued summary or policy amendment.

Benefit Highlights:

Benefit Amount	$125 per week
Minimum Benefit Amount	$15
Maximum Payment Duration	13 weeks
Elimination Period	Accident - 14 days Sickness - 14 days (number of days you must be disabled to collect disability benefits)
Accumulation of Elimination Days	You can satisfy the days of your elimination period with either total (off work entirely) or partial (working some hours at your current job) disability.

Eligibility

All Full-Time Employees Participating in the Idaho AGC Sponsored Medical Plan and working a minimum of 30 hours per week.

Standard Provisions:

- Maternity is covered the same as any other condition.
- Non Occupational
- 14 days recurrent disability/temporary recovery

Symetra® is a registered service mark of Symetra Life Insurance Company.

Contact Information for Claims

Phone: 1-877-377-6773
Fax: 1-877-737-3650

Symetra Life Insurance Company
Life and Absence Management Center
P.O. Box 1230
Enfield, CT 06083-1230

This summary provides only a brief description of the Disability Income Insurance coverage insured by Symetra Life Insurance Company under the GDC 4000 series Group Disability Income Insurance policy. For a complete description, including all definitions, exclusions, limitations, and reductions in coverage, as well as information on termination of benefits, please contact your benefit administrator or refer to the Group Insurance Certificate you will receive when you become insured. Coverage will be offered under Group Policy number 01-018070-00. All benefits are subject to the terms and conditions of the Group Policy. If there is a difference between the information in this summary and the information contained in the Group Insurance Certificate, the terms of the Group Insurance Certificate will prevail. The terms of coverage may change over time; always refer to your current Group Insurance Certificate for information regarding your insurance benefits.

Insured by Symetra Life Insurance Company

Symetra® is a registered service mark of Symetra Life Insurance Company.

Group Disability Insurance — Short Term Disability

SUMMARY OF BENEFITS — Class 1

Sponsored By: **Idaho AGC Health Benefit Plan**
Effective Date: **January 1, 2020**
Policy Number: **01-018070-00**

The information in this summary may be replaced by any subsequently issued summary or policy amendment.

Benefit Highlights:

Benefits:

Core plan	$125 per week
Buy-up plan	Additional $200 per week

Minimum Benefit Amount $15

Maximum Payment Duration 13 weeks

Elimination Period Accident - 14 days

Sickness - 14 days

(number of days you must be disabled to collect disability benefits)

Accumulation of Elimination Days You can satisfy the days of your elimination period with either total (off work entirely) or partial (working some hours at your current job) disability.

Eligibility

All Full-Time Employees Participating in the Idaho AGC Sponsored Medical Plan earning a minimum of $26,000 or more Annually and electing the $200 Buy Up working a minimum of 30 hours per week.

New Hire: Enroll within 31 days after becoming eligible under The Policy without Evidence of insurability.

Late Entrant: You will need to provide Evidence of Insurability if you apply for coverage more than 31 days after the date you are first eligible to apply.

Symetra® is a registered service mark of Symetra Life Insurance Company.

Standard Provisions:

- Maternity is covered the same as any other condition.
- Non Occupational
- 14 days recurrent disability/temporary recovery

Contact Information for Claims

Phone: 1-877-377-6773
Fax: 1-877-737-3650

Symetra Life Insurance Company
Life and Absence Management Center
P.O. Box 1230
Enfield, CT 06083-1230

Costs for Buy Up Short Term Disability coverage

Monthly costs:

AGE	Monthly Cost
Under 45	$3.20
45 - 49	$4.10
50 - 54	$4.78
55 - 59	$5.80
60 and over	$7.00

Insured by Symetra Life Insurance Company

This summary provides only a brief description of the Disability Income Insurance coverage insured by Symetra Life Insurance Company under the GDC 4000 series Group Disability Income Insurance policy. For a complete description, including all definitions, exclusions, limitations, and reductions in coverage, as well as information on termination of benefits, please contact your benefit administrator or refer to the Group Insurance Certificate you will receive when you become insured. Coverage will be offered under Group Policy number 01-018070-00. All benefits are subject to the terms and conditions of the Group Policy. If there is a difference between the information in this summary and the information contained in the Group Insurance Certificate, the terms of the Group Insurance Certificate will prevail. The terms of coverage may change over time; always refer to your current Group Insurance Certificate for information regarding your insurance benefits.

