Plan Summary for:

12493000 - Revalize, Inc.

SYMETRA
RETIREMENT | BENEFITS | LIFE

Summary of Benefits

Hospital Indemnity

Inpatient Hospital Benefits 500 days lifetime maximum unless otherwise noted	Plan 1
Hospital Confinement	$1,000 first day, $150 day 2+, 90 incident(s) pp/pcy
Intensive Care Unit	$1,000 first day, $300 day 2+, 30 incident(s) pp/pcy
Substance Abuse Facility	$100 per day, 30 day(s) pp/pcy
Mental Health Facility	$100 per day, 30 day(s) pp/pcy
Nursing Facility This benefit is paid only if following a covered hospital stay of at least three consecutive days.	$100 per day, 30 day(s) pp/pcy
Wellness Screening	$50 per day, 1 day(s) pp/pcy
Pregnancy Limitation Period	None
Plan is HSA Compatible	Yes
Portability	Included
Monthly Premium	**Plan 1**
Employee	$11.66
Employee + 1	$22.95
Employee + 2 or More	$33.09

pp/pcy= per person, per calendar year

To Calculate: Weekly=Monthly cost x 12 ÷52; Bi-Weekly =Monthly cost x 12÷26; Semi-Monthly=Monthly cost x 12 ÷24

Please refer to the Description of Benefits included in this packet for additional information on your benefits. These benefits are designed to be offered to those covered under a High-Deductible Health Plan ("HDHP") without the effect of disqualifying a participant from electing an HSA. Please consult with your Benefits Advisor to assist with determination that electing this limited benefit coverage is in fact permitted coverage under the rules applicable to an HSA.

Description of Benefits for:

12493000 - Revalize, Inc.

Hospital Indemnity Insurance

Inpatient Hospital/Intensive Care Unit First Day

Benefits are paid on the first day of a covered hospital stay (whether that is a regular hospital bed or ICU) of 24 hours or more. The benefit is paid one time per hospital stay, regardless of whether the insured is moved from the regular bed to ICU, or vice versa.

Inpatient Hospital/Intensive Care Unit Day 2+

Benefits are paid beginning the second day of a covered stay. ICU stays are included with the hospital stay benefit. Each facility has a calendar year maximum number of days as selected, 500 days per lifetime unless otherwise noted in the policy. Please refer to your Plan Summary for details.

Substance Abuse Facility

Benefits are paid on the first day of a covered substance abuse facility stay. Each facility has a calendar year maximum number of days as selected, 500 days per lifetime unless otherwise noted in the policy. Please refer to your Plan Summary for details.

Mental Health Facility

Benefits are paid on the first day of a covered mental health facility stay. Each facility has a calendar year maximum number of Please refer to your Plan Summary for details.

Nursing Facility

Benefits are paid on the first day of a covered nursing facility stay which follows a covered hospital stay of 3 consecutive days or more. Each facility has a calendar year maximum number of days as selected, 500 days per lifetime unless otherwise noted in the policy. Please refer to your Plan Summary for details.

Survivor Benefit

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

Portability/Extension of Coverage

Allows coverage to continue following termination of employment or loss of eligibility. Review the certificate of coverage to understand the full details of this provision.

Wellness Screening

This Rider provides a benefit if an Insured receives any of the screening tests described in this Rider. There is a specified calendar year maximum number of screening tests for which a benefit will be paid. Please refer to your Plan Summary for details. Included tests:

- Abdominal aortic aneurysm ultrasonography
- Blood test for lipids, including total cholesterol, LDL, HDL and triglycerides
- Bone density screening
- Bone marrow testing
- Breast MRI
- Breast ultrasound
- CA 15-3 blood test for breast cancer
- CA 125 blood test for ovarian cancer
- Carotid Doppler
- CEA blood test for colon cancer
- Chest X-ray
- Child sports physicals
- Colonoscopy or virtual colonoscopy
- CT angiography
- Electrocardiogram
- Fasting blood glucose test
- Flexible sigmoidoscopies
- Mammograms
- Pap smears
- Prostate-specific antigen (PSA) test
- Serum cholesterol test to determine level of HDL and LDL
- Stress test on a bicycle or treadmill
- Testicular ultrasound
- Thermography
- ThinPrep Pap Test

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

Policyholder: **Revalize, Inc.**
Policy Issue State: **FL**
Hospital Indemnity Plan
Insured by Symetra Life Insurance Company

Exclusions

No benefit will be paid when the Insured does not in cur a cost for services or supplies. In addition, benefits will not be paid when costs are incurred for services or supplies:

a. For which there is no legal obligation to pay.
b. Received before the Insured is covered for the benefit.
c. Received after Termination of Coverage, except as provided under the Policy.
d. Which are not furnished or prescribed by a Doctor.
e. Received for Experimental or Investigative treatment, procedures for research purposes, or practices when not generally recognized as accepted medical practices.
f. That are not approved or accepted as essential to the treatment of an Illness or Injury by any of the following:
    a. The American Medical Association
    b. The U.S. Surgeon General
    c. Department of Public Health
    d. The National Institute of Health
g. Related to cosmetic surgery or dental care done to beautify an Insured without medical or dental indication of Injury or Illness.
h. Related to elective medical, dental, or surgical procedures done without medical or dental indication of Illness or Injury.
i. For reversal procedures in connection with previous male or female sterilization.
j. In the nature of educational or vocational testing or training.
k. For outpatient food, food supplements, or vitamins.
l. For radial keratotomies.
m. For physical therapy, occupational therapy, speech therapy or chiropractic manipulations or modalities.
n. In connection with treatment of male or female infertility, in vitro and in vivo fertilization of an ovum, or artificial insemination.
o. For Durable Medical Equipment.
p. For Custodial Care.
q. For surgical Anesthesia.
r. For Ancillary Services in connection with surgery or other Illness, except as stated in the Schedule of Benefits.
s. Related to smoking cessation.
t. For the treatment of the following:
    a. Codependency
    b. Social, occupational, or religious maladjustments
    c. Compulsive Gambling
    d. Chronic marital or family problems when not related to the primary focus of treatment that must be a diagnosable Mental Disorder
u. For the treatment of obesity, weight reduction, or dietetic control, except for morbid obesity or disease etiology.

