**Symetra Life Insurance Company**
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Phone 1-800-796-3872 | www.symetra.com

Select Benefits

# Critical Illness Policy

Employer:

| | |
|---|---|
| Name: | NRP Investments LLC |
| Policy Number: | 13109000 - Plans 2 |
| Effective Date of Coverage: | July 1, 2025 |

## CERTIFICATE OF COVERAGE


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

## INTRODUCTION

This is **Your** Certificate of Coverage. It describes the benefits provided through **Your Employer** under the **Policy** issued by Symetra Life Insurance Company (referred to as "**We**, **Us** or **Our**").

This Certificate summarizes the major provisions of the **Policy**, which are important to **You**. The complete terms of the coverage provided are set forth in the **Policy**.

The terms "**You**, **Your** or **Yourself**" referred to in this Certificate of Coverage mean the **Certificateholder**.

Masculine pronouns used in this Certificate will apply to both genders.

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

Keep this Certificate in a safe place. Instructions for submitting a claim for benefits appear at the end of this Certificate.

This Certificate of Coverage replaces all others previously issued.

**YOU SHOULD NOT PURCHASE THIS POLICY UNLESS YOU ARE ALREADY COVERED BY COMPREHENSIVE MAJOR MEDICAL INSURANCE.**

**Notice: The Policy is a critical illness insurance policy. It provides a fixed-payment benefit for the critical illness conditions specified in the Policy. It does not pay benefits for any other loss caused by Illness or Injury.**

**THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Us.**

Notice to Ohio Residents: Holders of Certificates furnished by any insurer to a resident of Ohio in connection with, or pursuant to any provisions of, any group sickness and accident policy which insures residents of Ohio are entitled to all the protections afforded them under Ohio law, including without limitation, Title XXXIX of the Ohio Revised Code.

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## SCHEDULE OF BENEFITS

**Eligible Class(es) for Coverage**
Eligible class(es) of **Employees** is defined as follows:

| Class | Description |
|---|---|
| 1 | All Active Full-Time and Part-Time Employees working 20 hours or more per week |

**Service Waiting Period**
If **You** are in an Eligible Class on **Your Employer**'s **Effective Date of Coverage**, there is no **Service Waiting Period**. Otherwise, the **Service Waiting Period** is the first of the month coincident with or next following the date of hire.

**Annual Enrollment Period**
As determined by **Your Employer** on a yearly basis.

**Employee and Dependent Benefits**

**Employee Critical Illness Benefit**

| | |
|---|---|
| **Critical Illness Benefit** | **Option 1:** $5,000<br>**Option 2:** $10,000<br>**Option 3:** $15,000<br>**Option 4:** $20,000<br>**Option 5:** $25,000<br>**Option 6:** $30,000 |
| **Guaranteed Issue Amount** | up to $30,000 |
| **Recurrence Benefit** | 100% of the Critical Illness Benefit paid for the initial occurrence of the same condition |
| **Health Screening Benefit** | $100 per person, per **Calendar Year** |

**Spouse Critical Illness Benefit**

| | |
|---|---|
| **Critical Illness Benefit** | **Option 1:** $2,500<br>**Option 2:** $5,000<br>**Option 3:** $7,500<br>**Option 4:** $10,000<br>**Option 5:** $12,500<br>**Option 4:** $15,000 |
| **Guaranteed Issue Amount** | up to $15,000 |
| **Recurrence Benefit** | 100% of the Critical Illness Benefit paid for the initial occurrence of the same condition |
| **Health Screening Benefit** | $100 per person, per **Calendar Year** |

| | |
|---|---|
| **Child Critical Illness Benefit** | |
| **Critical Illness Benefit** | **Option 1:** $1,250<br>**Option 2:** $2,500<br>**Option 3:** $3,750<br>**Option 4:** $5,000<br>**Option 5:** $6,250<br>**Option 6:** $7,500 |
| **Guaranteed Issue Amount** | up to $7,500 |
| **Recurrence Benefit** | 100% of the Critical Illness Benefit paid for the initial occurrence of the same condition |
| **Health Screening Benefit** | $100 per person, per **Calendar Year** |

**Miscellaneous Goods and Services**

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

## DEFINITIONS

**Accident:** a sudden, unforeseen, unexpected and involuntary event definite as to time and place and which is independent of disease or bodily infirmity. In order for benefits under the **Policy** to be payable, the **Accident** must occur while the **Insured's** coverage is in force. Injury or injuries, for which benefits are provided, means accidental bodily injury sustained by the insured person and directly caused by an accident which is not the result of disease or bodily infirmity.

**Actively at Work: You** are at work with **Your Employer** on a day that is one of **Your Employer**'s scheduled workdays. On that day, **You** must be performing, for wage or profit, all of the normal duties of **Your** job:

a. In the usual way.
b. For **Your** usual number of hours.
c. At **Your Employer**'s normal place of business, or alternate location, if approved by the **Employer**.

**You** are also considered to be **Actively at Work** on any regularly scheduled vacation day or holiday, only if **You** were **Actively at Work** on the preceding scheduled workday.

**Amendment:** a document that modifies the **Policy** or Certificate, and becomes part of the **Policy** or Certificate, also known as a **Rider**.

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

**Beneficiary:** the person or entity to whom benefits for loss of life are payable.

**Benefit Year:** The time, designated by **Your Employer**, during which the benefit elections **You** make during an Annual Enrollment Period are in effect.

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

**Certificateholder:** the **Employee** who is eligible for coverage under the **Policy**, who is enrolled and for whom **Premium** is paid.

**Dependent:** the following persons:

a. **Your** spouse, as defined by state law.
b. **Your** child who is under 26 years of age (Limiting Age), regardless if that child lives with **You** or is claimed as a dependent on **Your** last-filed income tax return.
c. **Your** unmarried child, who is incapable of self-support due to a disabling physical or mental impairment, provided the disabling condition occurs prior to age 26.

A child can include: stepchildren; legally-adopted children; foster children, including any children legally placed with **You** for adoption; any children **You** support under court order; any other children, related to **You** by blood or marriage, who live with **You** in a regular parent-child relationship; or any children **You** claimed as a dependent on **Your** last-filed federal income tax return.

**Disabled**: **You** are unable, because of a Covered Critical Illness for which a benefit is payable under this Certificate, to perform the material and substantial duties of any occupation for which **You** are qualified by reason of education, experience or training.

**Doctor:** a person who meets all of the following conditions:

a. Is licensed and recognized as a doctor by the state in which he practices.
b. Is practicing within the scope of his license.
c. Is performing a service for which benefits are provided under the **Policy**.

Is not a person who:

a. Ordinarily resides in **Your** household.
b. Is a member of **Your** immediate family.
c. Is employed by or affiliated with **Your Employer**.

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

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

**Employer:** the entity, named on the **Schedule of Benefits**, who has obtained coverage under the **Policy**.

**Employee:** a person who is employed by, and paid by, the **Employer**.

**Guaranteed Issue Amount:** the amount of benefit available without having to provide evidence of insurability on the date **You** or **Your Dependent** are first eligible for coverage under the **Policy**.

**Hospital:** a licensed healthcare facility that:

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

**Hospital** does not include:

a. A rest home or nursing home, home for the aged, or convalescent home.
b. A nursing facility.
c. A hospice or a place for custodial care or a birthing center.
d. A place, including a section or wing/ward of a **Hospital**, primarily for the treatment of substance use disorders.

**Hospitalization:** admitted to a **Hospital** as an inpatient.

**Illness:** physical sickness or disease.

**Infertility:** the inability to get pregnant after a minimum of one year of unprotected sex for an eligible **Insured** who is under 35 years of age, or a minimum of 6 months of unprotected sex for an eligible **Insured** who is 35 years or older.

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

**Insured:** a person who is eligible for coverage under the **Policy** as an **Employee** or as a **Dependent**, is enrolled, and for whom **Premium** is paid.

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

**Mental Illness:** any of the named conditions in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), which includes, among others: Schizophrenia, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder, Borderline Personality Disorder, Post-Traumatic Stress Disorder, Obsessive Compulsive Disorder, Schizotypal Personality Disorder, and Schizoid Personality Disorder.

**Policy:** the contract between **Us** and the **Policyholder**. The **Policy** is comprised of the Policy Specifications, the **Employer** section, the Policy Contents and this Certificate. This Certificate describes all of **Your** covered benefits under the **Policy**.

**Policyholder:** the entity identified on the master application for the **Policy** as such and to whom the **Policy** is issued.

**Premium:** the dollar amount paid by **Your Employer** and/or **You** to keep the **Policy** in force.

**Prior Coverage:** any critical illness, specified disease, or any other like coverage which **Your Employer** has replaced with coverage under the **Policy**.

The cost of the **Prior Coverage** must have been paid through its date of termination. The termination date must have occurred within 1 day of **Your Employer**'s **Effective Date of Coverage** under the **Policy**.

**Proof of Loss:** a statement that must be furnished by **You** to **Us** before any benefits may be paid under the **Policy**.

**Provider:** any **Doctor**, health professional, **Hospital**, or recognized entity licensed to provide **Hospital** or medical services to **Insureds** covered under the **Policy**.

**Rider:** a document that modifies the **Policy** or Certificate, and becomes part of the **Policy** or Certificate, also known as an **Amendment**.

**Service Waiting Period:** the length of time **You** must wait from **Your** date of employment or (if later, the date **You** become a member of an Eligible Class before **Your** coverage can begin.

**Schedule of Benefits:** are the pages of the Certificate, which list the benefits available to **You** as selected by **Your Employer**.

**Specialist:** a person who:

a. Is licensed and recognized as a **Doctor** by the state in which he practices; and practices or attempts to practice an occupation or profession within the scope of the licensee's competency abilities or education needed to diagnose and treat the diseases or conditions covered as a critical illness under the policy.
b. Is practicing within the scope of his license.
c. Is board eligible or board certified in the appropriate specialty or sub-specialty needed to diagnose and treat the diseases or conditions covered as a critical illness under the **Policy**.

Examples of a **Specialist** are:

a. Cardiologist for Heart Attack
b. Neurologist for Advanced Alzheimer's Disease
c. Ophthalmologist for Loss of Sight
d. Oncologist for Invasive Cancer

A **Specialist** is not a person who:

a. Ordinarily resides in **Your** household.
b. Is a member of **Your** immediate family.
c. Is employed by or affiliated with **Your Employer**.

**We, Us, Our:** Symetra Life Insurance Company.

**You, Your, Yours:** a(n) **Employee** who is currently insured under the **Policy** and this Certificate. (See also **Insured**.)

# ELIGIBILITY FOR COVERAGE

## Eligible Employees

**You** are eligible for coverage under the **Policy** if all of the following conditions are met:

a. **You** are **Actively at Work**.
b. **You** are a member of an Eligible Class as described in the **Schedule of Benefits**.

### The Date You Are Eligible for Coverage

**You** first become eligible for coverage on the later of:

a. The **Employer**'s **Effective Date of Coverage**.
b. The first of the month following the date on which **You** complete the **Service Waiting Period**.
c. The first of the month following the date **You** become a member of an Eligible Class.

### Enrollment

In order to become covered for the benefits under the **Policy**, **You** must first enroll in writing on a form approved by **Us** giving the information **We** require. **You** may only enroll at the following times:

a. Within 31 days of **Your** eligibility date.
b. During an Annual Enrollment Period designated by the **Employer**.
c. Within 31 days of the date **You** have a qualifying life event change.

### Life Event Changes

Life event changes that qualify **You** to enroll earlier than the next Annual Enrollment Period are:

a. A change in **Your** legal marital status, including marriage, divorce, legal separation, annulment, or death of a spouse.
b. A change in the number of **Your Dependents**, including birth, death, adoption, placement for adoption, award of legal guardianship.
c. A change in the eligibility of a **Dependent** due to reaching the Limiting Age or any similar circumstance.
d. A change in employment status which causes **Your** spouse to become ineligible for group coverage.
e. A change in **Your** classification from part-time to full-time or from full-time to part-time.