Symetra® is a registered service mark of Symetra Life Insurance Company.

Group Disability Insurance — Buy Up Short Term Disability

SUMMARY OF BENEFITS — Class 2

Sponsored By: **Idaho AGC Health Benefit Plan**
Effective Date: **January 1, 2020**
Policy Number: **01-018070-00**

The information in this summary may be replaced by any subsequently issued summary or policy amendment.

Benefit Highlights:

Benefits:	
Core plan	$125 per week
Buy-up plan	Additional $400 per week
Minimum Benefit Amount	$15
Maximum Payment Duration	13 weeks
Elimination Period	Accident - 14 days Sickness - 14 days (number of days you must be disabled to collect disability benefits)
Accumulation of Elimination Days	You can satisfy the days of your elimination period with either total (off work entirely) or partial (working some hours at your current job) disability.

Eligibility

All Full-Time Employees Participating in the Idaho AGC Sponsored Medical Plan earning a minimum of $43,333 or more Annually and electing the $400 Buy Up working a minimum of 30 hours per week.

New Hire: Enroll within 31 days after becoming eligible under The Policy without Evidence of insurability.

Late Entrant: You will need to provide Evidence of Insurability if you apply for coverage more than 31 days after the date you are first eligible to apply.

Symetra® is a registered service mark of Symetra Life Insurance Company.

Standard Provisions:

- Maternity is covered the same as any other condition.
- Non Occupational
- 14 days recurrent disability/temporary recovery

Contact Information for Claims

Phone: 1-877-377-6773
Fax: 1-877-737-3650

Symetra Life Insurance Company
Life and Absence Management Center
P.O. Box 1230
Enfield, CT 06083-1230

Cost for Buy Up Short Term Disability coverage

Monthly cost:

AGE	Monthly Cost
Under 40	$8.80
40 - 44	$9.20
45 - 49	$11.60
50 - 54	$14.00
55 - 59	$17.20
60 and over	$20.00

This summary provides only a brief description of the Disability Income Insurance coverage insured by Symetra Life Insurance Company under the GDC 4000 series Group Disability Income Insurance policy. For a complete description, including all definitions, exclusions, limitations, and reductions in coverage, as well as information on termination of benefits, please contact your benefit administrator or refer to the Group Insurance Certificate you will receive when you become insured. Coverage will be offered under Group Policy number 01-018070-00. All benefits are subject to the terms and conditions of the Group Policy. If there is a difference between the information in this summary and the information contained in the Group Insurance Certificate, the terms of the Group Insurance Certificate will prevail. The terms of coverage may change over time; always refer to your current Group Insurance Certificate for information regarding your insurance benefits.

Insured by Symetra Life Insurance Company

Symetra® is a registered service mark of Symetra Life Insurance Company.

Symetra Life Insurance Company
First Symetra National Life Insurance Company of New York

Accident Coverage

Help when the unexpected happens

Accidents can happen to anyone, at any time. Could you afford the financial hit if an accident happened to you or someone in your family? Select Benefits accident coverage can help with some of the costs after an accident, so you and your family can get the care you need and get back to your daily routine.

How it works

Select Benefits accident coverage provides benefits for **up to three accidents per covered person per calendar year**. That means **all eligible expenses associated with an accident are covered at 100%, up to the benefit limits**. Benefits are paid no matter what other coverage you may have, and you can visit any provider you like.

The first expense must be incurred within 60 days of the accident, with all remaining expenses incurred within 52 weeks of the accident.

Why accident coverage?

Understanding how accident coverage fits into your overall benefits package can help you decide if it's right for you and your family.

Consider your health care out-of-pocket liability. **Accident coverage can help close coverage gaps when there are deductible, copay or coinsurance requirements to meet.**

Accident coverage benefits can also be used to pay for additional costs triggered by an accident, such as child or elder care during recovery.

Turn the page to learn more

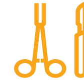
What's covered?

X-rays

Benefits are provided for eligible expenses incurred in connection with an accident when they are ordered or performed by a physician.