[1]Regardless of where the policy is issued.

[2]Review your Summary of Plan Benefits to determine whether or not your plan includes a Pregnancy Exclusion/Limitation period and its duration.

*Check with your employer if you want more information about the number of employees in certain states.

This document is intended as a summary of information on exclusions and state-required plan variations. For complete details, please see the certificate of coverage that will be provided for those who enroll. If there is a discrepancy between this summary and the terms of the policy, the policy will govern.

v. For the following, except as specifically stated in the Schedule of Benefits section of the Policy:
   a. For dental treatment and oral surgery
   b. For treatment of Mental Disorders
   c. For treatment of Substance Abuse Disorders
   d. For refractions, eyeglasses, or hearing aids or their fitting
   e. For routine physicals or general health exams, routine immunizations and vaccinations

w. For treatment of Temporomandibular Joint Dysfunction (TMJ) pain syndrome, orofacial, or myofascial syndrome whether medical or dental in scope.

x. For an Illness or Injury caused wholly or partly, directly or indirectly by:
   i. Declared or undeclared war or act of war when serving in the military or an auxiliary unit thereto.
   ii. Committing or attempting to commit an assault or felony.
   iii. Inciting or taking part in any form of public violence. (N/A for policies issued in NH or for residents of NH[1].)
   iv. Intentionally self-inflicted Injury, while sane or insane. (N/A for policies issued in MI)

If the benefits below are included in your plan, some variation of the following exclusions & limitations may apply; please see your plan's enrollment material to determine if these exclusions apply.

Emergency Room Benefit

This benefit is always included for policies issued in DC. This benefit is not available for policies issued in CA, CO, NH, and when the majority of the group resides in NY[1]. Emergency Room Benefits will not be paid when services or supplies are received for:

a. Drugs, supplies or additional Ancillary Services that may be required for a particular emergency treatment.
b. Doctor visits (including Emergency Room Doctors, who bill separately for their services).
c. Diagnostic X-ray and laboratory tests.

Inpatient Hospital Benefit

Inpatient Hospital Benefits will not be paid when services or supplies are received for:

a. Care received in an Emergency Room.
b. Care received in an outpatient Hospital facility or clinic or Urgent Care facility.
c. Care received in a Hospital for Observation Services lasting less than 24-48 hours.
d. Care received in any other portion of a Hospital which provides services that do not require Confinement.

The following additional exclusion will also apply to the Inpatient Hospital Benefit ONLY in the rare event that the plan includes a Pregnancy Limitation (Exclusion) Period[2]:

Inpatient Hospital Benefits will not be paid when services or supplies are received for Care received in a Hospital or Healthcare Facility due to normal pregnancy or childbirth during the Pregnancy Limitation Period.

1Regardless of where the policy is issued.
2Review your Summary of Plan Benefits to determine whether or not your plan includes a Pregnancy Exclusion/Limitation period and its duration.
*Check with your employer if you want more information about the number of employees in certain states.

This document is intended as a summary of information on exclusions and state-required plan variations. For complete details, please see the certificate of coverage that will be provided for those who enroll. If there is a discrepancy between this summary and the terms of the policy, the policy will govern.

State-Specific Benefit Disclosures

If the benefits below are included in your plan, the following state requirements may apply, depending on the state where you live or the policy issue state (as shown above). Apart from any state requirements, please see your plan's enrollment material to determine if these benefits are available.

Wellness Screening Rider
This benefit is not available for policies issued in CO, ID, MI, MN, NH, NJ, NM, or NY.

Portability
This benefit is not available for policies issued in CO, KY, LA, MN, NH, NJ, NM, NY, NV, OR, TX, UT, VT, WA or WV, and for residents of the following states: ID[1], LA[1], NY[1], MN[1], NH[1], VT[1], WV[1].

Ambulance Benefit
This benefit is not available for policies issued in CO. This benefit will always be included for policies issued in DC.

Emergency Room Benefit
This benefit is not available for policies issued in CO. This benefit will always be included for policies issued in DC.

Home Health Care Benefit
This benefit is not available for policies issued in NY. This benefit will always be included for policies issued in CT and for CT residents under any policy where the majority of the group resides within CT.*

Second Opinion Benefit
This benefit will always be included for policies issued in MD or for MD[1] residents.

THE POLICY IS A FIXED-PAYMENT INSURANCE POLICY. IT PROVIDES FIXED-PAYMENT LIMITED MEDICAL BENEFITS. YOUR COVERAGE UNDER THE POLICY IS NOT COMPREHENSIVE MEDICAL COVERAGE AND IS NOT INTENDED TO COVER THE COST OF ALL HOSPITAL OR OTHER MEDICAL SERVICES. THE POLICY DOES NOT SATISFY THE MINIMUM ESSENTIAL COVERAGE REQUIREMENTS OF THE AFFORDABLE CARE ACT.

1Regardless of where the policy is issued.
2Review your Summary of Plan Benefits to determine whether or not your plan includes a Pregnancy Exclusion/Limitation period and its duration.
*Check with your employer if you want more information about the number of employees in certain states.

This document is intended as a summary of information on exclusions and state-required plan variations. For complete details, please see the certificate of coverage that will be provided for those who enroll. If there is a discrepancy between this summary and the terms of the policy, the policy will govern.

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