



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

Telephone: 1-800-SYMETRA or 1-800-796-3872

## **Important information regarding your Certificate of Insurance:**

This Certificate evidencing your insurance coverage is made available to you by your group insurance policyholder.

Symetra Life Insurance Company is only responsible for the accuracy of the Certificate which Symetra provides to the policyholder. The policyholder is **solely** responsible for the accuracy of the information contained herein.

From time to time your Certificate may be modified by Symetra, and an updated electronic Certificate will be made available to you by the policyholder. You are advised to periodically review your Certificate to ensure that you have the most current version.

You have the right to request a paper copy of your current Certificate at any time. If you wish to receive a paper copy of your Certificate you may obtain one by contacting the policyholder.

# Idaho AGC Health Benefit Plan

## Group Disability Income Insurance Benefits Summary Plan Description

**PLEASE READ THIS IMPORTANT NOTICE**

The Employee Retirement Income Security Act of 1974 (ERISA) requires that the Plan Sponsor provide a Summary Plan Description to Plan Participants.

This document, together with the attached Certificate of Insurance (“Certificate”) issued by Symetra Life Insurance Company (“Symetra”) to the Plan Sponsor, is your Summary Plan Description. It provides you an overview of the Plan and addresses certain information that may not be included in the attached Certificate.

This document is not intended to give a Plan Participant any substantive rights to benefits that are not already provided by the attached Certificate. If the terms of this summary document conflict with the terms of the insurance contract, then the terms of the insurance contract will control, unless superseded by applicable law.

**Plan Name**

Idaho AGC Health Plan Group Disability Insurance Plan

**Plan Year**

January 1 to December 31

**Plan Effective Date**

January 1, 2020

**Type of Plan**

Fully Insured Group Short Term Disability Plan

**Policyholder**

Trustees of the Idaho AGC Benefit Plan Trust  
1649 W. Shoreline Drive, Suite 100  
Boise, Idaho 83702

**Policy Number**

01 018070 00

**Plan Sponsor, EIN and Number**

Idaho AGC Health Plan  
Plan EIN: 82-0447719  
Plan Number: 3936

**Insurance Company and Contact Information**

Symetra Life Insurance Company  
P. O. Box 2993  
Hartford, CT 06104-2993  
Toll Free Number: 1-800-943-2107  
Fax Number: 1-860-392-3672

**Type of Plan Administration**

Symetra and Plan Administrator

**Claims Administrator**

Claims administration for disability income benefits under your Plan is provided by Symetra Life Insurance Company (Symetra) according to the terms of a Group Disability Income Insurance policy. The Plan Administrator has designated Symetra as a Named Fiduciary for benefit claims.

**Plan Administrator and Named Fiduciary**

Idaho AGC Health Plan  
1649 W. Shoreline Drive, Suite 100  
Boise, Idaho 83702  
Telephone Number: (208) 344-9755

**Agent for Service of Legal Process for the Plan**

Idaho AGC Health Plan  
1649 W. Shoreline Drive, Suite 100  
Boise, Idaho 83702

Service of legal process may also be made on the Plan Administrator or a Plan Trustee, if any.

**Trustees of the Plan**

Adam Warr, Vice President of Accounting, PO Box 190476, Boise, ID 83719  
Rebecca Strickland, Contoller, 5319 S Apple St, Boise, ID 83715  
Kori Bonney, Owner-Manager, 301 N 700 W, Blackfoot, ID 83221  
Charles Paulin, Engineer, 2345 S Whisperwood Way, Boise, ID 83709  
Ila Eberhardt, HR Manager, 225 S Wooddale Ave #105, Eagle, ID 83616

**If you have questions regarding the Plan, please contact the Policyholder or Plan Administrator.**

### **Funding Medium and Type of Plan Administration**

The Plan is fully insured. Benefits are provided under the terms of a Group Life Insurance policy entered into between Idaho AGC Health Benefit Plan and Symetra. Claims for benefits are sent to the Insurance Company. Symetra (not Idaho AGC Health Benefit Plan) is responsible for paying benefits. Idaho AGC Health Benefit Plan is the Plan Administrator. As the Plan Administrator, Idaho AGC Health Benefit Plan is responsible for satisfying certain legal requirements under ERISA with respect to the Plan (for example, distributing SPDs and filing an annual report about the Plan with the U.S. Department of Labor).

Insurance premiums for covered individuals are paid in part by the Plan Sponsor out of its general assets, and in part by employee payroll deductions.

Idaho AGC Health Benefit Plan provides a schedule of the applicable premiums; contact the Health Plan Director of Idaho AGC Health Benefit Plan if you need another copy.

### **Plan Interpretation**

The Plan Administrator has delegated to Symetra the exclusive right, power, and authority, in its sole and absolute discretion, to interpret the Plan (including the terms of the Plan set forth in the attached Certificate) including (but not limited to) the sole and absolute discretionary authority to take all actions and make all decisions regarding questions of coverage, eligibility, and entitlement to benefits, and benefit amounts, and to process and approve or deny all claims for benefits.

### **Amendment or Termination**

Idaho AGC Health Benefit Plan, as the sponsor of the Plan, has the general right to amend or terminate the Plan or any component benefit program under the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by the Idaho AGC Health Benefit Plan or any of its delegates who are authorized to amend or terminate the Plan.

### **No Contract of Employment**

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and Idaho AGC Health Benefit Plan to the effect that you will be employed for any specific period of time.

### **Information in Attached Certificate of Insurance**

Benefits under the Plan are described in the attached Certificate issued by Symetra to the Plan Sponsor. The Certificate contains important information about your coverage, including:

Eligibility and Participation Requirements	Termination Provisions
Enrollment Requirements	Continuation of Coverage
Description of Benefits	Effective Date of Coverage
Definitions	Benefit Reductions, Exclusions and Limitations

In order to understand your benefits under the Plan, you must read the attached Certificate.

### **Claims Procedures**

The Plan's claims procedures are set forth in the attached certificate of insurance, as supplemented by the Symetra Disability Plan Claim Procedures and Symetra Non-Disability Plan Claim Procedures (including Group Life Claims). The Symetra Disability Plan Claim Procedures and Symetra Non-Disability Plan Claim Procedures (including Group Life Claims) are being furnished to you automatically, without charge, as a separate document accompanying this Summary Plan Description.

### **Statement of ERISA Rights**

#### **Your Rights**

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

**If you have questions regarding the Plan, please contact the Policyholder or Plan Administrator.**

### **Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the employee welfare benefit plan. The people who operate your plan, called "fiduciaries," have a duty to do so prudently in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you from obtaining a welfare benefit or exercising your rights under ERISA.

### **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator, to provide the materials and pay you up to \$110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance With Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory), or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**Your Certificate of Insurance, issued by Symetra Life Insurance Company, is attached.**

**This Certificate is furnished to you automatically without charge.**

**If you have questions regarding the Plan, please contact the Policyholder or Plan Administrator.**

## Symetra Disability Plan Claim Procedures

Symetra's Disability Plan Claim Procedures are set forth in the attached certificate of insurance, as supplemented by the procedures set forth below. The Disability Plan Claim Procedures are followed by Symetra Life Insurance Company and First Symetra National Life Insurance Company of New York when processing group short term disability claims, group long term disability claims, and waiver of premium claims under a group life insurance plan.

These Disability Plan Claim Procedures are being furnished to you automatically, without charge, as a separate document accompanying the Summary Plan Description.

### **What you should do and what you should expect if you have a disability claim?**

To claim benefits under the Plan, you\* must first apply for the benefit according to Symetra's requirements. Claims can be submitted telephonically, electronically, or via paper application. You may request the claim form from Symetra by calling (877) 377-6773 or from the Plan Administrator by contacting your benefits coordinator. If Symetra's claim form or instructions for completing it are not available, you must submit to Symetra a written statement of the reasons you are entitled to benefits, and you must include your name, address and contact information, and your employer's name, address and contact information. After you have completed the claim form or written statement, you must submit it to Symetra at the following address:

Symetra Claims Department  
P.O. Box 1230  
Enfield, CT 06083

For purposes of the Plan's claims procedures, you will be considered to have filed your claim under the Plan when your claim form or written statement is received at this address.

The Plan Administrator has appointed Symetra as the claims administrator of the Plan for adjudicating claims for benefits under the Plan and for deciding any appeals of denied claims. Symetra shall have the authority, at its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All benefits decisions made by Symetra shall be final and binding to the full extent permitted by law.