Inpatient prescription drugs

Benefits are provided for eligible expenses incurred in connection with an accident if the insured is confined in a hospital, and the drugs are prescribed by a physician and administered in the hospital by a licensed health care provider.



Surgery

Benefits are provided for eligible expenses incurred in connection with an accident when surgical procedures are performed by a licensed physician.

Dental

Benefits are provided for eligible expenses performed by a licensed physician or licensed dentist in connection with the following accidents:

- Dislocation of jaw
- Injury to natural teeth
- Closed or open reduction of a fracture

Medical

Benefits are provided for the following services and supplies when they are provided or prescribed by a licensed physician or other licensed health care provider in connection with an accident:

- Physician office visits
- Emergency room visits
- Outpatient hospital visits
- Urgent care visits
- Chiropractic visits
- Rehabilitation services
- Nursing services

Inpatient hospital

Benefits are provided for eligible expenses incurred in connection with an accident if all of the following conditions are met:

- The insured is confined in a hospital.
- A charge is made for room and board.
- The entire duration of the hospital confinement is recommended and approved by a physician.
- Confinement is the result of a non-occupational accident.
- The services and supplies used are not excluded under the exclusions and limitations provision of the policy.

DID YOU KNOW?

LACK THE SAVINGS TO COVER A $500 EXPENSE[1]

Claims Example

Carlos and Angela both work at ABC, Inc. and knew that enrolling in their company's accident coverage was the right decision for their lifestyles. Carlos chose to cover himself and his family while Angela only needed coverage for herself. Here's how the year went for these two employees:

ABC, Inc. offers a Symetra accident plan that pays up to $2,500 per occurrence for up to three occurrences per person, per year.

Carlos and his family

One morning Carlos falls off a ladder while cleaning the gutters and hurts his back and head.

Emergency room: $720
X-ray: $510
MRI: $1,025
Physician fees: $300

Total expenses: $2,555
Benefits paid: $2,500
Out-of-pocket: **$55**

While playing soccer, Carlos and his son Jason run into each other. Jason loses a tooth and Carlos sprains his ankle.

Carlos:

Doctor's office: $234
X-ray: $180
Physical therapy: $500

Total expenses: $914
Benefits paid: $914
Out-of-pocket: **$0**

Jason:

Dental exam: $288
Dental implant surgery: $1,500

Total expenses: $1,788
Benefits paid: $1,788
Out-of-pocket: **$0**

Angela

One evening, Angela crashes her bike and ends up cutting her knee and breaking her collarbone.

Urgent care: $200
Stitches: $1,250
X-ray: $115
Physician fees: $175

Total expenses: $1,740
Benefits paid: $1,740
Out-of-pocket: **$0**

For illustrative purposes only.

Even though Carlos and Angela also enrolled in the ABC, Inc. major medical plan, they were able to use their Symetra accident coverage to help meet their deductible requirement.

Turn the page to learn more

Why enroll?

Let's face it, our lives are busy. Whether we're going straight from work to the grocery store or heading to after-school activities, we're not thinking about things taking unexpected turns. But if they do, Select Benefits accident coverage can help. By paying 100% of all eligible expenses up to the policy limit, these valuable benefits help allow you to focus on recovery after an accident, not your finances.

To learn more about how Select Benefits accident coverage can make a difference for you and your family, talk to your HR or benefits representative.

In addition to a lower group rate, enrolling in Symetra accident coverage through your employer also means:

- **Easy enrollment**
- **No medical questionnaires**
- **Convenient payroll deduction**

Get started

- ☑ Review your enrollment material.
- ☑ Follow the steps outlined by your benefits team.
- ☑ Complete the enrollment process.

Don't miss your opportunity to enroll in this valuable coverage at work.
To get started, talk to your HR or benefits representative.

www.symetra.com
www.symetra.com/ny

Symetra® is a registered service mark of Symetra Life Insurance Company.

Accident coverage is designed to pay benefits up to a preselected, per-occurrence amount for eligible expenses related to an accidental injury. It is not a replacement for a major medical policy or other comprehensive coverage and may be subject to exclusions, limitations, reductions and termination of benefit provisions. For costs and complete details of the coverage, contact your benefits representative.