### Effective Date of Your Coverage

**Your** coverage becomes effective on the first day of the month following the latest of the following dates:

a. The date **You** become eligible (if **You** enroll before that date).
b. The date **You** enroll for coverage (if **You** do so within 31 days from the date **You** first become eligible or have a qualifying life event change).
c. The date the next **Benefit Year** begins (if **You** enroll during an Annual Enrollment Period)
d. The date the required contribution or **Premium** is received.

If, because of **Illness** or **Injury**, **You** are not **Actively at Work** on the date **Your** coverage would normally take effect, **Your Effective Date of Coverage** will be delayed until the first day of the month following the date **You** have returned to active work for a period of 5 days.

If **You** have any questions about **Your** eligibility or enrollment, contact **Your Employer**.

## Eligible Dependents

This section applies if the **Schedule of Benefits** shows **You** are entitled to elect **Dependent** benefits. A family member is eligible for coverage under the **Policy** if all of the following conditions are met:

a. **You** are eligible for coverage under the **Policy**.
b. The family member qualifies as a **Dependent** as defined under the **Policy**.
c. The **Dependent** is not covered as an **Employee** under the **Policy**.

If both **You** and **Your** spouse are covered under the **Policy** as **Employees**, either, but not both, may elect to cover children who are eligible **Dependents**.

**The Date a Dependent is Eligible for Coverage**
A **Dependent** first becomes eligible to be an **Insured** on the later of:

a. The date **You** become eligible.
b. The first day of the month following the date **You** acquire a **Dependent** such as through marriage, birth, adoption, or placement for adoption.

**Enrollment**

In order for a **Dependent** to become an **Insured**, **You** must first enroll the **Dependent** in writing on a form approved by **Us** giving the information **We** require. **You** may enroll a **Dependent** at the sametime as **You** enroll **Yourself** for coverage. If **You** have already enrolled **Yourself**, **You** may add a **Dependent** at the following times:

a. Within 31 days of the **Dependent**'s eligibility date.
b. During an Annual Enrollment Period designated by the **Employer**.
c. Within 31 days of the date **You** have a qualified life event change.

It is important that **You** promptly notify **Us** of additional **Dependents** to assure accurate claim handling.

If **You** have not enrolled **Yourself**, **You** may not enroll a **Dependent**.

**Effective Date of Dependent Coverage**
**Dependent** coverage becomes effective on the first day of the month following the latest of the following dates:

a. The date the **Dependent** becomes eligible (if **You** enroll the **Dependent** before that date).
b. The date **You** enroll the **Dependent** for coverage (if **You** do so within 31 days from the **Dependent's** eligibility date or the date of a life event change).
c. The date the next **Benefit Year** begins (if **You** enroll the **Dependent** during an Annual Enrollment Period).
d. The date **Premium** is received.

If **You** did not elect **Dependent** coverage before the birth or adoption of a child, coverage will take effect for that child on the date of birth or adoption, if:

a. **You** notify **Us**, in writing, of the birth or adoption of such child; and
b. Within 60 days of the date of birth or adoption, **You** authorize **Your Employer** to deduct **Your** required contribution toward the cost of **Your Dependent** coverage from **Your** pay.

However, **Your** child will be covered for Critical Illness Benefits for 31 days following the date of birth, adoption, or placement for adoption without authorizing **Your Employer** to deduct any amounts from your pay.

If a **Dependent**, other than a newborn child, is **Hospitalized** on the date he would otherwise become an **Insured**, he will become an **Insured** on the first day following his release from the **Hospital** or **Health Care Facility**.

If **You** have any questions about a **Dependent's** eligibility or enrollment, contact **Your Employer**.

## Continuity with Prior Coverage

If **You** and **Your Dependents** were insured under **Prior Coverage** on the day it terminated and enroll for coverage under the **Policy** to take effect on the **Employer**'s **Effective Date of Coverage**, the following provisions apply to prevent a loss of coverage.

**Effective Date of Coverage**

**Your Effective Date of Coverage** will not be delayed if **You** were not **Actively at Work**, because of an **Illness** or **Injury**, on the date coverage under the **Policy** would otherwise take effect.

Coverage will not be delayed for a **Dependent** who is **Hospitalized** or other healthcare facility on the date coverage under the **Policy** would otherwise take effect.

## Change in Amounts of Benefits

The following paragraph applies if the **Schedule of Benefits** shows different levels of coverage for Hourly **Employees** or benefit amounts based on class.

Any change in the amount of benefits due to a change in **Your** class or status, is effective on the first of the month following the date **Your** class or status changes, provided:

a. **You** are performing all the normal duties of **Your** job at **Your Employer**'s normal place of business.
b. **You** make any required contribution or **Premium** payment for the change to take effect.

Changes in the amount of benefits due to an **Amendment** or **Rider** to **Your Employer**'s coverage under the **Policy**, take effect for an **Insured** on the **Effective Date** of the **Amendment** or **Rider**.

Benefits, payable under the **Policy**, are based on the coverage amounts in effect at the time a Covered Critical Illness condition is diagnosed.

## Change in Amounts of Coverage

Once **You** have enrolled, **You** cannot make any changes in **Your** elected coverage until **Your Employer**'s next Annual Enrollment Period.

## Effective Date of Change

Any decrease in the amount of coverage is effective on the first day of the next **Benefit Year**.

Any increase in the amount of coverage is effective on the first day of the next **Benefit Year**, provided:

a. **You** are **Actively at Work**; and
b. **You** make any required contribution or **Premium** payment for the change to take effect. Any decrease in the amount of coverage is effective on the first day of the next **Benefit Year**.

## Termination of Your Coverage

**Your** coverage will cease on the earliest of:

a. The date the **Policy** is canceled.
b. The date **Your Employer**'s coverage ceases under the **Policy**.
c. The date the first of the following events occurs:
    i. **Your** membership in an eligible class ceases.
    ii. **Your** employment with **Your Employer** ceases.
    iii. **You** are no longer **Actively at Work**.
    iv. **You** or **Your Employer** cease to make contributions or **Premium** payments for **Your** coverage subject to the 31 day Grace Period. Coverage will terminate on the last day of the grace period if the premium due is not paid by the end of the grace period.
    v. **You** are pensioned or retired, as defined by **Your Employer**.
    vi. The date **You** begin active duty as a member of the armed forces (land, water, air) of any country or international authority, except as provided under the Continuation of Coverage provision.

## Termination of Dependent Coverage

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

a. The date the **Policy** is canceled.
b. The date **Your** coverage ceases.
c. The date all **Dependent** coverage ceases under the **Policy**.
d. The date the first of the following occurs:
    i. **You** are no longer in a class eligible for **Dependent** coverage.
    ii. The family member ceases to be an eligible **Dependent**.

Coverage will be continued for a **Dependent** child beyond the Limiting Age for as long as the child is: unmarried, incapable of self-support because of a disabling mental or physical impairment and dependent on the **Certificateholder** for support.

Proof of the disabling impairment must be given to **Us** no later than 31 days after the date **Your** child attains the Limiting Age. Subsequently, **We** have the right to require proof of **Your** child's impairment, but not more often than once per year after two years from the date the Limiting Age is attained.

See "Continuation of Coverage", and "Portability" provision for any exceptions to the Termination provisions.

## Continuation of Coverage During Temporary Absence

Coverage may continue, as described below, beyond the day it would otherwise cease under the Termination provisions if **You** are absent from work due to any of the following reasons. Any continued coverage:

a. Is subject to payment of the required contribution or **Premium**.
b. Must be requested, in writing, by **Your Employer**.
c. Terminates if:
    i. The **Policy** terminates.
    ii. **Your Employer** ceases to be an **Employer** under the **Policy**.
    iii. **You** begin work for pay or profit with another employer.

In no event will coverage continue beyond the maximum time shown below for any temporary absence. If **You** qualify to continue coverage for more than one reason, the periods of continuation will run concurrently. The continuation periods may not be applied consecutively.

If **You** are absent from work due to any of the following reasons ("Absences"), coverage may be continued up to the maximum time shown for each type of Absence.

**Illness or Injury:**
If **You** are absent from work due to an **Illness** or **Injury**, all of **Your** coverage may be continued for a period of 6 consecutive month(s) from the date **You** were last **Actively at Work**.

**Personal Leave of Absence**
If **You** are on an employer-approved leave of absence, all of **Your** coverage may be continued for up to 2 month(s) following the date **You** were last **Actively at Work**. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

**Family Medical Leave of Absence**
If **You** are on a leave of absence approved in accordance with the federal Family and Medical Leave Act of 1993 and any amendments to it (FMLA) or a similar state law, all of **Your** coverage may be continued for up to 3 month(s) following the date **You** were last **Actively at Work**. If the leave terminates prior to the agreed upon date, this continuation will cease immediately. Continuation under this FMLA leave provision will not apply if coverage may be continued for a longer period of time under the provision for temporary absence due to **Illness** or **Injury**.

**Military Leave of Absence**
If **You** are on a military leave of absence taken in accordance with the federal Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments to it (USERRA), all of **Your** coverage may be continued for up to 12 month(s) following the date **You** were last **Actively at Work**. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

**Sabbatical**
If **You** are on an employer-approved sabbatical, all of **Your** coverage may be continued for up to 2 month(s) following the date **You** were last **Actively at Work**. If the sabbatical terminates prior to the agreed upon date, this continuation will cease immediately.

**Temporary Layoff**
If **You** are temporarily laid off by the **Employer** due to lack of work, all of **Your** coverage may be continued for up to 2 month(s) following the date **You** were last **Actively at Work**. If the layoff becomes permanent, this continuation will cease immediately.

**Temporary Production Shutdown**
If **You** are not at work due to a temporary production shutdown by the **Employer**, all of **Your** coverage may be continued for up to two month(s) following the date **You** were last **Actively at Work**. If the production shutdown becomes permanent, this continuation will cease immediately.

**Labor Strike/Labor Dispute**

If **You** are not at work due to a labor strike or dispute, all of **Your** coverage may be continued for up to one month(s) following the date **You** were last **Actively at Work**. If the labor strike or dispute ends earlier, this continuation will cease immediately.

If **Your** coverage is continued for any Absence described above, **Dependent** coverage may continue until **Your** coverage ends.

**Your** coverage will not be continued for any Absence occurring within 30 days after any Absence for which coverage was continued.

In all other respects, the terms of **You** and **Your Dependent** coverage remain unchanged. Upon written request from **Your Employer**, **We** may agree to continue **Your** coverage for reasons other than those listed above, provided **Your Employer** provides a plan of continuation which applies to all **Employees** the same way.

## Post-Termination Continuation of Coverage

**Employee** coverage may be continued following termination of employment if **You** meet all of the following conditions:

a. **You** were **Actively at Work** on the date **Your** employment ceases.
b. **You** are under 65 years of age.
c. **You** are not pensioned or retired, as defined by **Your Employer**.
d. **You** are not scheduled for immediate deployment as a full-time member of the armed services of any country.

**You** have 31 days from the date **Your** employment ceases to elect continuation of coverage. If **You** choose to continue coverage **You** must pay the full cost of coverage each month. The coverage will be identical to the coverage **You** had immediately prior to the date **Your** employment ceased.

Coverage may be continued up to the date the first of the following events occurs:

a. **You** begin work for pay or profit with another employer.
b. **You** attain 65 years of age.
c. **You** are pensioned or retired, as defined by **Your Employer**.
d. **You** enter full-time active duty as a member of the armed forces (land, water, air) of any country or international authority.
e. **You** request, in writing, to cancel coverage.

Any continued coverage:

a. Is subject to payment of the required **Premium**.
b. Terminates if the **Policy** terminates.

## Reinstatement

If **You** ceased to be eligible for coverage, coverage that terminated may be reinstated if **You** become eligible again within 30 days from the date **You** were last eligible. **Your** reinstated coverage will take effect on the first day of the calendar month following the date in **You** become eligible again. If **You** do not qualify for reinstatement within 30 days from the date **You** were last eligible, **You** will be treated as a new **Employee**.

Evidence of insurability will not be required to reinstate coverage.

**Reemployment**

If **You** are rehired, **You** will be treated as a new **Employee**, unless **Your** coverage may be reinstated as described in this Certificate.