Symetra has 45 days from the date your claim is filed to determine whether or not benefits are payable to you in accordance with the terms and provisions of the Plan, and, if so, the amount of benefits. If more time is needed to review your claim due to circumstances beyond the Plan's control, Symetra must notify you in writing that the review period has been extended. The extension notice will describe the circumstances requiring the extension, the expected date of a decision, the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on your claim, and the additional information needed to resolve those issues. This extension may be for up to 30 days beyond the end of the normal 45-day review period. A second 30-day extension may apply if, for reasons beyond the Plan's control, additional time, beyond the first 30-day extension, is needed to review your claim. In this case, Symetra will notify you in writing that the review period has been further extended. Symetra will provide the same information required in the first notice of extension.

If an extension of the review period is made because you must furnish additional information in order for Symetra to decide your claim, Symetra will specify the additional information that is needed in the extension notice. You will have at least 45 days to return the specified information to Symetra. Until you return that information (or the time to provide the information expires), the review period will be "tolled," further extending the review period beyond the normal 45-day period or the extended 75- or 105-day period. For example, if Symetra advises you on the 20th day after your claim was filed that your claim is incomplete because it lacks a physician's statement regarding your ability to perform various tasks, the number of days from the date of Symetra's request for the physician's statement until you provide the physician's statement will not count as part of the review period. In this example, the day you provided the physician's statement will be treated as the 21st day of the review period.

If needed in order to decide your claim, Symetra may require you to submit to a medical examination, at Symetra's expense. If a medical examination is required, Symetra will notify you of the date and time of the examination and the physician's name and location. This will be treated as a request for additional information, as described above, and the review period will be tolled until Symetra receives the results of the examination. It is important that you keep any appointments made for you by Symetra, since rescheduling examinations will delay the claim process.

If your claim is approved, you will receive the appropriate benefit from Symetra.

If your claim is denied, in whole or in part, you will receive a written notice from Symetra within the review period. The written notice of claim denial must include the following information:

1. The specific reason(s) the claim was denied, including an explanation of the basis for disagreeing with or not following:
  - the views that you presented to Symetra of health care professionals that treated you and vocational professionals that evaluated you;
  - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claim denial, without regard to whether Symetra relied upon the advice in denying your claim; and
  - the disability determination made by the Social Security Administration, if you presented such a disability determination to Symetra.
2. Specific reference to the Policy provision(s) on which the denial was based.
3. A description of any additional material or information necessary to perfect your claim, and the reason this material or information is necessary.
4. If your claim was denied based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
5. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying your claim or, alternatively, a statement that in denying your claim, Symetra did not rely upon any specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan in existence.
6. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.
7. A statement informing you of your right to appeal the decision, and an explanation of the appeal procedure, as outlined below.

#### **Appeal procedure for denied disability claims**

Whenever a claim is denied in whole or in part, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request to appeal Symetra's decision within 180 days from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal. This request for review should be directed to Symetra at the address given above for claims submissions. When requesting a review, you should state the reasons you believe the claim denial was improper, and you should submit any additional information, material, or comments which you consider appropriate. You may also review and, upon request, obtain copies of any documents that have a bearing on the claim, including the documents which establish and control the Plan.

Once your request has been received by Symetra, a full and fair review of your claim must take place. This review will give no deference to the original claim decision and will not be made by the person who made the initial claim decision, nor a subordinate of that person. Any medical or vocational experts consulted by Symetra in reviewing your claim will be identified. If your claim was denied in whole or in part based on a medical judgment, Symetra, in deciding your appeal of that determination, will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. In no case will such health care professional be an individual who was consulted in connection with the original claim decision. In conducting the review, Symetra will take into account all comments, documents, and other information that you submit, whether or not it was submitted at the time of the initial claim decision.

In conducting the review, Symetra will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by Symetra (or at the direction of Symetra) in connection with your claim. Symetra will provide you with this evidence as soon as possible and sufficiently in advance of the date on which the review period expires, as further described below, in order to give you a reasonable opportunity to respond to the new or additional evidence prior to that date.

Before Symetra can deny your appeal based on a new or additional rationale, Symetra must provide you, free of charge, with the new or additional rationale. Symetra will provide you with the new or additional rationale as soon as possible and sufficiently in advance of the date on which the review period expires, as further described below, in order to give you a reasonable opportunity to respond to the new or additional rationale prior to that date.

Symetra has 45 days from the date it receives your appeal to review the original claim decision for your claim and notify you of its decision. Under special circumstances, Symetra may require more time to review your claim. If this should happen, Symetra must notify you, in writing, that its appeal review period has been extended for an additional 45 days, noting the special circumstances requiring the extension and the date by which a decision on the appeal is expected.

If an extension of the appeal review period is made because you must furnish additional information in order for Symetra to decide your appeal, Symetra will specify the additional information that is needed in the extension notice. You will have at least 45 days to return the specified information to Symetra. Until you return that information (or the time to provide the information expires), the review period will be "tolled," further extending the review period beyond the normal 45-day period.

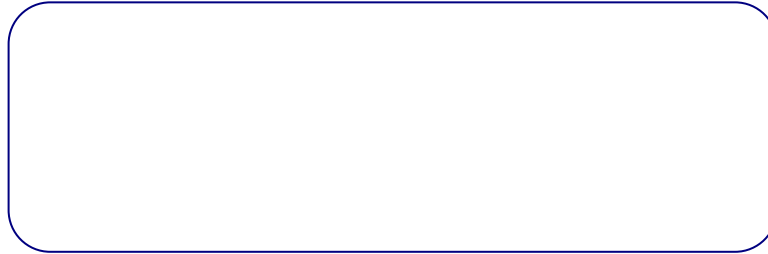
Once its review is complete, Symetra must notify you, in writing, of the results of the review and must include in its notice the following information:

1. The specific reason(s) the appeal was denied, including an explanation of the basis for disagreeing with or not following:
  - the views that you presented to Symetra of health care professionals that treated you and vocational professionals that evaluated you;
  - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claim denial, without regard to whether Symetra relied upon the advice in denying your claim; and
  - the disability determination made by the Social Security Administration, if you presented such a disability determination to Symetra.
2. Specific reference to the Policy provision(s) on which the denial was based.
3. A statement that you are entitled to receive, upon request and free of charge, all documents, records, and copies of all documents, records, and other information relevant to your claim for benefits under the Plan.



4. If your claim was denied based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
5. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying your claim or, alternatively, a statement that in denying your claim, Symetra did not rely upon any specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan in existence.
6. The written notice will include a statement regarding your right to file suit in federal or state court to recover benefits under the terms of the Plan, including pursuant to ERISA Section 502(a) as applicable, together with a description of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for your claim.

\* You may have an authorized representative, such as a guardian or an individual having a valid power of attorney, act on your behalf in pursuing a claim for benefits under this Plan. The Plan will take reasonable steps to determine whether an individual claiming to be acting on your behalf is, in fact, validly empowered to do so under the circumstances. Throughout this description of the Plan's claims and appeals procedures, the word "you" is used to refer to you and/or any representative acting on your behalf in claiming benefits under the Plan.



## Employee Benefits

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## Insurance Certificate

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SHORT TERM DISABILITY INCOME INSURANCE

CLASS 2



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

**Symetra Life Insurance Company is known as Symetra in this certificate.**

**"You" and "your" refer to the insured employee in this certificate.**

**This certificate summarizes the major parts of the policy under which you are insured. Your insurance is subject to all the terms of the policy. This certificate replaces all others previously issued.**

**Signed for Symetra as of the policy effective date.**

*Jacqueline M. Veneziani*      *Margaret Meister*

**Jacqueline M. Veneziani,**  
**Secretary**

**Margaret Meister,**  
**President**

**READ THIS CERTIFICATE CAREFULLY**

## GROUP SHORT TERM DISABILITY INSURANCE

### CERTIFICATE OF COVERAGE

Policyholder: Trustees of the Idaho AGC Health Plan Benefit Plan Trust  
Policy Number: 01 018070 00  
Policy Effective Date: January 1, 2020

Symetra Life Insurance Company (referred to as "the Company", "we", "us", or "our") welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Your certificate of coverage is written in plain English. There are a few terms and provisions written as required by insurance law. If you have any questions about any of the terms and provisions, please consult our claims paying office. We will assist you in understanding your benefits.

If the terms and provisions of the certificate of coverage (issued to you) differ from the policy (issued to the Policyholder), the policy will govern. Your coverage may be canceled or changed in whole or in part under the terms and provisions of the policy.

The policy is delivered in and is governed by the laws of Idaho and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. When making a benefit determination under the policy, we have discretionary authority to determine your eligibility for benefits and to interpret the terms and provisions of the policy.