Select Benefits accident coverage policies are insured by Symetra Life Insurance Company, 777 108th Avenue NE, Suite 1200, Bellevue, WA 98004. Policy form number is LGC-10011C 10/11 in most states. Not available in all U.S. states or any U.S. territory.

In New York, a Select Benefits accident coverage policy is insured by First Symetra National Life Insurance Company of New York, New York, NY. Mailing address: P.O. Box 34690, Seattle, WA 98124. Policy form number is LGC-10011C/NY 10/11.

Symetra Life Insurance Company is a direct subsidiary of Symetra Financial Corporation. First Symetra National Life Insurance Company of New York is a direct subsidiary of Symetra Life Insurance Company and is an indirect subsidiary of Symetra Financial Corporation (collectively, "Symetra"). Neither Symetra Financial Corporation nor Symetra Life Insurance Company solicits business in the state of New York and they are not authorized to do so. Each company is responsible for its own financial obligations.

[1] 6 in 10 Americans don't have $500 in savings: http://money.cnn.com/2017/01/12/pf/americans-lack-of-savings/index.html

Select Benefits Plan Design for
12306000 - The Idaho AGC

SYMETRA
RETIREMENT | BENEFITS | LIFE

Group Accident

Group Accident Benefit	up to $2,500 per occurrence 3 occurrences per person, per calendar year maximum
Monthly Premium	
Employee	$14.12
Employee + Spouse	$30.09
Employee + Children	$23.14
Family	$41.90

Value-add benefits are included at no additional cost to you. These services are provided by Health Advocate, Inc., 3043 Walton Road, Suite 150, Plymouth Meeting, PA 19462. Please review the Value-add benefits flier for more information on these services. Not an insured benefit.

Description of Benefit

Group Accident Benefit
This benefit pays eligible expenses up to the benefit amount selected per accident occurrence. Expenses must be incurred within 52 weeks from the date of the accident with the first expense incurred within 60 days of the date of the accident.

Health Advocacy
Personalized assistance with a full range of health coverage and insurance-related issues such as locating doctors and other providers, scheduling appointments, getting cost estimates and more.

NurseLine™
Direct access to a registered nurse 24/7 for non-urgent concerns.

Medical Bill Saver™
Help negotiating with providers for medical and dental bills that are not covered by your insurance.

EAP+Work/Life
Licensed professional counselors and work/life specialists provide confidential, short-term help with personal, family and work-related issues.

Wellness Program
Unlimited access to highly trained wellness coaches by telephone, email or instant messaging. Includes a comprehensive, secure wellness website.