## Portability

Coverage may continue for **You** and any **Dependent(s)** when coverage ends under the **Policy**. **Your** portable coverage will be provided under an insurance policy **We** make available for this purpose. Coverage under **Your** portable insurance may not be identical to coverage under this **Policy**.

If **You** are age 65 or younger, **You** may request portability coverage for **You** and any **Dependent(s)** when:

a. **You** are no longer **Actively at Work** and are not eligible for coverage under any other Continuation of Coverage provision in this Certificate;
b. **You** are no longer employed by the **Policyholder**, including retirement; or
c. the **Policy** terminates and the **Policyholder** does not obtain a replacement policy with another insurance carrier within 31 days.

If **You** are eligible to request portability coverage, then **You** must elect insurance under the portability policy in order for any **Dependent(s)** to be eligible for coverage under the portability policy.

A **Dependent** who is **Your** spouse who is age 65 or younger may request portability coverage for him/herself and any insured **Dependent** child(ren):

a. in the event of **Your** death;
b. in the event of divorce, dissolution of partnership or legal separation from **You**; or
c. when **You** enter active duty service or training in any military for a period of 31 days or more and are no longer eligible under the **Policy** as an **Employee**.

If a **Dependent** spouse elects coverage under the portability policy, the **Dependent** spouse will become the primary **Insured** under the portability policy. Any **Dependent** child(ren) may only be covered under one portability policy.

When coverage under the **Policy** ends, notice of the right to request portability coverage will be given. To elect coverage under a group portability policy, **You** or **Your Dependent** spouse must send a request to **Us**. The benefits and premium rates of the portability policy are described on **Our** portability request form, which can be obtained by contacting the **Policyholder** or **Us**.

The request and the initial **Premium** due must be received within 31 days after insurance under the **Policy** ends. If timely notice is not given, an extension of the period of time in which to request portability coverage will be allowed. **You** or **Your Dependent** spouse will have 15 days from the date notice is received to submit his/her request and initial **Premium**. However, in no event will a request be accepted by **Us** if received more than 91 days after the date coverage under the **Policy** would otherwise end, even if notice is not received.

The continued group insurance coverage under the portability policy is available as a result of portability rights that arise solely from the **Policy**, as arranged for the **Employee** as an employee welfare benefit subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

# BENEFITS

## Critical Illness Benefit

The Critical Illness Benefit will be paid if, while covered under the **Policy**, an **Insured** is diagnosed with a Covered Critical Illness as described below. The benefit payable is based on a percentage of the benefit amount in effect for the **Insured**. The benefit amount in effect is determined by the benefit amount as shown in the **Schedule of Benefits**.

The Covered Critical Illnesses categorized as Childhood Conditions Benefits are payable only for a diagnosis in a **Dependent** child.

**Covered-Critical Illness**

| Core Benefits<br>Covered Critical Illness | Percentage of<br>Benefit Amount Payable |
|---|---|
| Invasive Cancer | 100% |
| Minor Cancer (In Situ) | 30% |
| Heart Attack (Myocardial Infarction) | 100% |
| Coronary Artery Disease Needing Surgery or Angioplasty | 30% |
| Stroke | 100% |
| Major Organ Failure | 100% |
| Stem Cell (Bone Marrow) Transplant | 100% |
| End Stage Renal Failure | 100% |
| Loss of Sight | 100% |
| Loss of Speech | 100% |
| Loss of Hearing | 100% |
| Paralysis | 100% |
| Severe Burns | 100% |
| Severe Chronic Heart Failure | |
| Class III | 100% |
| Class IV | 100% |

| Infectious Disease<br>Covered Critical Illness | Percentage of<br>Benefit Amount Payable |
|---|---|
| Infectious Disease Benefit | 25% |
| Occupational HIV | 100% |

| Neurological Conditions<br>Covered Critical Illness | Percentage of<br>Benefit Amount Payable |
|---|---|
| ALS and Other Motor Neuron Diseases | 100% |
| Advanced Alzheimer's Disease | 100% |
| Parkinson's Disease | 100% |
| Huntington's Disease | 100% |
| Advanced Multiple Sclerosis | 100% |
| Coma | 100% |
| Benign Brain Tumor | 75% |

| Childhood Conditions Benefits<br>Covered Critical Illness | Percentage of<br>Benefit Amount Payable |
|---|---|
| Major Congenital Structural Anomaly | 100% |
| Congenital Metabolic Disorder | 100% |
| Congenital Chromosomal Abnormality | 100% |
| Chronic Medical Condition Commonly Diagnosed in Childhood | 100% |

A benefit is payable once for a specific Covered Critical Illness. A Recurrence Benefit may be payable if the same critical illness is subsequently diagnosed.

Only one benefit is payable if the date of diagnosis of two or more Covered Critical Illnesses is the same day. The single benefit paid will be for the Covered Critical Illness that provides the largest benefit amount. If the benefit amounts are equal, the benefit paid will be for the Covered Critical Illness selected by the **Employee**.

If **You** are diagnosed with a different Covered Critical Illness described below, **We** will pay an additional Critical Illness Benefit.

## Covered Critical Illness Descriptions

## Core Benefits

**Invasive Cancer**
Invasive Cancer is defined as a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and invasion of neighboring tissue that is supported by histological evidence of malignancy. Invasive Cancer includes:

a. Leukemia.
b. Lymphoma.
c. Sarcoma.
d. Malignant melanoma greater than 1mm in thickness.
e. Any type of breast cancer.
f. Multiple myeloma.

*Diagnosis Requirements*
Invasive Cancer must be diagnosed by a **Specialist** according to a Pathological or Clinical Diagnosis.

a. Pathological Diagnosis

   A diagnosis on a pathology report of Invasive Cancer based on a microscopic study of fixed tissue or preparations from the blood system. This type of diagnosis must be done by a **Specialist** whose diagnosis of malignancy conforms to the standards set by the American College of Pathology.

b. Clinical Diagnosis

   A diagnosis of Invasive Cancer based on the study of symptoms and diagnostic test results.

   We will accept a Clinical Diagnosis of Invasive Cancer only if the following conditions are met:
   i. A Pathological Diagnosis cannot be made because it is medically inappropriate or life threatening;
   ii. There is medical evidence to support the diagnosis; and
   iii. A **Specialist** is treating the **Insured** for Invasive Cancer.

*Diagnosis Date*
The date of diagnosis is the date of biopsy or other test that generates a definite diagnosis of cancer that satisfies the Invasive Cancer description.

*Exclusions and Limitations*
An Invasive Cancer Critical Illness Benefit will not be paid for the following:

a. Pre-malignant tumors or polyps.
b. Any Non-Melanoma Skin Cancer.
c. Any Minor Cancer (In Situ).

**Minor Cancer (In Situ)**
Minor Cancer (In Situ) is defined as a cancer wherein the tumor cells lie within the tissue of origin and have not spread to neighboring tissue. Non-Invasive Cancer includes:

a. Chronic lymphocytic leukemia that has not progressed beyond RAI Stage 0;
b. Stage 1A (T1a) malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion); or
c. Early prostate cancer classified as T1a or T1b (or equivalent staging) without lymph node or distant metastasis.

*Diagnosis Requirements*
The diagnosis must be confirmed with a report from a **Specialist** that includes the pathology report.

*Diagnosis Date*
The date of diagnosis is the date of biopsy or other test that generates a definite diagnosis of cancer that satisfies the Minor Cancer (In Situ) description.

*Exclusions and Limitations*
A Minor Cancer (In Situ) Critical Illness Benefit will not be paid for the following:

a. skin cancer other than invasive malignant melanoma of the dermis or deeper or skin malignancies that have become metastatic;
b. pre-malignant lesions (such as intraepithelial neoplasia);
c. any Non-Melanoma Skin Cancer;
d. any Invasive Cancer; or
e. benign tumors or polyps.

**Non-Melanoma Skin Cancer**

Non-Melanoma Skin Cancer is defined as a malignant growth that arises on the surface of the skin that is any of the following:

a. Basal cell carcinoma.
b. Squamous cell carcinoma.
c. Merkel cell carcinoma.

*Diagnosis Requirements*
The diagnosis must be made by a **Specialist** and based on a pathological examination of tissue from skin lesions.

*Diagnosis Date*
The date of diagnosis is the date of biopsy or other test that generates a definite diagnosis of cancer that satisfies the Non-Melanoma Skin Cancer description.

*Exclusions and Limitations*
A Non-Melanoma Skin Cancer Benefit will not be paid for the following:

a. All tumors which are histologically described as benign, non-malignant, pre-malignant, borderline, low malignant potential, dysplasia (all grades) or intraepithelial neoplasia;
b. Melanoma skin cancer.

**Heart Attack (Myocardial Infarction)**

Heart Attack (Myocardial Infarction) is defined as the ischemic death of a portion of the heart muscle due to a blockage of one or more coronary arteries.

*Diagnosis Requirements*
The diagnosis must be made by a **Specialist** and based on serial measurement of cardiac biomarkers in the blood showing a pattern and to a level consistent with a diagnosis of Heart Attack (Myocardial Infarction) and any other diagnostic criteria to meet the clinically accepted definition for heart attack.

*Diagnosis Date*
The date of diagnosis is the date of the Heart Attack as confirmed by a **Specialist**.

*Exclusions and Limitations*
A Heart Attack Critical Illness Benefit will not be paid for the following:

a. Established or old heart attack (myocardial infarction) found on imaging or electrocardiogram.
b. Angina.
c. Cardiomyopathy.
d. Myocarditis.
e. All other forms of acute coronary syndromes.

**Coronary Artery Disease Needing Surgery or Angioplasty**

Coronary Artery Disease Needing Surgery or Angioplasty is defined as coronary artery disease with blockages in one or more coronary artery(s) demonstrated on cardiac catheterization coronary angiography that requires the **Insured** to undergo either coronary artery bypass surgery or coronary angioplasty.

*Diagnosis Requirements*
The **Insured** must require coronary bypass or angioplasty surgery intervention on the coronary artery(s) following clinically accepted cardiovascular surgery guidelines, either for prognostic benefit or for symptomatic coronary artery disease that cannot be adequately managed on optimal medical therapy.

*Diagnosis Date*
The date of diagnosis is the date the **Insured** is diagnosed with coronary artery disease that satisfies this Coronary Artery Disease Needing Surgery or Angioplasty description.

*Exclusions and Limitations*
A Critical Illness Benefit will not be paid for coronary artery conditions that are treatable by non-surgical intervention procedures including, but not limited to, diagnostic coronary angiography.

**Stroke**

Stroke is defined as an acute cerebrovascular incident resulting in irreversible death of brain tissue due to intra-cranial hemorrhage or cerebral infarction due to embolism or thrombosis in an intra-cranial vessel.

*Diagnosis Requirements*
This event must result in:

a. neurological functional impairment with objective neurological abnormal signs on physical examination by a **Specialist** and
b. the diagnosis must also be supported by findings on brain imaging and must be consistent with the diagnosis of a new Stroke.

*Diagnosis Date*
The date of diagnosis is the date of the Stroke as confirmed by neurological evidence.

*Exclusions and Limitations*
A Stroke Critical Illness Benefit will not be paid for the following:

a. Transient Ischemic Attacks (TIA);
b. Brain damage due to an **Accident**, **Injury** or hypoxia;
c. Vascular disease affecting the eye, optic nerve, or vestibular functions;
d. Asymptomatic silent stroke found on imaging.

**Major Organ Failure**

Major Organ Failure is defined as the permanent failure or loss of one or more of the following organs: heart, liver, lung, or pancreas, that requires a surgical transplant of a human organ.

*Diagnosis Requirements*
A **Specialist** must determine that a transplant of one or a combination of the above mentioned organs is necessary to treat organ failure in the **Insured** and the **Insured** must be actively engaged in a course of treatment with the goal of eventual transplant. The transplant goal requirement is waived if the **Insured** is too ill to undergo transplant surgery, but surgery would otherwise be recommended due to the organ failure.

*Diagnosis Date*
The date of diagnosis is the date the **Insured** is diagnosed as needing a transplant as the result of organ failure.

*Exclusions and Limitations*
The need for transplant of any other organs, parts of organs, tissues or cells is not included in this definition.