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

## TABLE OF CONTENTS

Your certificate is divided into the following sections:

SECTION 1A - HIGHLIGHTS OF YOUR PLAN

SECTION 1B - HIGHLIGHTS OF YOUR VOLUNTARY PLAN

SECTION 2 - GENERAL INFORMATION

SECTION 3 - ELIGIBILITY FOR COVERAGE

SECTION 4 - BENEFIT SPECIFICS

- disability defined
- details on calculating benefit payments
- exclusions and limitations that may apply

SECTION 5 - CLAIM INFORMATION

For your ease in finding information in your certificate, we:

- Start each section with a summary of the contents and the terms we define in the section.
- Shade all of the defined terms within a section.

## SECTION 1A: HIGHLIGHTS OF YOUR STD PLAN

This is a brief overview of your plan of benefits. We refer to these terms often throughout this certificate. Whenever we use these terms in the certificate they have the following meaning, unless we advise you otherwise.

Eligible Class 2 = All Full-Time Employees Participating in the Idaho AGC Sponsored Medical Plan earning a minimum of \$43,333 or more Annually and electing the \$525 Buy Up.

You must be working at least 30 hours per week.

Benefit Amount = \$125, not to exceed 100% of your pre-disability earnings\*

\* We may reduce the amount we pay you by other income amounts and any income you earn or receive from any form of employment. Some disabilities may not be covered under this plan. A pre-existing conditions exclusion and other limitations may apply to the STD plan.

Minimum Payment Amount = \$15

We may apply all payments to you toward overpayments.

Elimination Period = If disability is due to an injury: 14 days.

If disability is due to a sickness: 14 days.

Pre-disability earnings means your gross weekly rate of earnings from your employer in effect just prior to the date disability begins. It does not include commissions, bonuses, overtime pay or other extra compensation.

If your disability begins while you are on a covered layoff, military leave of absence or leave of absence, we will use your pre-disability earnings from your employer in effect just before the date your absence begins.

Our payments to you will be based on the amount of your pre-disability earnings covered by this plan and for which premium has been paid.

**SECTION 1A: HIGHLIGHTS OF YOUR STD PLAN  
(continued)**

Maximum Payment Duration = 13 weeks

Waiting Period:

If you are in an eligible class on or before the plan effective date: None.

If you are entering an eligible class after the plan effective date: None.

If your membership ends and you rejoin the policyholder within 3 months, we will apply your previous membership in an eligible class toward completing the waiting period. All other provisions of this plan apply.

Cost of Coverage:

The employer pays the cost of your coverage.

The cost of your coverage must be paid for any period of time during which you are disabled under this plan.

Noninsurance benefits:

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

## SECTION 1B: HIGHLIGHTS OF YOUR VOLUNTARY STD PLAN

This is a brief overview of your plan of benefits. We refer to these terms often throughout this certificate. Whenever we use these terms in the certificate, they have the following meaning, unless we advise you otherwise.

Eligible Class 2 = All Full-Time Employees Participating in the Idaho AGC Sponsored Medical Plan earning a minimum of \$43,333 or more Annually and electing the \$525 Buy Up.

You must be working at least 30 hours per week.

Weekly Payment = \$525, not to exceed 100% of your pre-disability earnings\*

\* We may reduce the amount we pay you by other income amounts and any income you earn or receive from any form of employment. Some disabilities may not be covered under this plan.

Minimum Payment Amount = \$15

We may apply all payments to you toward overpayments.

Elimination Period = If disability is due to an injury: 14 days.

If disability is due to a sickness: 14 days.



**SECTION 1B: HIGHLIGHTS OF YOUR VOLUNTARY STD PLAN  
(continued)**

Pre-disability earnings means your gross weekly rate of earnings from your employer in effect just prior to the date disability begins. It does not include commissions, bonuses, overtime pay or other extra compensation.

If your disability begins while you are on a covered layoff, military leave of absence or leave of absence, we will use your pre-disability earnings from your employer in effect just before the date your absence begins.

Our payments to you will be based on the amount of your pre-disability earnings covered by this plan and for which premium has been paid.

Maximum Payment Duration = 13 weeks

Waiting Period:

If you are in an eligible class on or before the plan effective date: None.

If you are entering an eligible class after the plan effective date: None.

If your membership ends and you rejoin the policyholder within 3 months, we will apply your previous employment in an eligible class toward completing the waiting period. All other provisions of this plan apply.

Cost of Coverage:

You pay the cost of your coverage.

Waiver of Premium: The cost of your coverage will be suspended for any period of time after the first of the month following the date you are disabled under this plan. If you return to active employment with your employer, and want your coverage to continue, the cost of your coverage must begin to be paid again.

Noninsurance benefits:

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

## SUMMARY OF THE GENERAL INFORMATION SECTION 2

What will you find in this section?

- information we have access to
- how we use statements made in applying for coverage
- insurance fraud
- time limits for legal proceedings

What terms do we define in this section?

- you
- we
- us
- our
- member
- policyholder
- insured
- plan

## SECTION 2: GENERAL INFORMATION

### WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by us and may include attachments. It tells you:

- the coverage to which you may be entitled
- to whom we make payments

AND

- the limitations, exclusions and requirements applying to a plan.

**You means a member who is eligible for the coverage of this plan.**

**We, us and our means the Insurance Company named on the first page of your Certificate of Coverage.**

**Member means a person who is a citizen or permanent resident of the United States in active employment unless we advise you otherwise. This plan excludes temporary and seasonal workers from coverage.**

**Policyholder means individual, company, trust or corporation where you are in active membership, and includes any division, subsidiary or affiliated company named in the policy.**

**Insured means a person covered under this plan.**

**Plan means a line of coverage under the policy.**

## **SECTION 2: GENERAL INFORMATION (continued)**

### **TO WHAT INFORMATION DO WE HAVE ACCESS?**

The policyholder will give us information about you including:

- if you are eligible for coverage
- if your amount of coverage changes, including salary change information
- if your coverage terminates
- other information we may reasonably require.

The policyholder's records that we believe have a bearing on coverage under this plan are open for our inspection at any reasonable time.

Clerical error or omission will not:

- prevent you from receiving coverage
- affect the amount of your coverage

OR

- effect or continue your coverage if it should not be in effect or continue in effect.

### **HOW CAN WE USE STATEMENTS YOU OR THE POLICYHOLDER MADE IN APPLYING FOR COVERAGE?**

We consider any statements you or the policyholder made in a signed application for coverage a representation and not a warranty. If any of the statements you or the policyholder made are not complete and/or not true at the time they were made, we can:

- reduce or deny any claim

OR

- cancel your coverage back to the date your coverage became effective.

We will use only statements made in a signed application as a basis for doing this. You will receive a copy of the signed application.

## **SECTION 2: GENERAL INFORMATION (continued)**

### **HOW WILL WE HANDLE INSURANCE FRAUD?**

We promise to focus on all means necessary to support fraud detection, investigation, and prosecution. It is a crime if you or the policyholder or your employer knowingly, and with intent to injure, defraud or deceive us, file a claim containing any false, incomplete or misleading information. These actions, as well as submission of false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

### **WHAT IF FACTS ABOUT YOU ARE NOT ACCURATE?**

If relevant facts about you were not accurate, then we will use accurate information to decide if your coverage should be in effect and what your amount of coverage should be. If the cost of your coverage is affected, we will make a fair adjustment in the cost.

### **DOES THE POLICYHOLDER ACT AS YOUR AGENT?**

For all purposes of the policy, the policyholder acts on its own behalf or as your agent. The policyholder is not our agent.

### **WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?**

You can start legal action regarding your claim 60 days after the date you sent us proof of claim. You have up to three years after the date you sent us proof of claim to start legal action, unless otherwise provided by law.

### **DOES THIS PLAN REPLACE OR AFFECT ANY REQUIREMENT FOR WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?**

The plan does not replace or affect requirements for coverage by Workers' Compensation Insurance or state disability insurance.

## SUMMARY OF THE ELIGIBILITY FOR COVERAGE SECTION 3

What will you find in this section?

- eligibility for coverage
- waiting period
- when coverage becomes effective
- evidence of insurability requirements
- what happens to coverage during a layoff, military leave of absence, leave of absence or a family or medical leave of absence
- when coverage under this plan ends

What terms do we define in this section?

- waiting period
- active membership
- active employment
- work site
- evidence of insurability
- layoff
- military leave of absence
- leave of absence
- family or medical leave of absence

**THIS PAGE APPLIES TO COVERAGE IN YOUR SECTION 1A: HIGHLIGHTS OF YOUR  
NON-VOLUNTARY SHORT TERM DISABILITY PLAN.**

## SECTION 3: ELIGIBILITY FOR COVERAGE

### WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are in an eligible class you may apply for coverage under this plan on the later of:

- the date the plan is effective;

OR

- the date you complete the waiting period.