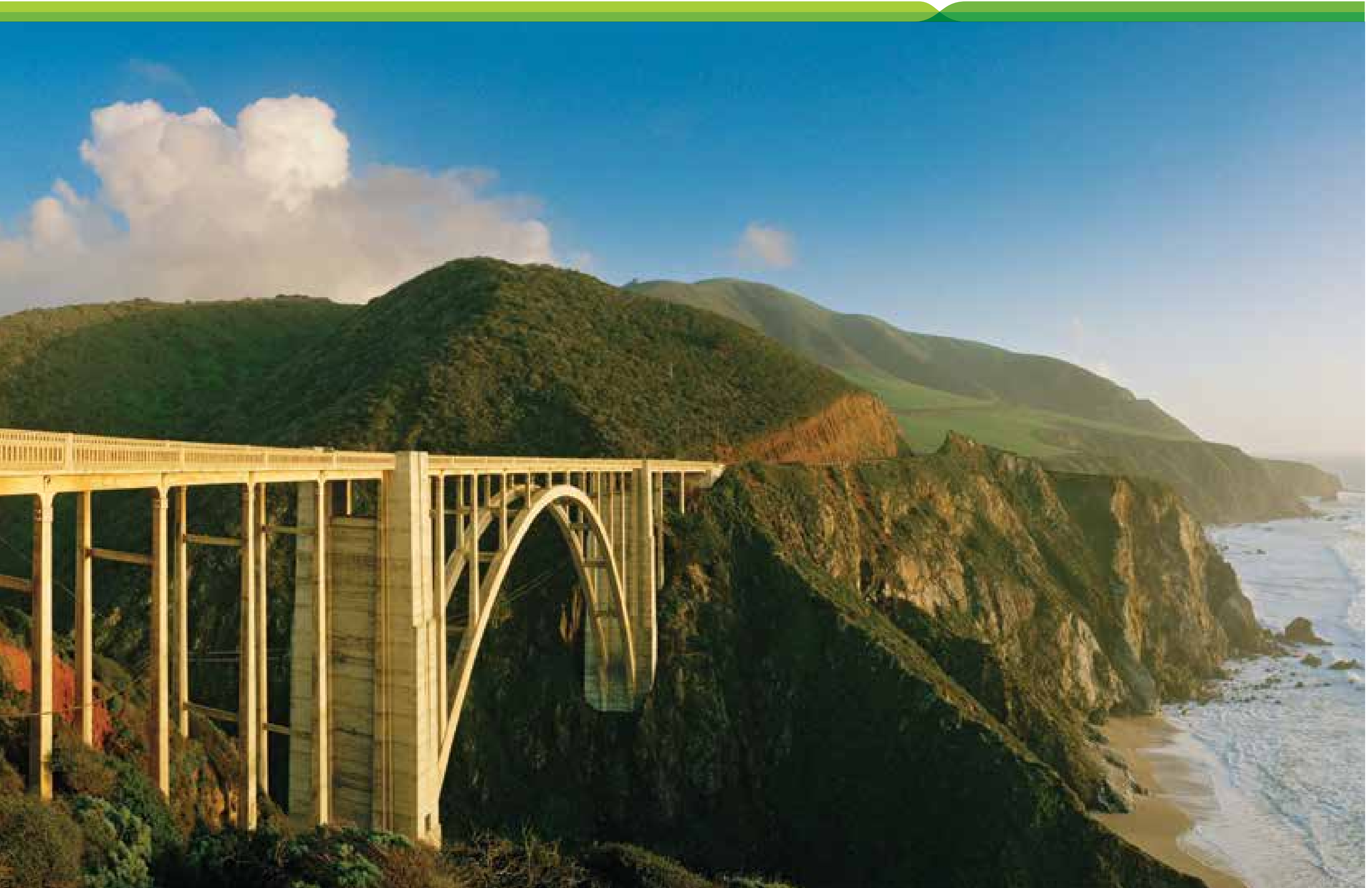
If there is any conflict between this information and the policy issued, the terms of the policy will prevail.

Select Benefits insurance policies are not a replacement for a major medical policy or other comprehensive coverage and do not satisfy the minimum essential coverage requirements of the Affordable Care Act. They are designed to provide benefits at a preselected, fixed-dollar amount. Coverage may be subject to exclusions, limitations, reductions, and termination of benefit provisions. Select Benefits policies are insured by Symetra Life Insurance Company located at 777 108th Avenue NE, Suite 1200, Bellevue, WA 98004, and are not available in all U.S. states or any U.S. territory. Coverage is provided under generic policy form numbers SBC-00500, SBC-00535, and LGC-10011 or LGC-9072.

SYMETRA®
RETIREMENT | BENEFITS | LIFE

A network of support

Value-Add Programs for Group Life and Disability Income Insurance



Support for life's changes

We can't predict where life is going to take us. An injury or illness could send an otherwise active person out on disability leave for an indefinite period of time. Or the loss of a loved one may leave a family struggling to cope with the emotional and financial stress of rebuilding their lives.

That's when employees truly appreciate the network of professional support offered with **Group Life and Disability Income Insurance** from Symetra Life Insurance Company and First Symetra National Life Insurance Company of New York. Our value-add programs complement the insurance benefits provided under each policy and strengthen our goal of getting people to a better place.

Employee Assistance Program (EAP) with Will Preparation

Finds the resources employees need to help with a variety of issues such as finding child or elder care, managing a serious illness or dealing with work/life issues.

Health Care Navigation

Encourages employees on a covered disability leave to become educated, engaged consumers in their health care.

Travel Assistance

Provides support when employees are traveling 100 miles or more away from home.

Identity Theft Protection Program

Helps protect employees from ID theft while providing support in the event their identity is stolen.

Beneficiary Companion

Offers a helping hand for families after a loss.