If an **Insured** is diagnosed with the need for multiple organ transplants, only one benefit will be paid.

**Stem Cell (Bone Marrow) Transplant**

Stem Cell Transplant is defined as the need for an autologous or allogeneic stem cell transplant, necessitated by compromise of the bone marrow's ability to produce sufficient blood cells.

*Diagnosis Requirements*
Diagnosis must be made by a **Specialist** who is a hematologist or oncologist and the **Insured** must be actively engaged in a course of treatment with the goal of eventual transplant.

The transplant goal requirement is waived if the **Insured** is too ill to undergo stem cell transplant, but stem cell transplant would otherwise be recommended due to compromised bone marrow ability to produce sufficient blood cells.

*Diagnosis Date*
The date of diagnosis is the date the **Insured** is diagnosed as needing a Stem Cell Transplant.

*Exclusions and Limitations*
The need for transplant of any other organs, parts of organs, tissues or cells is not included in this definition.

If an **Insured** is diagnosed with the need for multiple Stem Cell Transplants during the course of a single treatment, only one benefit will be paid.

**End Stage Renal Disease**

End Stage Renal Failure (Kidney Failure) is defined as the total and irreversible failure of both kidneys which requires permanent regular renal dialysis or a kidney transplant.

*Diagnosis Requirements*
A **Specialist** must confirm that either of the following is necessary:

a. The **Insured** must undergo regular renal dialysis at least weekly.
b. The **Insured** needs a kidney transplant.

*Diagnosis Date*
The date of diagnosis is the date a **Specialist** determines that permanent regular renal dialysis is necessary or the date the **Insured** is diagnosed with the need for a kidney transplant.

*Exclusions and Limitations*
A Critical Illness Benefit will not be paid for acute reversible kidney failure that only needs temporary renal dialysis.

**Loss of Sight**
Loss of Sight is defined as permanent and irreversible loss of sight in both eyes. Loss of Sight is a Covered Critical Illness when it is due to an **Accident** or cataracts, glaucoma, macular degeneration, or similar disease. Loss of Sight is also a Covered Critical Illness if it is due to a congenital disorder in a newborn child.

*Diagnosis Requirements*
A **Specialist** must clinically confirm that the **Insured's** corrected visual acuity is 20/200 or less or the field of vision is less than 20 degrees in both eyes.

*Diagnosis Date*
The date of diagnosis is the date Loss of Sight satisfying the diagnostic requirements above is confirmed by a **Specialist**.

*Exclusions and Limitations*
A Critical Illness Benefit will not be paid if the blindness is correctable by aides or surgical procedures or for loss of sight caused by a Childhood Condition for which a benefit was paid in the last 12 months.

**Loss of Speech**

Loss of Speech is defined as permanent loss of the ability to speak to the extent that the **Insured** is unintelligible to another person with normal hearing. Loss of Speech is a Covered Critical Illness when it is due to an **Accident** or Guillain Barre syndrome, Huntington's disease chorea, or similar disease. Loss of Speech is also a Covered Critical Illness if it is due to a congenital disorder in a newborn child.

*Diagnosis Requirements*
The **Insured** must be able to demonstrate that the loss has been continuous for at least 180 days. The diagnosis of loss must be made by a **Specialist**.

*Diagnosis Date*
The date of diagnosis is the date Loss of Speech satisfying the diagnostic requirements above is confirmed by a **Specialist**.

*Exclusions and Limitations*
A Critical Illness Benefit will not be paid for Loss of Speech resulting from the following:

a. Stroke or Invasive Cancer.
b. All psychiatric causes.
c. Loss of speech caused by a Childhood Condition for which a benefit was paid in the last 12 months.

**Loss of Hearing**

Loss of Hearing is defined as permanent reduction of hearing in both ears to a point that the **Insured** is unable to hear sounds at or below 90 decibels. Loss of Hearing is a Covered Critical Illness when it is due to an **Accident** or bacterial meningitis, Meniere's disease, or similar disease. Loss of Hearing is also a Covered Critical Illness if it is due to a congenital disorder in a newborn child.

*Diagnosis Requirements*
The diagnosis must be made by a **Specialist** as diagnosed by audiometric testing.

*Diagnosis Date*
The date of diagnosis is the date Loss of Hearing satisfying the diagnostic requirements above is confirmed by a **Specialist**.

*Exclusions and Limitations*
A Critical Illness Benefit will not be paid for hearing loss that is correctable with aids or surgery or for hearing loss caused by a Childhood Condition for which a benefit was paid in the last 12 months.

**Paralysis**

Paralysis is defined as damage to the brain or spinal cord caused by an **Accident** or **Illness** that results in quadriplegia, paraplegia, hemiplegia, or diplegia.

*Diagnosis Requirements*
There must be complete and permanent loss of use of two or more limbs that is present for a continuous period of at least 180 days.

*Diagnosis Date*
The date of diagnosis is the date Paralysis satisfying the diagnostic requirements above is confirmed by a **Specialist**.

**Severe Burns**

Severe Burns is defined as having sustained third degree burns.

*Diagnosis Requirements*
The third degree burns must cover at least 20% of the surface area of an **Insured's** body.

*Diagnosis Date*
The date of diagnosis is the date an **Insured** is diagnosed with Severe Burns that satisfy the diagnostic requirements above.

*Exclusions and Limitations*
A Critical Illness Benefit will not be paid when the degree of burn damage is classified as first-degree or second-degree.

**Severe Chronic Heart Failure**

Chronic Heart Failure is defined as a clinical syndrome that results from any structural or functional impairment of ventricular filling or ejection of blood from the heart that persists for more than 180 days.

*Diagnosis Requirements*
The diagnosis must be made by a **Specialist** and designated as a Class III or IV condition according to the New York Heart Association Functional Classification. The amount payable is based on the classification (Class III or IV) made by the **Specialist**, as shown in the **Schedule of Benefits**.

*Diagnosis Date*
The date of diagnosis is the date a **Specialist** confirms the diagnosis of Chronic Heart Failure that satisfies the diagnostic requirements above.

*Exclusions and Limitations*
A Critical Illness Benefit will not be paid for the diagnosis of Severe Chronic Heart Failure if the **Insured** has received a Critical Illness Benefit in the last 12 months for a Heart Attack, a Coronary Artery Disease Needing Surgery or Angioplasty, or for a Childhood Condition related to a congenital defect of the heart.

If, after a Severe Chronic Heart Failure Critical Illness Benefit is paid for a Class III diagnosis of Severe Chronic Heart Failure, the **Insured** is subsequently diagnosed with Class IV Severe Chronic Heart Failure, **We** will pay the difference between the amount initially paid and the larger benefit for the Class IV diagnosis.

## Infectious Disease

### Infectious Disease

Infectious Disease is defined as any of the following:

a. A community acquired infection.
b. A nosocomial infection (healthcare-associated or **Hospital**-acquired), including surgical site infections following **Hospital** discharge or following the date of a surgical procedure.
c. Infections in individuals who are immunocompromised.

Infectious Disease includes an infection of any organ or tissue, including but not limited to, subcutaneous tissue, eyes, lungs, central nervous system, bone, muscle, blood (sepsis/bacteremia), liver, urinary tract, gastrointestinal tract.

While the agent(s) responsible for the Infectious Disease cannot always be identified and an **Insured** may be treated empirically based on the **Specialist's** clinical assessment of an infection, an Infectious Disease may be caused by bacteria, viruses, fungi, or protozoa. Examples of infectious agents include staphylococcus aureus (methicillin resistant and methicillin susceptible), streptococcus, enterococcus, anaerobic bacteria, clostridium difficile, Escherichia coli, hepatitis, influenza, candida, aspergillus, and plasmodium, among others.

*Diagnosis Requirements*
The diagnosis of an Infectious Disease must be confirmed by a **Specialist** and supported by objective findings in a laboratory test. The Infectious Disease must result in a **Hospitalization** for the treatment of the Infectious Disease that lasts at least 5 consecutive days.

*Diagnosis Date*
The date of diagnosis is the date a **Specialist** confirms the diagnosis of an Infectious Disease that satisfies the description above.

*Exclusions and Limitations*
A Critical Illness Benefit will not be paid for an Infectious Disease that is acquired and treated during a **Hospitalization** that initially occurred for a reason other than treatment of the Infectious Disease. This limitation does not apply to an Infectious Disease contracted during a **Hospitalization** that results in a subsequent **Hospitalization** specifically for the treatment of the Infectious Disease.

If a Critical Illness Benefit is payable for an Infectious Disease for which an Occupational HIV benefit is also payable, only the larger of the benefits will be paid.

A Critical Illness Benefit for the diagnosis of an Infectious Disease is only payable once per **Insured** per 12-month period.

### Occupational Human Immunodeficiency Virus (HIV)

Occupational Human Immunodeficiency Virus (HIV) Infection is defined as infection with the human immunodeficiency virus (HIV) resulting from an accidental **Injury** which exposed the **Insured** to HIV-contaminated blood or bodily fluids during the course of the duties of the **Insured's** normal occupation.

The **Accident** causing the infection of HIV must have occurred in the United States or its territories and while covered under the **Policy**. In addition, the **Insured** must report the **Accident** to the employer within 24 hours of the **Accident**.

*Diagnosis Requirements*
All of the following conditions must be satisfied:

a. A blood test showing no HIV or HIV antibodies must be carried out within 14 days of the **Accident**.
b. Seroconversion must be proven with another HIV test within 180 days of the **Accident**, indicating presence of infection by HIV.

*Diagnosis Date*
The date of diagnosis is the date of the **Accident** that caused the HIV infection.

*Exclusions and Limitations*
A Critical Illness Benefit will not be paid for the following:

a. HIV infection acquired via sexual transmission.
b. HIV infection acquired via intravenous (IV) drug use.
c. HIV infection determined not to be the result of an **Accident**.

## Neurological

### Amyotrophic Lateral Sclerosis (ALS) and other Motor Neuron Diseases

Amyotrophic Lateral Sclerosis (ALS) and other Motor Neuron Diseases is defined as a definite diagnosis by a **Specialist** of spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease) or primary lateral sclerosis.

*Diagnosis Requirements*
There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be permanent functional neurological impairment with objective evidence of motor dysfunction with muscle weakness that has persisted for a continuous period of at least 90 days.

*Diagnosis Date*
The date of diagnosis is the date the diagnosis of a covered motor neuron disease is confirmed by a **Specialist**.

### Advanced Alzheimer's Disease

Advanced Alzheimer's Disease is defined as dementia due to Alzheimer's Disease, where there is progressive and permanent deterioration of memory and intellectual capacity.

*Diagnosis Requirements*
The diagnosis of Alzheimer's Disease must be confirmed by a **Specialist** and the diagnosis must be supported by clinically accepted standardized cognitive testing and neurological examination.

There must be Advanced Alzheimer's Disease where there is significant reduction in mental and social functioning where the **Insured** is unable to perform independently, at least 2 of the following 6 "Activities of Daily Living" for a continuous period of at least 180 days:

Activities of Daily Living are defined as:

a. Bathing - washing oneself by sponge bath or in the tub or shower, including the task of getting into or out of the tub or shower.
b. Dressing - putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs;
c. Eating - feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously.
d. Transferring - moving into and out of bed or a wheelchair.
e. Toileting - getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
f. Continence - the ability to maintain control of bowel and bladder function or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).

*Diagnosis Date*
The date of diagnosis is the date Alzheimer's satisfying the diagnostic requirements above is confirmed by a **Specialist**.

*Exclusions and Limitations*
A Critical Illness Benefit will not be paid for other causes of dementia including, but not limited to, the following:

a. Psychiatric illnesses.
b. Alcohol or other drug related brain damage.
c. Stroke and vascular dementia.
d. Parkinson's disease.
e. Huntington's disease.
f. Coma.

### Coma

Coma is defined as a state of profound unconsciousness from which an **Insured** cannot be aroused to consciousness by external or internal stimulation, as determined by a **Doctor** as the result of an **Accident** or **Illness**.