### WHAT IS YOUR WAITING PERIOD?

Your waiting period appears in the PLAN HIGHLIGHTS.

**Waiting period is the number of days you must be in active membership in an eligible class before you may apply for coverage.**

If you have been continuously a member of the policyholder but were not in an eligible class, we will apply any prior period of membership with the policyholder toward the waiting period.

**Active membership means you are:**

- a member of the policyholder;

**AND**

- performing the duties of your usual occupation on your normal (i.e. part-time or full-time) basis.

**Active employment means you are:**

- working for your employer at your work site for earnings your employer pays on a regular basis;

**AND**

- performing the material and substantial duties of your regular occupation.

**Active employment includes normal non-work days such as vacation, weekends and holidays.**

**Your work site must be:**

- your employer's usual place of business;
- an alternative location if directed by your employer;

**OR**

- a location to which your occupation requires you to travel.

**THIS PAGE APPLIES TO COVERAGE IN YOUR SECTION 1A: HIGHLIGHTS OF YOUR NON-VOLUNTARY SHORT TERM DISABILITY PLAN.**

**SECTION 3: ELIGIBILITY FOR COVERAGE  
(continued)**

**WHEN DOES YOUR COVERAGE BECOME EFFECTIVE?**

Your coverage will be effective on the day determined as follows:

If you apply for coverage within the first 31 days after the date you are first eligible to apply AND

-you are paying for some or all of the cost of your coverage	THEN	your coverage is effective on the date you apply.
---	------	--

OR

-you are not paying for any of the cost of your coverage	THEN	your coverage is effective on the date you are eligible.
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**THIS PAGE APPLIES TO COVERAGE IN YOUR SECTION 1A: HIGHLIGHTS OF YOUR  
NON-VOLUNTARY SHORT TERM DISABILITY PLAN.**



### SECTION 3: ELIGIBILITY FOR COVERAGE (continued)

#### WHEN IS EVIDENCE OF INSURABILITY REQUIRED?

You will need to provide evidence of insurability to us with your application if you:

- apply for coverage more than 31 days after the date you are first eligible to apply;
- OR
- voluntarily terminate your coverage and want to reapply for coverage;
- OR
- apply for an amount of coverage for which we require proof of insurability.

You must apply for coverage in writing through the policyholder and use an application form that is satisfactory to us. Your coverage will be effective on the date we approve your application.

**Evidence of insurability means a statement of your medical history which we will use to assess if you will be approved for coverage.**

#### WHAT IF YOU ARE NOT IN ACTIVE MEMBERSHIP ON THE DATE YOUR COVERAGE WOULD BE EFFECTIVE?

If you are not in active membership as a result of your injury or a sickness then your coverage will be effective on the date you return to active membership. This applies to your initial coverage, as well as any increases or additions to coverage occurring after your initial coverage is effective.

#### WILL YOUR COVERAGE CONTINUE IF YOU ARE ON A LAYOFF, MILITARY LEAVE OF ABSENCE OR LEAVE OF ABSENCE?

The policyholder may continue your coverage if you are on a layoff, military leave of absence or on an approved leave of absence. Your coverage may continue. Your layoff coverage may continue for up to three months following the month your layoff begins, your military leave of absence coverage may continue for up to 12 weeks following the date your military leave of absence begins and your leave of absence coverage may continue for up to three months following the date your leave of absence begins. The cost of your coverage must be paid during the layoff, military leave of absence or leave of absence period.

**Layoff, military leave of absence or leave of absence means your employer has agreed in writing and in advance to a temporary absence from active employment for a specified period of time. Your normal vacation time or any period of disability is not considered a temporary layoff, military leave of absence or leave of absence.**

**THIS PAGE APPLIES TO COVERAGE IN YOUR SECTION 1A: HIGHLIGHTS OF YOUR  
NON-VOLUNTARY SHORT TERM DISABILITY PLAN.**

### SECTION 3: ELIGIBILITY FOR COVERAGE (continued)

#### WHAT HAPPENS TO YOUR COVERAGE IF YOU ARE ON A FAMILY OR MEDICAL LEAVE OF ABSENCE?

If you are on a family or medical leave of absence, your coverage will be governed by your employer's Human Resource policy on family and medical leaves of absence.

We will continue your coverage if the following conditions are met:

- premiums for the cost of your continued coverage are paid;

AND

- your leave is approved in advance and in writing by your employer.

Your coverage will continue for up to the greater of:

- the leave period required by the Federal Family and Medical Leave Act of 1993, and any amendments;

OR

- the leave period required by applicable state law.

While you are on an approved family or medical leave of absence, we will use earnings from your regular occupation you were performing just prior to the date your leave of absence started to determine our payments to you.

If your coverage does not continue during a family or medical leave of absence, then when you return to active employment:

- you will not have to meet a new waiting period, including a waiting period for coverage of a pre-existing condition;

AND

- you will not have to give us evidence of insurability to reinstate the coverage you had in effect before your leave began.

**Family and medical leave of absence means a leave of absence for the birth, adoption or foster care of a child, or for the care of you, your child, spouse or parent who has a serious health condition as those terms are defined by the Federal Family and Medical Leave Act of 1993 and any amendments, or by applicable state law.**

**THIS PAGE APPLIES TO COVERAGE IN YOUR SECTION 1A: HIGHLIGHTS OF YOUR  
NON-VOLUNTARY SHORT TERM DISABILITY PLAN.**

### SECTION 3: ELIGIBILITY FOR COVERAGE (continued)

#### WHEN DOES YOUR COVERAGE UNDER THIS PLAN END?

Your coverage under this plan will end on the earliest of the following:

- the date the policy or plan terminates;
- the last day of the month following date you are no longer in an eligible class;
- the date your class is no longer eligible for coverage;
- the last day for which premium for your coverage has been paid;
- the date you cease active employment due to a labor dispute, including but not limited to strike, work slowdown, or lockout;
- the last day of the month following the date you cease active membership with the policyholder, unless you are disabled or on an approved layoff, military leave of absence or leave of absence;
- the last day of the month following the date you cease active employment with your employer, unless you are disabled or on an approved layoff, military leave of absence or leave of absence.

We will provide coverage for a payable disability claim that occurs while you are covered under the policy or plan.

#### Extended Pregnancy Coverage

This provision is included in the policy in accordance with the requirements of Idaho Insurance Code Section 41-2214.

If you are pregnant on the date the policy terminates, you will be covered for a period of disability resulting from that pregnancy or involuntary complication of pregnancy, provided that:

1. You must become disabled as a result of that pregnancy or involuntary complication of pregnancy within 365 days after the date the policy terminates.
2. No STD benefits will be payable for the STD elimination period.
3. No STD benefits will be payable after the end of 365 days from the date the policy terminates.
4. Any STD benefits payable under this provision will be reduced by the full amount of any similar benefits payable under any replacement coverage (without any reduction in the replacement coverage benefits because of benefits otherwise payable under this provision). For purposes of this provision, any replacement coverage will be your primary coverage.

This provision will terminate automatically on the date Idaho Insurance Code Section 41-2214 is amended or repealed.

**THIS PAGE APPLIES TO COVERAGE IN YOUR SECTION 1A: HIGHLIGHTS OF YOUR  
NON-VOLUNTARY SHORT TERM DISABILITY PLAN.**

## SUMMARY OF THE ELIGIBILITY FOR COVERAGE SECTION 3

### VOLUNTARY PLANS

What will you find in this section?

- eligibility for coverage
- waiting period
- when coverage becomes effective
- changing coverage under this plan
- what happens to coverage during a layoff, military leave of absence, leave of absence or a family or medical leave of absence
- when coverage under this plan ends

What terms do we define in this section?

- waiting period
- active membership
- active employment
- work site
- re-enrollment period
- enrollment period
- initial enrollment period
- layoff
- military leave of absence
- leave of absence
- evidence of insurability
- family or medical leave of absence

**THIS PAGE APPLIES TO COVERAGE IN YOUR SECTION 1B: HIGHLIGHTS OF YOUR VOLUNTARY SHORT TERM DISABILITY PLAN.**

## SECTION 3: ELIGIBILITY FOR COVERAGE

### VOLUNTARY PLANS

#### WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are in an eligible class you may apply for coverage under this plan on the later of:

- the date the plan is effective;

OR

- the date you complete the waiting period.

#### WHAT IS YOUR WAITING PERIOD?

Your waiting period appears in the PLAN HIGHLIGHTS.