Employee Assistance Program (EAP)

It's tough for employees to do their best at work when faced with challenges such as finding child or elder care, dealing with substance abuse or managing family relationships. That's where an EAP can help.

Program Highlights

Five confidential face-to-face sessions[1]

Enrolled employees and their household family members are eligible for up to five confidential sessions with a counselor, financial planner or lawyer each calendar year.

- Consultations may be face-to-face or by phone
- Sessions are per household and may be divided between the three types of professionals
- Counselors provide an assessment of concerns and refer participants to appropriate resources and providers
- Financial and legal professionals assist with matters such as tax-filing questions, debt issues, guardianship and power of attorney
- An additional five sessions are available in the event of a covered disability claim

Will preparation

EAP also includes will preparation services via the "Featured Programs" section of www.guidanceresources.com. Employees can create a simple, legally binding will for just $14.99; printing and mailing services are available for an additional fee. Prices may be subject to change—contact ComPsych for additional information.

Who's Eligible?

DisabilityGuidance® (provided by ComPsych®) is available to anyone covered by a Symetra Group Disability Income Insurance policy at no additional employer cost.

For more information on the full service GuidanceResources® EAP option, which provides valuable tools for HR representatives and managers, contact your Symetra representative.

Accessing Services

Employees can call toll-free **1-888-327-9573**. The website, **www.guidanceresources.com.** provides access to self-assessment tools; tailored searches for child and elder care, attorneys and CPAs; and other helpful services. **Use SYMETRA in the Organization Web ID field to log in.**

[1] In California, counseling sessions are limited to three sessions in a six-month period.

Health Care Navigation

Employees generally find themselves on their own when it comes to dealing with their medical plan. They're eager to find resources that can reassure them they are making the best decisions—a partner who can help navigate through their medical plan benefits.

Administrative Support

- Easy-to-understand explanation of benefits—help identifying what's covered and what's not
- Step-by-step guidance on medical claims and billing issues
- Cost estimation for covered and/or non-covered treatment options
- Fee and payment plan negotiation
- Referral to financial resources for the underinsured and uninsured
- Explanation of the appeals process

Clinical Support

- One-on-one reviews of employee health concerns
- Straightforward, easy-to-understand answers regarding specific diagnosis and treatment options
- Support and preparation for upcoming doctor's visits, lab work, tests and surgeries
- Coordination with appropriate health care plan provider(s)
- Referral to community resources and applicable support groups

Administrative and clinical specialists may also refer employees to DisabilityGuidance® EAP services and other work/life resources.

Who's Eligible?

HealthChampion℠ (provided by ComPsych) is available for employees on a covered short- or long-term disability leave.

For more information on buy-up programs including options that offer HealthChampion to all employees, regardless of disability claim status, contact your Symetra representative.

Accessing Services

Claimants can call **1-866-263-4365** to access the health care navigation program 24 hours a day, seven days a week.

Assistance While Traveling

The Travel Assistance Program is available 24 hours a day to help protect employees, their spouses and dependent children from the unpredictable, whenever they travel 100 miles or more from home for less than 90 consecutive days.*

Key Services

- Help finding physicians, dentists and medical facilities
- Medical monitoring to determine if care is appropriate
- Transportation to a hospital/treatment facility or return home for treatment
- Arrangement for a dependent or traveling companion's return home
- Replacement of medication and eyeglasses
- Emergency message relay to and from friends, relatives and business associates
- Emergency cash
- Assistance locating lost or stolen items
- Legal assistance/bail
- Interpretation/translation services

Additionally, participants can call anytime and from anywhere to get pre-trip information or ask questions.

Who's Eligible?

Travel Assistance (provided by Europ Assistance) is available to individuals covered by Symetra Group Life and/or Disability Income Insurance policies.

For more information and plan design requirements, contact your Symetra representative.

Accessing Services

Employees just pick up the phone—24 hours a day, seven days a week—and call **1-877-823-5807** from North America or **(240) 330-1422** from anywhere else in the world.

*Students are covered for longer.