*Diagnosis Requirements*
This diagnosis must be supported by evidence of all the following:

a. No response to external stimuli for at least 96 hours.
b. Life support measures are necessary to sustain life.
c. Brain damage resulting in permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

*Diagnosis Date*
The date of diagnosis is the date the **Insured** entered a coma that persisted continuously for at least 96 hours.

*Exclusions and Limitations*
A Critical Illness Benefit will not be paid for the following:

a. Medically induced coma.

**Multiple Sclerosis**

Multiple Sclerosis is defined as a diagnosis made by a **Specialist** of definite Multiple Sclerosis.

*Diagnosis Requirements*
Both of the following two (2) criteria must be present:

1. There must be permanent functional neurological impairment with objective evidence of motor or sensory dysfunction, which must have persisted for a continuous period of at least 180 days.
2. The diagnosis must also be confirmed with objective neurological investigations, such as lumbar puncture, evoked visual responses, evoked auditory responses and MRI evidence of lesions of the central nervous system.

*Diagnosis Date*
The date of diagnosis is the date Multiple Sclerosis satisfying the diagnostic requirements above is confirmed by a **Specialist**.

**Benign Brain Tumor**
Benign Brain Tumor is defined as a non-malignant tumor that is located in the cranial vault and limited to the brain, meninges, cranial nerves, or pituitary gland.

*Diagnosis Requirements*
The Benign Brain Tumor must require surgery or radiation treatment or cause irreversible objective neurological deficits.

*Diagnosis Date*
The date of diagnosis is the date a **Specialist** determines a Benign Brain Tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

**Parkinson's Disease**

Parkinson's Disease is defined as an unequivocal diagnosis of idiopathic Parkinson's disease.

*Diagnosis Requirements*
There must be resting tremor, rigidity, bradykinesia and gait disturbance compatible with the diagnosis of Parkinson's Disease as assessed by a **Specialist**.

*Diagnosis Date*
The date of diagnosis is the date Parkinson's Disease that satisfies the diagnostic requirements above is confirmed by a **Specialist**.

*Exclusions and Limitations*
A Critical Illness Benefit will not be paid for drug-induced or toxic causes of Parkinsonism.

**Huntington's Disease**

Huntington's Disease is defined as a neurodegenerative genetic disorder that affects muscle coordination and leads to cognitive decline and psychiatric problems.

*Diagnosis Requirements*
The diagnosis must be documented by symptoms and verified by the presence of the genetic defect via genetic testing.

Symptoms include:

a. Personality changes, mood swings, and depression.
b. Forgetfulness and impaired judgment.
c. Unsteady gait and involuntary movements.
d. Slurred speech and difficulty swallowing.

*Diagnosis Date*
The date of diagnosis is the date Huntington's satisfying the diagnostic requirements above is confirmed by a **Specialist**.

## Childhood Conditions

**Major Congenital Structural Anomaly**
Major Congenital Structural Anomaly is defined as a structural malformation that arises in utero and results in significant medical, social or cosmetic consequences for the affected individual, and requires medical treatment. Examples of Major Congenital Structural Anomalies include, but are not limited to, complex congenital heart disease, spina bifida (excluding occulta), cleft lip/palate, anencephaly, omphalocele, and club foot. For the purposes of this chapter, the term significant deviation is defined to be a deviation which impairs the function of the body and includes, but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be congenital anomalies.

*Diagnosis Requirements*
A Major Congenital Structural Anomaly must be diagnosed and named by a **Specialist** according to clinically accepted diagnostic criteria. The **Specialist** must establish a treatment plan specific to the condition.

*Diagnosis Date*
The date of diagnosis is the date a **Specialist** confirms the diagnosis of a Major Congenital Structural Anomaly that satisfies the diagnostic requirements described above.

*Exclusions and Limitations*
A Critical Illness Benefit will not be paid for:

a. A condition that arises secondary to maternal alcohol use or use of drugs that are not prescribed for clinically accepted reasons for treatment of a maternal medical condition.
b. A condition for which another Childhood Condition Critical Illness Benefit was already paid.
c. Minor structural anomalies that pose little or no significant health problems, have limited social or cosmetic consequences for the affected **Dependent** child, and do not require medical treatment.

**Congenital Metabolic Disorder**

Congenital Metabolic Disorder is defined as a genetic or inherited disorder resulting from an enzyme defect in biochemical and metabolic pathways affecting proteins, fats, carbohydrates metabolism or impaired organelle function presenting as complicated medical conditions involving several human organ systems. Examples of Congenital Metabolic Disorders include, but are not limited to, phenylalanine hydroxylase deficiency, Niemann-Pick, Tay Sachs, Gaucher's Disease, phenylketonuria, and cystic fibrosis.

*Diagnosis Requirements*
A Congenital Metabolic Disorder must be diagnosed and named by a **Specialist** according to clinically accepted diagnostic criteria. The **Specialist** must establish a treatment plan specific to the condition.

*Diagnosis Date*
The date of diagnosis is the date a **Specialist** confirms the diagnosis of a Congenital Metabolic Disorder that satisfies the diagnostic requirements described above.

*Exclusions and Limitations*
A Critical Illness Benefit will not be paid for:

a. A condition that arises secondary to maternal alcohol use or use of drugs that are not prescribed for clinically accepted reasons for treatment of a maternal medical condition.
b. A condition for which another Childhood Condition Critical Illness Benefit was already paid.
c. An **Insured** who is diagnosed with a carrier status of genes for the metabolic disorder, such as Tay Sachs.

**Congenital Chromosomal Abnormality**

Congenital Chromosomal Abnormality is defined as a congenital abnormality present at birth in the number or structure of chromosomes, other than those causing Congenital Metabolic Disorders, which leads to conditions requiring medical treatment. Examples of Other Chromosomal Abnormalities include, but are not limited to, Down syndrome, DiGeorge syndrome, Turner syndrome, sickle cell disease, achondroplasia, fragile X, hemophilia, neurofibromatosis, muscular dystrophy, Prader Willi, and glucose-6-posophate dehydrogenase deficiency (G6PD).

*Diagnosis Requirements*
The diagnosis of a Congenital Chromosomal Abnormality must be diagnosed and named by a **Specialist** according to clinically accepted diagnostic criteria. The **Specialist** must establish a treatment plan specific to the condition.

*Diagnosis Date*
The date of diagnosis is the date a **Specialist** confirms the diagnosis of a Congenital Chromosomal Abnormality that satisfies the diagnostic requirements above.

*Exclusions and Limitations*
A Critical Illness Benefit will not be paid for

a. An **Insured** who is diagnosed with a carrier status for genes for the chromosomal abnormality, such as sickle cell disease or cystic fibrosis.
b. A condition for which another Childhood Condition Critical Illness Benefit was already paid.

If a **Dependent** child is diagnosed with Huntington's disease, the Critical Illness Benefit will be paid for a Congenital Chromosomal Abnormality.

**Chronic Medical Condition Commonly Diagnosed in Childhood**

Chronic Medical Condition Commonly Diagnosed in Childhood is defined as a named condition requiring ongoing medical treatment that is expected to persist for at least five years following diagnosis. Examples of Chronic Medical Conditions Commonly Diagnosed in Childhood include, but are not limited to, epilepsy, human growth hormone deficiency, bronchopulmonary dysplasia, cerebral palsy, scoliosis, asthma, and Type 1 Diabetes.

*Diagnosis Requirements*
The Chronic Medical Condition Commonly Diagnosed in Childhood must be diagnosed by a **Specialist** based on the appropriate clinically accepted criteria for the named condition. The condition must be severe, which means the condition meets at least one of the following criteria:

a. A condition requiring medical treatment for a minimum of 12 consecutive months, where treatment includes prescribed oral, inhaled, injected, or infused medication taken on a regular schedule and excluding antibiotic prophylaxis.
b. A condition that requires physical, speech, or occupational therapy for a minimum of 12 consecutive months.
c. A condition that requires bracing or other ongoing prescribed non-surgical treatment for a minimum of 12 consecutive months.
d. Asthma that requires daily use of inhaled corticosteroids and at least one other long-acting inhaled drug for a minimum of 12 consecutive months.

The **Specialist** must establish a treatment plan specific to the condition.

*Diagnosis Date*
The date of diagnosis is the date a **Specialist** confirms the diagnosis of a Chronic Medical Condition Commonly Diagnosed in Childhood that satisfies the diagnostic requirements above.

*Exclusions and Limitations*
A Critical Illness Benefit will not be paid for:

a. Conditions treated solely with topical medications.
b. Conditions limited to the skin, including among others, eczema and acne.
c. Conditions requiring only medication as needed, such as food or seasonal allergies and migraine headaches.
d. Allergic conditions.
e. Conditions treated solely with antibiotic prophylaxis.
f. Chronic psychiatric conditions.

## Recurrence Benefit

The Recurrence Benefit will be paid, as shown in the **Schedule of Benefits**, if, after an initial Critical Illness Benefit is paid, the Insured is diagnosed with a subsequent occurrence of the same Covered Critical Illness. The following conditions must be satisfied:

a. The subsequent diagnosis is made while coverage is in force for the **Insured** under the **Policy**.
b. The subsequent diagnosis is for a distinct and separate occurrence of a Covered Critical Illness and is not a continuation or a re-diagnosis of the same Covered Critical Illness for which a benefit was already paid.
c. The subsequent condition occurs and is diagnosed at least 180 days after the date of diagnosis of the initial Covered Critical Illness.
d. The subsequent condition is not excluded by name or specific description.

There is no limit on the number of Recurrence Benefits payable.

## Health Screening Benefit

This benefit applies to **You** and **Your** spouse only if it is shown in the **Schedule of Benefits**.

The Health Screening Benefit will be paid when one or more of the following exams, X-rays, laboratory are administered during a **Calendar Year**.

Tests to screen for Cancer

a. Biopsy
b. Bone marrow testing
c. Breast ultrasound
d. CA 125 (blood test for ovarian cancer)
e. CA 15-3 (blood test for breast cancer)
f. CEA (blood test for colon cancer)
g. Colonoscopy
h. Flexible sigmoidoscopy
i. Hemoccult stool specimen
j. Mammogram
k. Pap test
l. PSA (prostate-specific antigen tests)
m. Serum protein electrophoresis (blood test for myeloma)
n. Thermography

Tests to screen for Heart-related Disease

a. Blood test for triglycerides
b. Chest x-ray
c. Serum cholesterol test to determine HDL/LDL level
d. Stress test on a bicycle or treadmill

Tests to screen for Organ-related Disease

a. Fasting blood glucose test

A Health Screening Benefit is payable once during a **Calendar Year**, regardless of the number of exams, X-rays, laboratory tests administered during that year.

## EXCLUSIONS AND LIMITATIONS

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

### Exclusions

No benefit is payable for any **Illness**, **Injury**, or disease that is not specifically named or described in the Benefits section. Further, no benefit will be paid when the **Insured** has a critical illness that is:

a. Diagnosed before the **Insured** is covered under the **Policy**.
b. Diagnosed after the **Insured's** coverage terminates, except as provided under the **Policy**.
c. Not diagnosed by a **Specialist**.
d. Diagnosed by a physician outside the United States or its territories.
e. Diagnosed more than once while covered under the **Policy**, except as provided under the Recurrence Benefit.
f. Contributed to or caused by: another Covered Critical Illness, a complication of another critical illness, or treatment of another critical illness for which the **Insured** has been paid a benefit under the **Policy**.
g. Caused wholly or partly, directly or indirectly by:
    i. Declared or undeclared war or act of war.
    ii. Committing or attempting to commit an assault or felony.
    iii. Inciting or taking part in any form of public violence.
    iv. Intentionally self-inflicted **Injury**, while sane or insane.
    v. Full-time active duty as a member of the armed forces (land, water, air) of any country or international authority.
    vi. Being intoxicated or under the influence of alcohol, drugs or any narcotic (including overdose) unless as prescribed by or administered by a physician.
    vii. Alcoholism or drug addiction.

## GENERAL PROVISIONS

### Notice of Claim

The **Insured** must give **Us** written notice of claim within 20 days after the commencement of Loss for which benefits are payable.

**You** must give **Us** written notice of claim within the following time period:

a. 20 days after the date a Covered Critical Illness is diagnosed.
b. 20 days after the date of a health screening test.