**Waiting period is the number of days you must be in active membership in an eligible class before you may apply for coverage.**

If you have been continuously a member of the policyholder but were not in an eligible class, we will apply any prior period of membership with the policyholder toward the waiting period.

**Active membership means you are:**

- a member of the policyholder;

**AND**

- performing the duties of your usual occupation on your normal (i.e. part-time or full-time) basis.

**Active employment means you are:**

- working for your employer at your work site for earnings your employer pays on a regular basis;

**AND**

- performing the material and substantial duties of your regular occupation.

**Active employment includes normal non-work days such as vacation, weekends and holidays.**

**Your work site must be:**

- your employer's usual place of business;
- an alternative location if directed by your employer;

**OR**

- a location to which your occupation requires you to travel.

**THIS PAGE APPLIES TO COVERAGE IN YOUR SECTION 1B: HIGHLIGHTS OF YOUR VOLUNTARY SHORT TERM DISABILITY PLAN.**

**SECTION 3: ELIGIBILITY FOR COVERAGE  
(continued)**

VOLUNTARY PLANS

**WHEN MAY YOU ENROLL OR CHANGE YOUR COVERAGE UNDER THIS PLAN?**

You may enroll or change your coverage only during an enrollment period as follows:

1. During the initial enrollment period:

If you are eligible for coverage on the plan effective date	THEN	you may apply for a coverage option for the first enrollment period.
---	------	--

If you become eligible for coverage after the plan effective date	THEN	you may apply for a coverage option for the enrollment period in which you are first eligible.
---	------	--

2. During a re-enrollment period:

You may:

- keep your same coverage under the plan;
- choose no coverage under the plan;
- enroll for coverage under the plan if you are not currently enrolled.

Coverage applied for or changes in coverage will apply until the next re-enrollment period.

If you are currently enrolled for coverage and do not re-enroll for coverage during a re-enrollment period you will continue to be insured for the same coverage as previously enrolled.

If you do not enroll for coverage within 31 days of an enrollment period, then you will be eligible to enroll for coverage only as a late enrollee. You will need to submit evidence of insurability satisfactory to us at your own expense.

**THIS PAGE APPLIES TO COVERAGE IN YOUR SECTION 1B: HIGHLIGHTS OF YOUR  
VOLUNTARY SHORT TERM DISABILITY PLAN.**

**SECTION 3: ELIGIBILITY FOR COVERAGE  
(continued)**

**VOLUNTARY PLANS**

**WHAT IF YOU REJOIN THE POLICYHOLDER WITHIN THE SAME PLAN YEAR DURING WHICH YOUR MEMBERSHIP TERMINATED?**

If you rejoin the policyholder within the same plan year during which your membership terminated, then:

- you will be insured for the same plan and level of coverage that was in effect for you on the date your membership terminated;

AND

- you may not change the plan or level of coverage during the rest of the plan year.

**Re-enrollment period means a period of time as set by the policyholder and us during which you may apply, in writing, for coverage under this plan, or change your coverage under this plan if you are currently enrolled.**

**Enrollment period means the initial enrollment period and any re-enrollment period.**

**Initial enrollment period means one of the following periods during which you may first apply in writing for coverage under this plan:**

- if you are eligible for coverage on the plan effective date, a period before the plan effective date as set by the policyholder and us;
- if you become eligible for coverage after the plan effective date, the period ending 31 days after the date you are first eligible to apply for coverage.

**THIS PAGE APPLIES TO COVERAGE IN YOUR SECTION 1B: HIGHLIGHTS OF YOUR  
VOLUNTARY SHORT TERM DISABILITY PLAN.**

**SECTION 3: ELIGIBILITY FOR COVERAGE  
(continued)**

VOLUNTARY PLANS

**WHEN DOES YOUR COVERAGE BECOME EFFECTIVE?**

Your coverage will be effective on the later of:

1. the first day of the pay period for which contributions for your coverage are deducted;
- OR
2. the day determined as follows:

For coverage applied for during the initial enrollment period and before your eligibility date	THEN	your coverage is effective on your eligibility date
For coverage applied for during the initial enrollment period and within the first 31 days after the date you are first eligible to apply	THEN	your coverage is effective on the date you apply
For coverage applied for more than 31 days after the date you are first eligible to apply	THEN	your selected coverage will be effective on the first day following the date we approve your application.
For an increase in coverage applied for within 30 days of the effective date of a change in salary, and for decreases in coverage	THEN	the first day of the pay period for which contributions for your coverage are deducted

**THIS PAGE APPLIES TO COVERAGE IN YOUR SECTION 1B: HIGHLIGHTS OF YOUR  
VOLUNTARY SHORT TERM DISABILITY PLAN.**



**SECTION 3: ELIGIBILITY FOR COVERAGE  
(continued)**

**VOLUNTARY PLANS**

**WHAT IF YOU ARE NOT IN ACTIVE MEMBERSHIP ON THE DATE YOUR COVERAGE WOULD BE EFFECTIVE?**

If you are not in active membership as a result of your injury or a sickness then your coverage will be effective on the date you return to active membership. This applies to your initial coverage, as well as any increases or additions to coverage occurring after your initial coverage is effective.

**WILL YOUR COVERAGE CONTINUE IF YOU ARE ON A LAYOFF, MILITARY LEAVE OF ABSENCE OR LEAVE OF ABSENCE?**

The policyholder may continue your coverage if you are on a layoff, military leave of absence or on an approved leave of absence. Your coverage may continue. Your layoff coverage may continue for up to three months following the month your layoff begins, your military leave of absence coverage may continue for up to 12 weeks following the date your military leave of absence begins and your leave of absence coverage may continue for up to three months following the date your leave of absence begins.. The cost of your coverage must be paid during the layoff, military leave of absence or leave of absence period.

**Layoff, military leave of absence or leave of absence means your employer has agreed in writing and in advance to a temporary absence from active employment for a specified period of time. Your normal vacation time or any period of disability is not considered a temporary layoff, military leave of absence or leave of absence.**

**WHEN IS EVIDENCE OF INSURABILITY REQUIRED?**

You will need to provide evidence of insurability to us with your application. You must apply for coverage in writing through the policyholder and use an application form that is satisfactory to us.

**Evidence of insurability means a statement of your medical history which we will use to assess if you will be approved for coverage.**

**THIS PAGE APPLIES TO COVERAGE IN YOUR SECTION 1B: HIGHLIGHTS OF YOUR  
VOLUNTARY SHORT TERM DISABILITY PLAN.**

**SECTION 3: ELIGIBILITY FOR COVERAGE  
(continued)**

VOLUNTARY PLANS

**WHAT HAPPENS TO YOUR COVERAGE IF YOU ARE ON A FAMILY OR MEDICAL LEAVE OF ABSENCE?**

If you are on a family or medical leave of absence, your coverage will be governed by your employer's Human Resource policy on family and medical leaves of absence.

We will continue your coverage if the following conditions are met:

- premiums for the cost of your continued coverage are paid;

AND

- your leave is approved in advance and in writing by your employer.

Your coverage will continue for up to the greater of:

- the leave period required by the Federal Family and Medical Leave Act of 1993, and any amendments;

OR

- the leave period required by applicable state law.

While you are on an approved family and medical leave of absence we will use earnings from your regular occupation you were performing just prior to the date your leave of absence started to determine our payments to you.

If your coverage does not continue during a family or medical leave of absence, then when you return to active employment:

- you will not have to meet a new waiting period, including a waiting period for coverage of a pre-existing condition;

AND

- you will not have to give us evidence of insurability to reinstate the coverage you had in effect before your leave began.

**Family and medical leave of absence means a leave of absence for the birth, adoption or foster care of a child, or for the care of you, your child, spouse or parent who has a serious health condition as those terms are defined by the Federal Family and Medical Leave Act of 1993 and any amendments, or by applicable state law.**

**THIS PAGE APPLIES TO COVERAGE IN YOUR SECTION 1B: HIGHLIGHTS OF YOUR  
VOLUNTARY SHORT TERM DISABILITY PLAN.**

**SECTION 3: ELIGIBILITY FOR COVERAGE  
(continued)**

**VOLUNTARY PLANS**

**WHEN DOES YOUR COVERAGE UNDER THIS PLAN END?**

Your coverage under this plan will end on the earliest of the following:

- the date the policy or plan terminates;
- the last day of the month following date you are no longer in an eligible class;
- the date your class is no longer eligible for coverage;
- the last day for which premium for your coverage has been paid;
- the date you cease active employment due to a labor dispute, which includes but is not limited to strike, work slowdown, or lockout;
- the last day of the month following the date you cease active membership with the policyholder, unless you are disabled or on an approved layoff, military leave of absence or leave of absence;
- the last day of the month following the date you cease active employment with your employer, unless you are disabled or on an approved layoff, military leave of absence or leave of absence.