Identity Theft Protection Program

Identity theft is a rising concern. The Symetra Identity Protection Program provides employees with information to protect themselves and step-by-step coaching to help identify and resolve identity theft.[1]

Key Services

- Lost wallet assistance[2]
- Credit information review[3]
- 3-bureau fraud alert placement assistance
- ID theft affidavit assistance
- Translation services while traveling
- Emergency cash advance while traveling (a repayment guarantee is needed)

A comprehensive Identity Theft Resolution Kit will provide employees with information and includes documentation and details about how to tackle the problem if their identity has been compromised.

Who's Eligible?

Identity Theft Protection (provided by Europ Assistance) is available to individuals covered by Symetra Group Life and/or Disability Income Insurance policies.

For more information and plan design requirements, contact your Symetra representative.

Accessing Services

Employees can call anytime, from anywhere—24 hours a day, seven days a week. The number for North America is **1-877-823-5807** and those traveling anywhere else in the world can call **(240) 330-1422.**

[1] Identity thefts discovered prior to enrollment in Symetra Group Insurance are not eligible for services.

[2] Europ Assistance will assist you with cancelling lost credit cards and provide information to help you replace lost items such as your driver's license and Social Security card.

[3] Member must provide a copy of their credit report which can be obtained free of charge at www.annualcreditreport.com (once every 12 months).

A Helping Hand for Beneficiaries

The Beneficiary Companion Program is there to help with paperwork and other time-consuming details, providing relief from the confusion and frustration of managing a loved one's final affairs.

Key Services

- Guidance on how to obtain death certificate copies for final notifications
- Dedicated Beneficiary Assistance Coordinators to manage notifications and close loved one's accounts, including:

  Social Security Administration

  Credit reporting agencies

  Credit card companies/financial institutions

  Third-party vendors

  Government agencies

- Assistance protecting the loved one's identity and full resolution services in case the deceased's identity is stolen

Who's Eligible?

Beneficiary Companion (provided by Europ Assistance) is available to individuals covered by Symetra Group Life and/or Disability Income Insurance policies.

For more information and plan design requirements, contact your Symetra representative.

Accessing Services

Beneficiaries can call the Symetra-dedicated toll-free number at **1-877-823-5807** for 24/7 support.

About Symetra

Symetra is a financially strong, well-capitalized company on the rise, as symbolized by our brand icon—the swift. Swifts are quick, hardworking and nimble—everything we aspire to be when serving our customers. We've been in business for more than half a century, operating on a foundation of financial stability, integrity and transparency. Our commitment is to create employee benefits products that people need and understand.

To learn more about us, visit www.symetra.com, www.symetra.com/ny or contact your representative.

About ComPsych

ComPsych is the largest provider of employee assistance programs, managed behavioral health, work/life and crisis intervention services.

About Europ Assistance

As the inventor of the assistance concept in 1963, Europ Assistance has handled more than 225 million cases in their company history.

www.symetra.com
www.symetra.com/ny

Symetra® is a registered service mark of Symetra Life Insurance Company.

Symetra Life Insurance Company and First Symetra National Life Insurance Company of New York (collectively, 'Symetra') are subsidiaries of Symetra Financial Corporation. Each company is responsible for its own financial obligations. Symetra Life Insurance Company and Symetra Financial Corporation do not solicit business in the state of New York and are not authorized to do so.

Group insurance policies are insured by and absence management programs are provided by Symetra Life Insurance Company, 777 108th Ave NE, Suite 1200, Bellevue, WA 98004 and are not available in any U.S. territory.

In New York, group insurance policies are insured by and absence management programs are provided by First Symetra National Life Insurance Company of New York, New York, NY. Mailing address: P.O. Box 34690, Seattle, WA 98124. Value-add programs are not available with New York group term life insurance coverage.

Coverage may be subject to exclusions, limitations, reductions and termination of benefit provisions.

EAP, Will Preparation and Health Care Navigation are offered by ComPsych® Corporation through Symetra Financial Corporation subsidiaries. Benefits may not be available in all states. Travel Assistance, Identity Theft Protection and Beneficiary Companion programs are offered by Europ Assistance through Symetra Financial Corporation subsidiaries. Benefits may not be available in all states. ComPsych Corporation and Europ Assistance are not affiliated with any of the subsidiaries under Symetra Financial Corporation.