If **You** are not able to notify **Us** within the applicable time period, then **You** must notify **Us** as soon as reasonably possible.

**Your** notice must include the claimant's name, address and the **Policy** Number.

### Claim Forms

Within 15 days of receiving a notice of claim, **We** will send the forms needed to provide **Proof of Loss**. If **We** do not send the forms within 15 days, any other written proof which fully describes the nature and extent of the claim may be submitted.

### Proof of Loss

**Proof of Loss** may include, but is not limited to, the following:

a. A completed claim form.
b. Documentation of:
    ii. the date the Covered Critical Illness began.
    iii. the cause of the Covered Critical Illness.
    iv. satisfaction of the diagnosis requirements for the Covered Critical Illness.
c. The names and addresses of all **Specialists** and other health care **Providers** for the Covered Critical Illness.
d. **Your** signed authorization for **Us** to obtain and release medical information.
e. Any additional information required by **Us** to make a determination on the claim.

All proof submitted must be satisfactory to **Us**.

Written **Proof of Loss** must be given to **Us** within 90 days after the following:

a. The date of diagnosis for a Covered Critical Illness.
b. The date a health screening test is provided.

If it was not possible to give **Us** proof by the time it is due, then **You** must give **Us** proof as soon as possible. Unless **You**, or the person who has the right to claim benefits, is not legally competent, **Proof of Loss** must be given no later than two years after it is due.

### Time Payment of Claims

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

### Payment of Benefits

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

a. **You**;
b. **Your** legally appointed guardian if **You** are not legally able to accept such benefits; or
c. **Your** estate, in the event any payment is owed at the time of **Your** death.

In the event **You** die, any death benefits will be payable to **Your Beneficiary**. If, on the date **You** die, there is no living named **Beneficiary**, **We** may, at **Our** option, pay any benefits due under the **Policy** to the following surviving relatives of **Yours**:

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

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

## Physical Examination and Autopsy

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

## Examination of Specialist's Records

**We** may, at **Our** expense, examine **Your Specialist's** or other **Provider's** records as often as reasonably necessary while a claim pending.

## Right To Appeal a Denied Claim

If **You** disagree with a decision on a claim, **You** or **Your** representative may, within 180 days of receiving an initial denial notice appeal the decision by submitting a written request to:

**Symetra**
**118 Third Street East**
**PO Box 440**
**Ashland, WI 54806**
**1-800-497-3699**

**Your** written request should include:

a. A statement of the reasons(s) for disagreement;
b. Documentation of any new facts or data that apply to the claim.

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

## Legal Actions

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

a. Until 60 days have elapsed after **Proof of Loss** has been filed; or
b. After 3 years from the end of the time within which **Proof of Loss** is required by the **Policy**.

## Entire Contract

The **Policy**, the **Policyholder's** signed application, this Certificate and any **Riders**, endorsements or other attached papers make up the entire contract of insurance between the **Policyholder** and **Us**.

## Statements

All statements made by the **Policyholder** and persons insured under this **Policy** will be deemed representations and not warranties. No statement will be used in any contest unless it is in writing, signed by the person making it and a copy of it is given to the person who made it, or, in the event of the death or incapacity of the **Insured**, to the **Insured**'s **Beneficiary** or personal representative.

## Time Limit on Certain Defenses

Absent a showing of intentional fraud, no statement concerning insurability made by any **Insured** shall be used to contest the validity of the insurance for which the statement was made after this **Policy** has been in force for two years. In order to be used, the statement must be in writing and signed by the person making the statement. However, **We** are not precluded at any time from asserting defenses based upon the person's ineligibility for coverage under this **Policy**, or upon other provisions in the **Policy**.

**Symetra Life Insurance Company**
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
1-800-796-3872 | www.symetra.com
Domiciled in Iowa

RESIDENCE STATE AMENDMENT

Governing Jurisdiction: The **Policy** is delivered in and governed by the laws of the state of **Ohio**

If **You** do not reside in the Governing Jurisdiction state shown above, **Your** Certificate is hereby amended as stated below to comply with the laws of **Your** state of residence.

Only those references in this amendment to benefits, provisions or terms actually included in **Your** Certificate will apply to **You**. In addition, any reference made herein to **Dependent** coverage will only apply if **Dependent** coverage is provided in **Your** Certificate.

This amendment is attached to and made part of the Certificate that forms part of the **Policy**. All other provisions of **Your** Certificate remain unchanged.

**For Alaska Residents**

1. The definition of "Effective Date" appearing in the DEFINITIONS section is amended by adding:

For purposes of effective dates and ending dates under the **Policy**, all days begin at 12:01 a.m. and end at 12:00 midnight, Alaska time.

2. Item e. in the definition of "Hospital" appearing in the DEFINITIONS section shall read:

a. Operates pursuant to Law.

3. The first sentence in the second and third paragraphs of the "Evidence of Insurability" provision in the ELIGIBILITY FOR COVERAGE section shall read:

Evidence of insurability must be received by **Us**.

4. The first sentence in the second paragraph of the "Evidence of Insurability" provision for Dependents in the ELIGIBILITY FOR COVERAGE section shall read:

Evidence of insurability must be received by **Us**.

5. The initial clause in the first sentence in the second paragraph of the "Evidence of Insurability" provision for **Dependents** or spouses (if applicable) in the ELIGIBILITY FOR COVERAGE section shall read:

If **Your Dependent's** or spouse's (if applicable) evidence of insurability is not received by **Us**:

6. The initial clause in the first sentence of the third paragraph of the "Increase in Coverage" provision in the ELIGIBILITY FOR COVERAGE section shall read:

If **Your** evidence of insurability is not received by **Us**,

7. The initial clause in the first sentence of the fourth paragraph of the "Increases in Coverage" provision in the ELIGIBILITY FOR COVERAGE section shall read:

If evidence of insurability for **Your Dependents** or **Your** spouse is not received by **Us**,

8. The *Exclusions and Limitations* for "Coronary Artery Disease Needing Surgery or Angioplasty" (if included) in the BENEFITS section shall read:

A Critical Illness Benefit will not be paid for coronary artery conditions that are treatable by non-surgical intervention

procedures such as: diagnostic coronary angiography, cardiac ablation, or drug therapy.

9. The second paragraph of the “Infectious Disease” benefit (if included) in the BENEFITS section shall read:

Infectious Disease includes an infection of any organ or tissue, such as: subcutaneous tissue, eyes, lungs, central nervous system, bone, muscle, blood (sepsis/bacteremia), liver, urinary tract, gastrointestinal tract.

10. The second paragraph of the “Occupational Tuberculosis” benefit (if included) in the BENEFITS section shall read:

The **Accident** causing the infection of Tuberculosis must have occurred in the United States or its territories and while covered under the **Policy**. In addition, the **Insured** must report the **Accident** to the employer within 24 hours of the **Accident** (or when the **Insured** becomes aware of the **Accident**, if later).

11. The first sentence of the *Exclusions and Limitation for the* “Advanced Alzheimer’s Disease” benefit (if included) in the BENEFITS section shall read:

A Critical Illness Benefit will not be paid for other causes of dementia, including the following:…

12. The first sentence of the *Exclusions and Limitation for the* “Dementia” benefit (if included) in the BENEFITS section shall read:

A Critical Illness Benefit will not be paid for other causes of dementia, including the following:…

13. The last 4 lines of the “Health Screening Benefit” (if included) in the BENEFITS section shall read:

Childhood vaccination, such as vaccinations for Diphtheria, Tetanus, Pertussis (DTaP), Polio, Measles, Mumps, Polio (IPV).

Annual physical exam or routine wellness checkup.

Genetic screening tests, including biometric screening, carrier screening, newborn screening, and presymptomatic and predictive testing.

A Health Screening Benefit is payable once during a **Calendar Year**, regardless of the number of exams, X-rays, laboratory tests, genetic screening tests or childhood vaccinations administered during that year.

14. The second paragraph of the “Proof of Loss” provision appearing in the GENERAL PROVISIONS section shall read:

All proof submitted must be received by **Us**.

15. The “Time Payment of Claims” provision appearing in the GENERAL PROVISIONS section shall read:

**We** will pay benefits as soon as **We** receive, or no more than 25 days after, all essential information needed to make a determination on the claim. If **We** request additional information in order to pay a claim, **We** will make a determination on such claims within 15 days of the receipt of the additional information. If all essential information has been received, and the claim is not paid within 30 days, interest will be paid at a rate of 15% per year.

**For Arkansas Residents**

1. The third paragraph of the “Termination of Dependent Coverage” provision in the ELIGIBILITY FOR COVERAGE section shall read:

Proof of the disabling impairment must be given to **Us** as soon as possible once **Your** child attains the Limiting Age. Subsequently, **We** have the right to require proof of **Your** child’s impairment, at **Our** expense, but not more often than once per year after two years from the date the Limiting Age is attained.

2. Item h. vi. In the “Exclusions” provision in the EXCLUSIONS AND LIMITATIONS section shall read:

vi. Being intoxicated, as defined by the jurisdiction in which the loss occurred or under the influence of alcohol, illegal drugs or any narcotic (including overdose) unless as prescribed by or administered by a physician.

**For Connecticut Residents**

1. The INTRODUCTION section is amended by adding:

## CAUTION! THIS CERTIFICATE PROVIDES LIMITED COVERAGE. IT IS NOT A MAJOR MEDICAL CERTIFICATE. Read it carefully. It only pays benefits for the diagnosis of Critical Illness.

## You have the right to return the policy within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy, you are not satisfied for any reason.

2. In the TABLE OF CONTENTS, "Post-Termination Continuation of Coverage" is amended to read "Portability."

3. The definition of "Benefit Waiting Period" in the DEFINITIONS section is amended by adding:

Premiums paid for a certificate holder shall be refunded if the certificate holder is diagnosed with a covered disease, condition or syndrome during the waiting or probationary period.

4. The time period in the "Illness or Injury" part of the "Continuation of Coverage During Temporary Absence" provision in the ELIGIBILITY FOR COVERAGE section shall read "12 consecutive months."

5. The time period in the "Personal Leave of Absence" part of the "Continuation of Coverage During Temporary Absence" provision in the ELIGIBILITY FOR COVERAGE section shall read "30 months."

6. The "Temporary Layoff" part of the "Continuation of Coverage During Temporary Absence" provision in the ELIGIBILITY FOR COVERAGE section shall read:

### Temporary Layoff

If **You** are temporarily laid off by the **Employer** due to lack of work, all of **Your** coverage may be continued for up to 30 months following the date **You** were last **Actively at Work**.

If **Your** leave of absence, layoff or termination of employment results from **Your** eligibility to receive Social Security income, **Your** continuation of coverage for **You** and **Your** covered dependents will be continued until midnight of the day preceding **Your** eligibility for benefits under Title XVII of the Social Security Act.

7. The "**Post-Termination Continuation of Coverage**" provision in the ELIGIBILITY FOR COVERAGE section is deleted.

8. The ELIGIBILITY FOR COVERAGE section is amended by adding the following:

### Portability

Coverage may continue for **You** and any **Dependent(s)** when coverage ends under the **Policy**. **Your** portable coverage will be provided under an insurance policy **We** make available for this purpose. Coverage under **Your** portable insurance may not be identical to coverage under this **Policy**.

**You** may request portability coverage for **You** and any **Dependent(s)** when:

a. **You** are no longer **Actively at Work** and are not eligible for coverage under any other Continuation of Coverage provision in this Certificate;
b. **You** are no longer employed by the **Policyholder**, including retirement; or
c. The **Policy** terminates and the **Policyholder** does not obtain a replacement policy with another insurance carrier within 31 days.

If **You** are eligible to request portability coverage, then **You** must elect insurance under the portability policy in order for any **Dependent(s)** to be eligible for coverage under the portability policy.

A **Dependent** who is **Your** spouse may request portability coverage from him/herself and any insured **Dependent** child(ren):

a. In the event of **Your** death;
b. In the event of divorce, dissolution of partnership or legal separation from **You**; or
c. When **You** enter active duty service or training in any military for a period of 31 days or more and are no longer eligible under the **Policy** as an **Employee**.