We will provide coverage for a payable disability claim that occurs while you are covered under the policy or plan.

Extended Pregnancy Coverage

This provision is included in the policy in accordance with the requirements of Idaho Insurance Code Section 41-2214.

If you are pregnant on the date the policy terminates, you will be covered for a period of disability resulting from that pregnancy or involuntary complication of pregnancy, provided that:

1. You must become disabled as a result of that pregnancy or involuntary complication of pregnancy within 365 days after the date the policy terminates.
2. No STD benefits will be payable for the STD elimination period.
3. No STD benefits will be payable after the end of 365 days from the date the policy terminates.
4. Any STD benefits payable under this provision will be reduced by the full amount of any similar benefits payable under any replacement coverage (without any reduction in the replacement coverage benefits because of benefits otherwise payable under this provision). For purposes of this provision, any replacement coverage will be your primary coverage.

This provision will terminate automatically on the date Idaho Insurance Code Section 41-2214 is amended or repealed.

**THIS PAGE APPLIES TO COVERAGE IN YOUR SECTION 1B: HIGHLIGHTS OF YOUR  
VOLUNTARY SHORT TERM DISABILITY PLAN.**

## **SUMMARY OF THE SHORT TERM DISABILITY BENEFIT SPECIFICS SECTION 4**

What will you find in this section?

- what disability means
- when weekly payments start
- returning to work during the elimination period
- requirements of care from a doctor
- when will we not cover a disability
- our payment if you are disabled and not working
- our payment if you are disabled and working
- what are (are not) other income amounts
- cost of living increases to any other income amounts
- when weekly payments stop
- temporary recovery

What terms do we define in this section?

- disability
- material and substantial duties
- regular occupation
- reasonable employment option
- sickness
- injury
- elimination period
- regular care
- doctor
- maximum weekly payment
- gross weekly payment
- minimum weekly payment
- maximum capacity
- retirement plan
- disability benefits under a retirement plan
- retirement benefits under a retirement plan
- eligible retirement plan
- maximum payment duration
- prior group insurance plan

**THIS PAGE APPLIES TO COVERAGE IN YOUR SECTION 1A: HIGHLIGHTS OF YOUR  
NON-VOLUNTARY SHORT TERM DISABILITY PLAN.**

## **SUMMARY OF THE SHORT TERM DISABILITY BENEFIT SPECIFICS SECTION 4**

What will you find in this section?

- what disability means
- when weekly payments start
- requirements of care from a doctor
- when will we not cover a disability
- our payment if you are disabled
- what are (are not) other income amounts
- cost of living increases to any other income amounts
- when weekly payments stop
- temporary recovery
- payment limitations
- what happens if the policyholder changes insurance plans

What terms do we define in this section?

- disability
- material and substantial duties
- regular occupation
- reasonable employment option
- sickness
- injury
- elimination period
- regular care
- doctor
- maximum weekly payment
- gross weekly payment
- minimum weekly payment
- maximum payment duration

**THIS PAGE APPLIES TO COVERAGE IN YOUR SECTION 1B: HIGHLIGHTS OF YOUR VOLUNTARY SHORT TERM DISABILITY PLAN.**

## SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS

### WHAT DOES DISABILITY MEAN?

**Disabled/Disability means our determination that your sickness or injury:**

- prevents you from performing with reasonable continuity the material and substantial duties of your regular occupation and a reasonable employment option offered to you by your employer; and
- as a result, the income you are able to earn is less than or equal to 80% of your pre-disability earnings.

**Material and substantial duties are the duties that:**

- are normally required for the performance of the occupation;
- AND**
- cannot be reasonably omitted or changed.

extended reg occ  
w/ residual

## **SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS (continued)**

**Regular occupation means the occupation, as it is performed nationally, that you are routinely performing when your disability begins. Your regular occupation does not mean the job you are performing for a specific employer or at a specific location.**

**Reasonable employment option means an employment position with your employer for which you are able to perform the material and substantial duties given your education, training and experience. If you have been working in a reasonable employment option for 6 months or more, the reasonable employment option will then be considered your regular occupation.**

**Sickness means an illness or disease. It also includes an injury which occurs before you are insured. It does not include risk of sickness. This plan does not cover an occupational sickness.**

**Injury means a bodily injury that occurs while you are insured and is the direct result of an accident and not related to any other cause. It does not include risk of injury. This plan does not cover an occupational injury.**

**Occupational sickness or occupational injury means a sickness or injury caused by or aggravated by any employment for pay or profit.**

### Related Rules:

You will not be considered disabled from work in an occupation because of a reduction in your earnings resulting from a change in economic conditions or other factors that are not directly related to your sickness or injury. Examples of factors that we will not consider in determining whether you are disabled include, but are not limited to, recession, job obsolescence, job restructuring or elimination, pay cuts, and job sharing.

You will not be considered disabled from work in an occupation solely because of:

1. Your employer's work schedule that is inconsistent with the normal work schedule of your regular occupation;
2. Your relationship with your employer or other employees of the employer; or
3. The physical relationship of your employer's workplace that is inconsistent with the normal physical environment of your regular occupation.

You will not be considered disabled from work in an occupation solely because of the loss, suspension, restriction, surrender, or failure to maintain a required state or federal license to engage in the occupation.

You will not be considered disabled from work in an occupation solely because of your inability to work more than 40 hours per week in the occupation, even if you were regularly required to work more than 40 hours per week prior to becoming disabled.

Your disability must begin while you are covered under the policy.

non-occ

**SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS  
(continued)**

**DOES YOUR DISABILITY NEED TO CONTINUE FOR A PERIOD OF TIME BEFORE OUR PAYMENTS TO YOU BEGIN?**

Your disability must continue through the elimination period before we begin making payments to you.

**Elimination period is a period of continuous days of disability. The elimination period begins on the first day of your disability.**

**WHAT HAPPENS IF YOU RETURN TO WORK DURING THE ELIMINATION PERIOD?**

We will consider your disability continuous if you have one or more periods of temporary recovery during the elimination period for a maximum of 7 days AND become disabled again due to the same sickness or injury.

Temporary recovery means any time when we do not consider you to be disabled. The days you are not disabled will not count toward the elimination period.

acc of ep = 7 days



**SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS  
(continued)**

**DO YOU NEED TO BE UNDER THE CARE OF A DOCTOR?**

We require you to be under the regular care of a doctor for the sickness or injury causing your disability in order to be eligible to receive payments from us.

**Regular care means:**

- **you personally visit a doctor as often as is medically required to effectively manage and treat your disabling condition(s), according to generally accepted medical standards;**

**AND**

- **you are receiving appropriate treatment and care, according to generally accepted medical standards. Treatment and care for the sickness or injury causing your disability must be given by a doctor whose specialty or experience is appropriate.**

**Doctor means a person:**

- **regularly performing tasks that are within the limits of the person's medical license;**

**AND**

- **who is licensed to practice medicine and prescribe and administer drugs or to perform surgery;**
- **with a doctoral degree in Psychology (Ph.D. or Psy.D.) and whose primary practice is treating patients; OR**
- **who is a legally qualified medical practitioner according to the laws and regulations of the jurisdiction in which regular care is being given.**

We will not recognize you, your spouse, children, parents, or siblings as a doctor for a claim you submit.

## **SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS (continued)**

### **MAY WE REQUIRE YOU TO BE EXAMINED OR INTERVIEWED BY INDIVIDUALS OTHER THAN THE DOCTOR PROVIDING REGULAR CARE?**

We may require you to be examined by doctor(s), other medical practitioner(s) or vocational expert(s) of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so. In addition, we may require an interview with you by an authorized representative of ours.

### **WHEN WILL WE NOT COVER A DISABILITY?**

We will not cover a disability if it is due to:

- war, declared or not, or any act of war;
- intentionally self-inflicted injuries or illness, while sane or insane;
- your active participation in a riot;
- your attempt to commit or your commission of a felony under federal or state law, or your being engaged in an illegal occupation;
- an injury arising out of, or in the course of, any work for wage or profit;
- a sickness for which you are entitled to benefits under any Workers' Compensation Act, Occupational disease law, Compulsory Benefit Act or law or similar law, unless you are a partner or sole proprietor not covered by any of these acts or laws;
- your service in the armed forces, military reserves or National Guard of any country or International authority, or in a civilian unit serving with such forces;
- cosmetic or reconstructive surgery, except for complications arising from any such surgery or for surgery necessary to correct a deformity caused by accidental injury or sickness;
- an accident resulting from or caused by your operation of a motor vehicle while intoxicated according to the laws of the jurisdiction where the accident occurred; or
- an accident resulting from or caused by your being under the influence of drugs or any controlled substance, unless taken as prescribed by your doctor.

**No benefits are payable for any period of disability during which you are incarcerated in a penal or correctional facility for a period of 30 or more consecutive days or for which you are not under the regular care of a doctor.**

If your professional or occupational license or your certification is suspended, revoked or surrendered, loss of your license or certification, by itself, does not mean you are disabled.

**SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS  
(continued)**

**HOW MUCH WILL OUR WEEKLY PAYMENT TO YOU BE IF YOU ARE DISABLED?**

Our payment will be figured by using the following Steps 1 and 2:

- Step 1: Take the amount you applied for under this plan.
- Step 2: Subtract from the amount in Step 1 any other income amounts.

**SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS  
(continued)**

**Maximum weekly payment means the maximum weekly amount for which you are insured under this plan.**

**Minimum weekly payment means the minimum weekly amount for which you are insured under this plan, except where necessary to recover an overpayment.**

**Gross weekly payment means the weekly payment amount before we subtract other income amounts.**

Your pre-disability earnings, benefit percentage, and maximum weekly payment appear in the PLAN HIGHLIGHTS.

**WHAT IF YOU ARE DISABLED FOR ONLY PART OF A WEEK?**

Your weekly payment from us is pro-rated. This means that if you are disabled for only part of a week, you will receive a payment equal to 1/7th of a full weekly payment for each day of the week you are disabled.

## SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS (continued)

### WHAT ARE OTHER INCOME AMOUNTS?

These are amounts, other than payments you are receiving from us, that include:

1. any benefits and awards you receive or are eligible to receive under:
  - a. Workers' Compensation Law
  - b. occupational disease law
  - c. any other similar act or law.
2. any disability income benefits you receive or are eligible to receive under:
  - a. any compulsory benefit act or law
  - b. any other group insurance plan with the employer or with an association
  - c. any other group insurance plan with another employer which you become insured under while you are disabled under this plan
  - d. any governmental retirement system as a result of your job with the employer.
3. any benefits under the United States Social Security Act, The Canada Pension Plan, The Quebec Pension Plan and includes any similar plan or act. Benefits include:
  - a. disability benefits you, your spouse, or your children receive or are eligible to receive as a result of your disability
  - b. retirement benefits you receive, your spouse or your children receive as a result of your receipt of retirement benefits.

If your disability begins after your 70th birthday, and you were receiving Social Security retirement benefits before your disability began, then we will not reduce our payments to you by these retirement benefits.

4. any benefits you receive from the employer's sick leave or formal salary continuation plan.
5. any income you earn or receive from any form of employment, including any income you could have earned while disabled by working to your maximum capacity, but you do not do so. We may require you to send us proof of your income. We will adjust our payments to you based on this information. As a part of the proof, we can require you to send us appropriate tax and financial records we believe we need to substantiate your income.

**Maximum capacity means, based on the limiting factors of your identified sickness or injury, the greatest extent of work you are able to do in an occupation from which you must be considered disabled in order to receive disability benefits.**

#### SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS (continued)

6. any benefits from the employer's retirement plan you:
  - a. receive as disability benefits
  - b. voluntarily choose to receive as retirement benefits
  - c. receive as retirement benefits once you reach the greater of age 62 or normal retirement age (as defined in the employer's retirement plan).

Regardless of how the retirement funds from the plan are distributed, for the purposes of figuring our payment to you, we consider employee and employer contributions to be distributed at the same time throughout your lifetime.

This plan does not reduce payments you receive from us for your contributions to the employer's retirement plan, or for amounts you roll over or transfer to an eligible retirement plan.

**Retirement plan is a defined contribution plan or defined benefit plan. These are plans that provide retirement benefits to employees and are not funded entirely by employee contributions.**

**Disability benefits under a retirement plan are benefits that are paid due to disability and which do not reduce the retirement benefit that would have been paid if the disability had not occurred.**

**Retirement benefits under a retirement plan are benefits that are paid based on the employer's contribution to the retirement plan. Disability benefits that reduce the retirement benefit under the plan will also be considered a retirement benefit.**

**Eligible retirement plan is defined in §402 of the Internal Revenue Code of 1986 and includes future amendments to §402 affecting the definition.**

7. any benefits for loss of time or lost wages you receive from the mandatory portion of a no-fault motor vehicle insurance plan, or automobile liability insurance policy.
8. any amounts you receive under any unemployment compensation law.
9. any amounts you receive from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.

**SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS  
(continued)**

**WHAT ARE OTHER INCOME AMOUNTS?**

These are amounts, other than payments you are receiving from us, that include:

1. any benefits and awards you receive or are eligible to receive under:
  - a. Workers' Compensation Law
  - b. occupational disease law
  - c. any other similar act or law
  
2. any disability income benefits you receive or are eligible to receive under:
  - a. any compulsory benefit act or law
  - b. any other group insurance plan with the employer or with an association
  - c. any other group insurance plan with another employer which you become insured under while you are disabled under this plan
  - d. any governmental retirement system as a result of your job with the employer
  
3. any benefits you receive from the employer's sick leave or formal salary continuation plan.

**SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS  
(continued)**

4. any benefits for loss of time or lost wages you receive from the mandatory portion of a no-fault motor vehicle insurance plan, or automobile liability insurance policy.
5. any amounts you receive under any unemployment compensation law.
6. any amounts you receive from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.



#### **SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS (continued)**

If you receive any of the other income amounts in a lump sum payment, we will pro-rate the lump sum on a weekly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a weekly basis to the end of your maximum payment duration.

Other income amounts must be payable as a result of the same disability for which you are receiving a payment from us, except for retirement benefits and any income you earn or receive from any form of employment.

#### **WHAT IF SUBTRACTING OTHER INCOME AMOUNTS RESULTS IN A ZERO PAYMENT TO YOU?**

We will pay you a minimum weekly payment under this plan, subject to any overpayments.

#### **DO WE HAVE THE RIGHT TO ESTIMATE OTHER INCOME AMOUNTS?**

We have the right to estimate the amount of benefits you may be eligible to receive under Other Income Amounts, items 1, 2 and 3. We can reduce our payments to you by this estimated amount if:

- you have not been awarded such benefits but have not been denied such benefits;
- OR
- you have been denied such benefits and the denial is being appealed;
- OR
- you are reapplying for such benefits.

We will not reduce our payments to you by these estimated amounts if:

- you apply (or reapply) for benefits and appeal your denial through all of the administrative levels we believe are necessary;

AND

- you sign our payment option form stating you promise to pay back to us any overpayment of benefits caused by an award.

If we reduce our payments to you by an estimated amount:

- then we will adjust our payments to you when you give us proof of the amount awarded;
- OR
- we will give you a lump sum refund of the estimated amount if you were denied benefits and have completed all appeals (or reapplications) we believe are necessary.

## **SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS (continued)**

### **WHAT ARE NOT OTHER INCOME AMOUNTS?**

We will not subtract from our payments to you any amounts you receive from the following:

- 401(k) plans
- profit sharing plans
- thrift plans
- tax sheltered annuities
- stock ownership plans
- credit disability insurance
- non-qualified plans of deferred compensation
- pension plans for partners
- military pension and military disability income plans
- a retirement plan from another employer
- individual retirement accounts (IRA)
- informal salary continuation plan
- benefits from individual disability plans

### **WHAT HAPPENS IF YOU RECEIVE A COST OF LIVING INCREASE TO ANY OF THE OTHER INCOME AMOUNTS?**

Other than for increases in income you earn or receive from any form of employment, once we have subtracted an other income amount from your gross disability payment, we will not further reduce our payments to you due to a cost of living increase in any other income amount.

## SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS (continued)

### WHEN WILL OUR PAYMENTS TO YOU STOP?

We will stop payments on the earliest of the following dates:

- the date you are no longer disabled according to this plan;
- the date you reach the end of the maximum payment duration;

**Maximum payment duration means the period of time during which we will send you a weekly payment. Your maximum payment duration appears in the PLAN HIGHLIGHTS.**

- the date your current income exceeds 80% of your pre-disability earnings. If your current income fluctuates, we may average amounts over a four (4) consecutive week period of time instead of stopping our payments on the date your current income reaches 80% of your pre-disability earnings;
- the date you die;
- the date you fail to provide proof of continuing disability;
- the date you refuse to participate in an approved rehabilitation program;
- the date you cease to be under the regular care of a doctor, or refuse to undergo, at our expense, an examination or testing by a doctor or vocational, rehabilitation, or health assessment testing when we require such examination or testing;
- the date you refuse to receive medical treatment, including taking prescribed medicines, that your doctor has recommended and that is generally acknowledged by doctors to cure or improve the sickness or injury for which you are claiming benefits under the policy so as to reduce its disabling effect;
- the date you refuse to make a good faith effort to adhere to necessary wellness programs that your doctor has recommended and that are generally acknowledged by doctors to cure or improve the sickness or injury for which you are claiming benefits under the policy so as to reduce its disabling effect. We will work with your treating doctor to determine the necessary wellness programs, if any, in accordance with generally accepted medical standards.

We will give you 30 days prior written notice of our intent to apply this provision to terminate benefits. During those 30 days you will have an opportunity to begin or resume reasonable efforts to adhere to the medically necessary Wellness Programs. We will not terminate benefits if there is no reasonable basis for believing that you will be able to return to productive employment in your regular occupation or another gainful occupation on a full-time or part-time basis if you adhere to the recommended wellness programs.

**Wellness programs include, but are not limited to, appropriate programs for dietary and nutritional improvement, weight management, smoking cessation, abstention from the excessive or illegal use of alcohol or narcotics, regular participation in exercise activities, stress management, pain management, behavioral therapy, coaching, and the regular taking of prescribed medications.**

**SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS  
(continued)**

**WHEN WILL OUR PAYMENTS TO YOU STOP? - continued**

- The date you refuse to try or attempt to work with the assistance of:
  1. modifications made to your work environment, functional job elements or work schedule;  
or
  2. adaptive equipment or devices,that a qualified doctor has indicated will accommodate the limiting factors of the sickness or injury for which you are claiming benefits under the policy and will enable you to perform the material and substantial duties of an occupation from which you must be considered disabled in order to receive disability benefits;
- If you are considered to reside outside the United States. You will be considered to reside outside the United States if you have been outside the United States for a total period of 6 months or more during any 12 consecutive months of disability benefits.

**SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS  
(continued)**

**WHAT HAPPENS IF YOU HAVE A TEMPORARY RECOVERY BUT YOU BECOME DISABLED AGAIN DUE TO THE SAME INJURY OR SICKNESS AS A PRIOR DISABILITY?**

If you return to work, earning more than 80% of your pre-disability earnings, and the same sickness or injury causes your disability to occur again within 14 days of the date the prior disability ended, we will resume our payments to you if you were continuously insured under the plan for the period of your temporary recovery. You will not need to complete a new elimination period for this disability.

Your current period of disability will be subject to the same terms of the plan that applied to your prior period of disability.

If you become entitled to payments under any other group short term disability plan (including a plan with the policyholder that became effective after your disability began), you will not be eligible for payments under this plan.

A disability due to other causes will be treated as a new disability and will be subject to all of the provisions of this plan.

**THIS PAGE APPLIES TO COVERAGE IN YOUR SECTION 1A: HIGHLIGHTS OF YOUR  
NON-VOLUNTARY SHORT TERM DISABILITY PLAN.**

**SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS  
(continued)**

**WHAT HAPPENS IF YOU HAVE A TEMPORARY RECOVERY BUT YOU BECOME DISABLED AGAIN DUE TO THE SAME INJURY OR SICKNESS AS A PRIOR DISABILITY?**

If you return to work, earning more than 80% of your pre-disability earnings, and:

1. the same sickness or injury causes your disability to occur again within 14 consecutive days of the date the prior disability ended

OR

2. you become disabled again within 1 full day of the date the prior disability ended from a sickness or injury unrelated to the sickness or injury that caused your prior disability, then we will resume our payments to you if you were continuously insured under the plan for the period of your temporary recovery. You will not need to complete a new elimination period for this disability.

Your current period of disability will be subject to the same terms of the plan that applied to your prior period of disability.

If you become entitled to payments under any other group short term disability plan (including a plan with the policyholder that became effective after your disability began), you will not be eligible for payments under this plan.

A disability due to other causes will be treated as a new disability and will be subject to all of the provisions of this plan.

If you do not satisfy item 1 or 2 above, your disability will be treated as a new disability and will be subject to all of the provisions of this plan.

**THIS PAGE APPLIES TO COVERAGE IN YOUR SECTION 1B: HIGHLIGHTS OF YOUR  
VOLUNTARY SHORT TERM DISABILITY PLAN.**

**SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS  
(continued)**

**WHAT IF THE POLICYHOLDER CHANGES INSURANCE PLANS AND YOU ARE NOT IN ACTIVE MEMBERSHIP DUE TO AN INJURY OR SICKNESS ON THE EFFECTIVE DATE OF THIS PLAN?**

**Continuity of Coverage**

We will cover you under this plan if you were insured by the prior group insurance plan, and the cost of your coverage under the prior group insurance plan was paid.

Our payments to you will be limited to the weekly amount the prior group insurance plan would have paid you had the plan stayed in effect. Our payments will be reduced by any amount the prior group insurance plan is responsible for paying.

**Prior group insurance plan means the group short term disability plan in effect with the policyholder just before the effective date of this plan.**

## SUMMARY OF THE CLAIM INFORMATION SECTION 5

What will you find in this section?

- notifying us of a claim
- giving us proof of claim
- filing a claim
- information needed in the proof of claim
- when payments to you begin
- who we make payments to



## **SECTION 5: CLAIM INFORMATION**

### **WHEN DO YOU NOTIFY US OF A CLAIM?**

You need to notify us in writing of your claim within 30 days after the date your disability begins. If you are not able to notify us within this time, then you need to notify us as soon as reasonably possible. Notice includes a notice you give, or which is given on your behalf, to us, or to an authorized agent of ours.

### **WHEN DO YOU NEED TO GIVE US PROOF OF YOUR CLAIM?**

Early proof of claim will allow us to make a timely claim decision. You need to send to us written proof of your claim within the first 90 days after the elimination period ends. If you are unable to give us proof of your claim within this time, then you must give us proof of your claim within the next 12 months. If you do not have the legal capacity to make responsible decisions concerning yourself, then you may give us proof of your claim after this period.

You must notify us immediately when you return to work in any capacity.

### **HOW DO YOU FILE A CLAIM?**

You can get a claim form from the policyholder, or you may ask us for a form. If you ask us for a claim form, but you do not receive the form from us within 15 days after asking for it, then you should send written proof of your claim to us without waiting for the form.

You and the policyholder must fill out your claim form. Once you and the policyholder have completed the claim form, give the claim form to the doctor providing you regular care for your sickness or injury causing disability. The doctor must fill out the physician section of the form. Send the completed form to us within the stated time frames.

### **WHAT AUTHORITY DO WE HAVE IN DETERMINING YOUR ELIGIBILITY FOR BENEFITS?**

We have the discretionary authority to determine your eligibility for benefits and to construe the terms of the policy to make a benefits determination.

## **SECTION 5: CLAIM INFORMATION (continued)**

### **WHAT INFORMATION DO YOU NEED TO INCLUDE IN YOUR PROOF OF CLAIM?**

Your proof of claim must include:

- that you are under the regular care of a doctor;
- the date your disability began;
- the cause of your disability as determined by objective medical tests and examinations acceptable to the medical community;
- the extent of your disability, including restrictions and limitations which prevent you from performing your regular occupation;
- the name and address of all hospital(s) or institution(s) where you received treatment, including all doctors who provided regular care;
- appropriate documentation of your earnings.

We may request that you send proof of continuing disability indicating that you are under the regular care of a doctor. We must receive this proof within 30 days of the date we ask for it. In some cases, we will require you to give us authorization to obtain additional medical and non-medical information as part of your proof of claim. We may temporarily suspend our payments to you if you do not cooperate, or do not submit the appropriate information.

### **WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?**

Once we approve your claim, you will begin to receive payments after you complete the elimination period. We will send you a payment for any period for which we are liable. If the policy or a plan is canceled, the cancellation will not affect a payable claim.

### **WHO DO WE MAKE PAYMENTS TO?**

We will make all payments to you.

### **WHAT HAPPENS IF WE OVERPAY YOUR CLAIM?**

We have the right to recover overpayments due to:

- fraud;
- an error we make in processing your claim;
- your receipt of other income amounts.

If we determine that we overpaid your claim, then we require you repay us in full. We will determine the method by which you will repay us. We reserve the right to apply our future payments to you toward overpayments. We have the right to recover overpayments from your eligible survivors or estate. We will not recover more money from you than the amount we paid to you.