If a **Dependent** spouse elects coverage under the portability policy, the **Dependent** spouse will become the primary **Insured** under the portability policy. Any **Dependent** child(ren) may only be covered under one portability policy.

When coverage under the **Policy** ends, notice of the right to request portability coverage will be given. To elect coverage under a group portability policy, **You** or **Your Dependent** spouse must send a request to **Us**. The benefits and premium rates of the portability policy are described on **Our** portability request form, which can be obtained by contacting the **Policyholder** or **Us**.

The request and initial **Premium** due must be received within 31 days after the insurance under the **Policy** ends. If timely notice is not given, an extension of the period of time in which to request portability coverage will be allowed. **You** or **Your Dependent** spouse will have 15 days from the date notice is received to submit his/her request and initial **Premium**. However, in no event will a request be accepted by **Us** if received more than 91 days after the date coverage under the **Policy** would otherwise end, even if notice is not received.

The continued group insurance coverage under the portability policy is available as a result of portability rights that arise solely from the **Policy**, as arranged for the **Employee** as an employee welfare benefit subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

9. In no event shall the amount shown for Non-Melanoma Skin Cancer (if included) in the "Covered Critical Illness" schedule in the BENEFITS section be less than $250.

10. The 2nd and 3rd paragraphs under "*Diagnosis Requirements*" for "Advanced Alzheimer's Disease" (if included) in the BENEFITS section are replaced by the following:

There must be Advanced Alzheimer's Disease where there is significant reduction in mental and social functioning and where the **Insured** can be classified as Functional Assessment Staging (FAST) Scale Stage 6.

11. The 2nd and 3rd paragraphs under "*Diagnosis Requirements*" for "Dementia" (if included) in the BENEFITS section are replaced by the following:

There must be Dementia where there is significant reduction in mental and social functioning and where the **Insured** can be classified as Functional Assessment Staging (FAST) Scale Stage 6.

12. Item h. vi. In the "Exclusions" provision of the EXCLUSIONS AND LIMITATIONS section shall read:

vi. Being intoxicate or under the influence of alcohol, or use of a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now and hereafter amended, (including overdose) unless as prescribed by or administered by a physician.

13. The phrase "Absent a showing of intentional fraud" is deleted from the start of the "Time Limit on Certain Defenses" provision in the GENERAL PROVISIONS section.

**For Idaho Residents**

1. The first page of the certificate is amended by adding the following:

Notice to Buyer: This is a specified disease policy. This policy provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read **Your** policy carefully with the outline of coverage.

**You** have the right to return the policy within ten (10) days of its delivery and to have the **Premium** refunded if, after examination of the policy, **You** are not satisfied for any reason.

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

Margaret Meister
President

Jacqueline M. Veneziani
Secretary

2. The term “Coronary Artery Disease Needing Surgery or Angioplasty” in the Table of Contents and the BENEFITS section (if included) is amended to read “Severe Coronary Artery Disease.”

3. References to “Spouse” shall read “Spouse or Partner.”

4. The DEFINITIONS section is amended by adding:

**Congenital Anomaly** means, for the purpose of this Certificate, a condition existing at or from birth that is a significant deviation from the common form or function of the body and which impairs the function of the body. Anomalies includes but may not be limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, or sixth toes or fingers.

5. The first paragraph of the definition of Dependent in the DEFINITIONS section shall read:

**Dependent:** the following persons:

1. **Your** spouse, as defined by state law, including any legally valid marriage.
2. **Your** civil union or domestic partner (“partner”).
3. **Your** child who is under 26 years of age (Limiting Age).
4. **Your** unmarried child, who is incapable of self-support due to a disabling physical or mental impairment, provided the disabling condition occurs prior to age 26.

7. The time period in the definition of “**Pre-existing Conditions Limitation**” (if included) in the DEFINITIONS section is amended to read “6 months.”

8. The 3rd paragraph of the “Effective Date of Dependent Coverage” provision in the ELIGIBILITY FOR COVERAGE section is replaced by:

However, **Your** child will be covered for Critical Illness Benefits for 60 days following the date of birth, adoption, or placement for adoption without paying **Premium** or authorizing **Your** Employer to deduct any amounts from **Your** pay. The due date for payment of any additional **Premium**, if required, shall be not less than thirty-one (31) days following receipt by the health plan member of a billing for the required **Premium**.

For the purposes of this provision, “placement” means physical placement in the care off the adopting **Insured(s)**. If physical placement is prevented due to the medical needs of the child, “placement” means the date the adopting health plan member signs an agreement for adoption of the child and assumes financial responsibility for the child.

9. The “Termination of Your Coverage” provision in the ELIGIBILITY FOR COVERAGE section shall be amended by adding the following:

Termination of the **Policy** will be without prejudice to the rights of any **Insured** with respect to any claim arising during the period the **Policy** is in force.

Your **Employer** has the sole responsibility to notify **You** of such termination.

10. The “Severe Coronary Artery Disease” provision (if included) in the BENFITS section shall read:

Severe Coronary Artery Disease is defined as coronary artery disease with at least 75% cross-sectional occlusion of one or more major coronary arteries (left, main, left anterior descending, circumflex, or right coronary artery).

*Diagnosis Requirements*
The **Insured** must be diagnosed with Severe Coronary Artery Disease by a qualified **Doctor**.

*Diagnosis Date*
The date of diagnosis is the date the **Insured** is diagnosed with severe coronary artery disease that satisfies this Severe Coronary Artery Disease description.

*Exclusions and Limitations*
A Critical Illness Benefit will not be paid for coronary artery conditions that do not meet the above criteria.

11. The first 4 paragraphs of the "Major Organ Failure" provision (if included) in the BENEFITS section shall read:

Major Organ Failure is defined as the permanent irreversible failure or loss of one or more of the following organs: heart, liver, lung, pancreas, or bone marrow.

*Diagnosis Requirements*
A Specialist must diagnose the permanent irreversible failure of one of the above-mentioned organs.

*Diagnosis Date*
The date of diagnosis is the date the **Insured** is diagnosed with permanent irreversible failure of one of the above-mentioned organs.

*Exclusions and Limitations*
The failure of any other organs, parts or organs, tissues or cells is not included in this definition.

12. The 2nd and 3rd paragraphs of the "*Diagnosis Requirements*" for Advanced Alzheimer's Disease (if included) in the BENEFITS section shall be replaced by:

There must be Advanced Alzheimer's Disease where there is significant reduction in mental and social functioning for a continuous period of at least 180 days.

13. The 1st three paragraphs of the "Dementia" provision (if included) in the BENEFITS section shall read:

Dementia is defined as a chronic or persistent disorder of the mental processes caused by brain disease or **Injury** that results in progressive and permanent deterioration of memory and intellectual capacity.

*Diagnosis Requirements*
The diagnosis of Dementia must be confirmed by a **Specialist** and the diagnosis must be supported by clinically accepted standardized cognitive testing and neurological examination.

There must be Dementia where there is significant persistent reduction in mental and social functioning.

14. The "Complication of Pregnancy" provision (if included) in the BENEFITS section shall read:

Complication of Pregnancy is defined as a health problem related to pregnancy that requires a distinct maternal **Hospitalization** at any point from the antepartum period extending through 6 weeks postpartum for the primary purpose of treating the complication. The Complication of Pregnancy must be a named complication of pregnancy or delivered, or a maternal condition exacerbated by pregnancy or delivery, or a maternal condition exacerbated by pregnancy such that **Hospitalization** is required.

Complication of Pregnancy also includes, but not be limited to, puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia and any other named pregnancy or delivery complication that results in an extended-stay delivery **Hospitalization** lasting a minimum of 4 days for vaginal delivery or 6 days for Cesarean section that is determined by a **Doctor** to be necessary for treatment of the mother.

*Diagnosis Requirements*
The Complication of Pregnancy must be diagnosed by a **Specialist** and include clinically accepted diagnostic testing.

*Diagnosis Date*
The date of diagnosis is the date a Complication of Pregnancy is diagnosed by a **Specialist** that satisfies the criteria described above.

*Exclusions and Limitations*

A Critical Illness Benefit will not be paid for:

a. A normal delivery **Hospitalization**.
b. A prolonged delivery **Hospitalization** that is not due to treatment of maternal complications of pregnancy.

A Complication of Pregnancy Critical Illness Benefit is only payable up to one time per pregnancy.

15. The 1st paragraph of the "Major Congenital Structural Anomaly" provision (if included) in the BENEFITS Section shall read:

Major Congenital Structural Anomaly is defined as a structural malformation that arises in utero and results in significant medical, social or cosmetic consequences for the affected individual, which impairs the function of the body, and requires medical treatment. Examples of Major Congenital Structural Anomalies include, but are not limited to, complex congenital heart disease, spina bifida (excluding occulta), cleft lip/palate, anencephaly, omphalocele, webbed fingers or toes, sixth toes or fingers, and club foot.

16. The 1st sentence of the 1st paragraph of the "Congenital Metabolic Disorder" provision (if included) in the BENEFITS section shall read:

Congenital Metabolic Disorder is defined as a genetic or inherited disorder, which impairs the function of the body, resulting from an enzyme defect in biochemical and metabolic pathways affecting proteins, fats, carbohydrates metabolism or impaired organelle function presenting as complicated medical conditions involving several human organ systems.

17. The 1st sentence of the 1st paragraph of the "Congenital Chromosomal Abnormality" provision (if included) in the BENEFITS section shall read:

Congenital Chromosomal Abnormality is defined as a congenital abnormality present at birth in the number of structure or chromosomes, other than those causing Congenital Metabolic Disorders, which impairs the function of the body and leads to conditions requiring medical treatment.

18. The "*Diagnosis Requirements*" within the provisions for Brain Aneurysm, Benign Spinal Tumor, and Benign Brain Tumor benefits (if included) in the BENEFITS section are deleted.

19. The 1st sentence of the 1st paragraph of the "Brain Aneurysm" provision (if included) in the BENEFITS section shall read:

Brain Aneurysm is defined as a cerebral aneurysm requiring treatment that has dissected or ruptured or is in immediate danger of dissecting or rupturing.

20. The 1st sentence of the 1st paragraph of the "Benign Spinal Tumor" provision (if included) in the BENEFITS section shall read:

Benign Spinal Tumor is defined as a non-malignant tumor that is located in the spine or spinal cord and that is causing or threatens to cause irreversible objective neurological deficits.

21. The 1st sentence of the 1st paragraph of the "Benign Brain Tumor" provision (if included) in the BENEFITS section shall read:

Benign Brain Tumor is defined as a non-malignant tumor that is located in the cranial vault and limited to the brain, meninges, cranial nerves, or pituitary gland and that is causing or threatens to cause irreversible objective neurological deficits.

22. Item h. in the "Exclusions" provision in the EXCLUSIONS AND LIMITATIONS section shall read:

h. Caused wholly or partly, directly or indirectly by:

i. Declared or undeclared war or act of war.
ii. Voluntary participation in felony.
iii. Intentionally self-inflicted Injury, while sane or insane.
iv. Full-time active duty as a member of the armed forces (land, water, air) of any country or international authority.
v. Alcoholism or drug addiction.

23. The “Time Payment of Claims” provision in the GENERAL PROVISIONS section shall read:

**Time Payment of Claims**
We will pay benefits immediately after **We** receive all essential information needed to make a determination on the claim.

**For Indiana Residents**

1. The definition of “**Accident**” in the **DEFINITIONS** section shall read:

**Accident:** a sudden, unforeseen, unexpected and involuntary event definite as to time and place and which is independent of disease or bodily infirmity, Injury or injuries, for which benefits are provided, means accidental bodily injury sustained by the **Insured** person and directly caused by an accident which is not the result of disease or bodily infirmity.

2. Any references to the “first of the month following” (if included) in the “**Date You Are Eligible for Coverage**” provision in the **ELIGIBILITY FOR COVERAGE** section shall not apply to **You**.

3. Any references to the “first of the month following” (if included) in the “**Date a Dependent is Eligible for Coverage**” provision in the **ELIGIBILITY FOR COVERAGE** section shall not apply to **Your Dependent**.

4. The following is added to the “**Notice of Claim**” provision in the **GENERAL PROVISIONS** section:

Failure to give **Us** notice within the 20-day period does not invalidate or reduce any claim, if it can be shown that it was not reasonably possible to give notice within that period, and hat notice was given to **Us** as soon as was reasonably possible.

5. The following is added to the “**Proof of Loss**” provision in the **GENERAL PROVISIONS** section:

Failure to give **Us** proof within the 90-day period does not invalidate or reduce any claim, if it can be shown that it was not reasonably possible to give proof within that period, and hat proof was given to **Us** as soon as was reasonably possible.

6. The “**Time Payment of Claims**” provision in the **GENERAL PROVISIONS** section shall read:

**Time Payment of Claims**
**We** will pay benefits within 45 days after **We** receive all essential information needed to make a determination on the claim.

**We** will notify **You** of any missing items required to handle **Your** claim within:
a. 30 days, if the claim was submitted electronically, or
b. 45 days, if the claim was filed on paper.

**For Kansas Residents**

1. The time frame stated in the item b. in the “Legal Actions” provision in the GENERAL PROVISIONS section shall read “5 years.”

**For Louisiana Residents**

1. References to “Spouse” are amended to read “Spouse, Civil Union or Domestic Partner.”

2. The reference to “**Portability**” (if included) in the **Table of Contents** shall not apply to you.

3. The “**Portability**” provision (if included) in the **ELIGIBILITY FOR COVERAGE** section shall not apply to you.

4. Item c. in the definition of **Dependent** shall read:

    b. **Your** unmarried child, who is incapable of self-support due to an intellectual or physical disability, provided the disabling condition occurs prior to age 26.

5. The last paragraph of the definition of Dependent shall read:

A child can include: stepchildren; legally-adopted children; foster children, including any children legally placed with **You**

for adoption; any children **You** support under court order; any other children, related to **You** by blood or marriage or a civil union or domestic partnership, who live with **You** in a regular parent-child relationship; or any children **You** claimed as a dependent on **Your** last-filed federal income tax return. It can also include any unmarried child who is placed in **Your** home pursuant to Title XI, XII, or XII-A of the Louisiana Children's Code, following execution of an act of voluntary surrender in **Your** favor, beginning on the date on which the act of voluntary surrender becomes irrevocable.

**For Maryland Residents**

1. The first page of the Certificate is amended by adding:

## THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. IT IS NOT DESIGNED TO FILL THE "GAPS" OF MEDICARE. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM US.

2. The following paragraphs are deleted from the INTRODUCTION section:

## YOU SHOULD NOT PURCHASE THIS POLICY UNLESS YOU ARE ALREADY COVERED BY COMPREHENSIVE MAJOR MEDICAL INSURANCE.

## THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT CERTIFICATE. IT IS NOT DESIGNED TO FILL THE "GAPS" OF MEDICARE. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM US.

3. References to "Pre-existing Conditions Limitation" and "Benefit Increases" are deleted from the Table of Contents.

4. The "Benefit Waiting Period" provision in the SCHEDULE OF BENEFITS section is deleted.

5. The DEFINITIONS section is amended as follows:

   a. The definitions of "Benefit Waiting Period" and "Pre-existing Condition Limitation" are deleted.
   b. The definition of Dependent shall read:

**Dependent:**
   a. **Your** child, from the moment of birth, who is under 26 years of age (Limiting Age).
   b. **Your** unmarried child, who is chiefly dependent for support incapable of self-support due to physical or mental incapacity, provided the disabling condition occurs prior to age 26 (Limiting Age).

A child can include:
   a. stepchildren;
   b. legally-adopted children;
   c. foster children, including any children legally placed with **You** for adopting or that **You** have filed a petition to adopt;
   d. any children **You** support under court order or any children whose coverage is required by any court or administrative order (any such child may be added upon issuance of a court or administrative order, without regard to Enrollment period restrictions);
   e. any other children, related to **You** by blood or marriage, who live with **You** in a regular parent-child relationship; or
   f. any children **You** claimed as a dependent on **Your** last-filed federal income tax return.

   c. The definition of Specialist shall read:

**Specialist**: a person who:
   a. Is licensed and recognized as a **Doctor** by the state in which he practices;
   b. Is practicing within the scope of his license; and
   c. Is board eligible or board certified in the appropriate specialty or sub-specialty needed to diagnose and treat the diseases or conditions covered as a critical illness under the **Policy**.

6. Item d. in the "Evidence of Insurability" provision in the ELIGIBILITY FOR COVERAGE section is amended by adding:

"except for a spouse who qualifies for enrollment due to a qualifying life event change because of their involuntary termination of employment other than for cause."

7. The "Benefit Waiting Period" provision in the ELIGIBILITY FOR COVERAGE section is deleted.

8. The second sentence of the last paragraph in the "Change in Amounts of Benefits" provision in the ELIGIBILITY FOR COVERAGE section is deleted.

9. The following sentence in the 2nd paragraph of the "Reinstatement" provision in the ELIGIBILITY FOR COVERAGE section is deleted:

Any **Pre-existing Condition Limitation** or **Benefit Waiting Period** will apply to the same extent it would have applied before coverage terminated.

10. The following sentence is the "Critical Illness" provision in the BENEFITS section is deleted:

No benefit or increase in benefit is payable for conditions diagnosed during the **Benefit Waiting Period**.

11. Item i. of the Diagnosis Requirements for "Occupational Tuberculosis" benefit (if included) in the BENEFITS section shall read:

i. The **Insured** is not a member of a group with high rates of Tuberculosis transmission, specifically homeless persons, and persons with HIV infection.

12. The exclusion for "Hepatitis infection acquired via intravenous (IV) drug use" in the "Occupational Hepatitis" benefit (if included) in the BENEFITS section is deleted.

13. The exclusion for "HIV infection acquired via intravenous (IV) drug use" in the Occupational HIV" benefit (if included) in the BENEFITS section is deleted.

14. Item b. in the exclusions for "Advanced Alzheimer's Disease" benefits (if included) and "Dementia" benefits (if included) in the BENEFITS section is deleted.
15. In the "*Exclusions and Limitations*" for Parkinson's Disease benefits (if included) in the BENEFITS section, the term "drug-induced" is amended to read "chemically-induced."

16. Item c. in the "*Exclusions and Limitations*" for Severe Autoimmune Disease (if included) and Autoimmune Thyroid Disease benefits (if included) in the BENEFITS section shall read:

c. Activation of autoimmune mechanisms secondary to use of a chemical.

17. Item h. in the "*Exclusions and Limitations*" for Post-Treatment Lyme Disease Syndrome benefits (if included) in the BENEFITS section shall read:

h. Diagnosis prior to completion of the standard course of antibiotic therapy for Lyme disease.

18. Item a. in the "*Exclusions and Limitations*" for Significant Mental Illness benefits (if included) in the BENEFITS section shall read:

a. The loss of **Actively at Work** status is the result of an **Injury**, **Illness** or any other condition that is not a Significant Mental Illness.

19. The "*Exclusions and Limitations*" for Severe Mental Illness benefits (if included) in the BENEFITS section are deleted.

20. Item a. in the *Exclusions and Limitations* for Major Congenital Structural Anomaly benefits (if included) and item a. in the *Exclusions and Limitations* for Congenital Metabolic Disorder benefits (if included) in the BENEFITS section are deleted.

21. The "Pre-existing Conditions Limitation" provision (if included) in the BENEFITS section is deleted.

22. The "Exclusions" provision in the EXCLUSIONS AND LIMITATIONS section is amended as follows:

a. Items a., c., h.ii., h.iii., h.vi., and h.vii. are deleted.
b. The following item is added:

   Treatment for health care services provided as a result of a prohibited referral as defined under the Health Occupation Article.

23. The “Notice of Claim” provision in the GENERAL PROVISIONS section is amended by adding:

We will not invalidate or reduce a claim if it is shown that it was not reasonably possible to give notice within the time frames as noted above, and notice was given as soon as was reasonably possible.

24. The “Claim Forms” provision in the GENERAL PROVISIONS section shall read:

**Claim Forms**
Within 15 days of receiving a notice of claim, **We** will send the forms need to provide Proof of Loss to the claimant (or to the group policyholder for delivery to the claimant).

If **We** do not send the forms within 15 days of receiving notice of a claim, **You** shall be deemed to have complied with the requirements of the Policy if **You** submit written proof of the occurrence, character, and extent of the loss within the time period noted in the Proof of Loss provision.

25. The “Proof of Loss” provision in the GENERAL PROVISIONS section is amended by adding:

Proof of Loss submitted by a provider, as assigned by the claimant, must be provided within 180 days after the date of loss.

Failure to furnish the Proof of Loss within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit proof within the required time, if the proof is furnished as soon as reasonably possible and, except in the absence of legal capacity of the claimant, not later than 1 year from the time proof is otherwise required.

26. The “Time Payment of Claims” provision in the GENERAL PROVISIONS section shall read:

**Time Payment of Claims**
**We** will pay benefits within 30 days after **We** receive all essential information needed to make a determination on the claim.

27. The second paragraph of the “Payment of Benefits” provision in the GENERAL PROVISIONS section shall read:

In the event **You** die, any death benefits will be payable to **Your Beneficiary**. If, on the date **You** die, there is no living named **Beneficiary**, **We** may, at **Our** option, pay any benefits, up to a maximum of $5,000, due under the **Policy** to the following surviving relatives of **Yours**:

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

28. The “Entire Contract” provision in the GENERAL PROVISIONS section shall read:

**Entire Contract**
The **Policy**, the **Policyholder’s** signed application, the **Insured**’s signed enrollment form, the **Insured**’s signed evidence of insurability form, if applicable, this Certificate and any **Riders**, endorsements or other attached papers make up the entire contract of insurance between the **Policyholder** and **Us**.

29. The “Statements” provision in the GENERAL PROVISIONS section shall read:

**Statements**
Absent fraud, all statements made by the **Policyholder** and persons **Insured** under this **Policy** will be deemed representations and not warranties. No statement will be used in any contest or to reduce benefits unless the statement is contained in a written instrument signed by the person making it and a copy of it is given to the person who made it, or, in

the event of the death or incapacity of the **Insured**, to the **Insured's Beneficiary** or personal representative.

30. The title of the "Time Limit on Certain Defenses" provision in the GENERAL PROVISIONS section is changed to "Contestability of Coverage" and the provision shall read:

**Contestability of Coverage**
Absent a showing of intentional fraud, no statement concerning insurability made by any **Insured** shall be used to contest the validity of the insurance for which the statement was made or to reduce benefits after this **Policy** has been in force for two years during the person's lifetime. In order to be used, the statement must be in writing, signed by the group **Policyholder** or **Insured**, and a copy of the written statement has been given to the group **Policyholder**, **Insured**, or **Beneficiary** of the **Insured**, However, **We** are not precluded at any time from asserting defenses based upon the person's ineligibility for coverage under this **Policy**, or upon other provisions in the **Policy**.

**For Mississippi Residents**

1. The time frame specified in the "Reinstatement" provision in the ELIGIBILITY FOR COVERAGE section shall read "60 days."

2. The "Time Payment of Claims" provision in the GENERAL PROVISIONS section shall read:

All benefits payable under this **Policy** for any loss, other than loss for which this **Policy** provides any periodic payment, will be paid within twenty-five (25) days after receipt of due written proof of such loss in the form of a clean claim where claims are submitted electronically, and will be paid within thirty-five (35) days after receipt of due written proof of such loss in the form of clean claim where claims are submitted in paper forma. Benefits due under the **Policies** and claims are overdue if not paid within twenty-five (25) days or thirty-five (35) days, whichever is applicable, after **We** receive a clean claim containing necessary medical information and other information essential for **Us** to administer any applicable preexisting condition provisions, if included in **your** plan. A "clean claim" means aa claim received by **Us** for adjudication and which required no further information, adjustment or alteration by your **Provider** of the services or **You** in order to be processed and paid by the insurer. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment form being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected. Errors, such as system errors, attributable to **Us**, do not change the clean claim status.

A clean claim does not include any of the following:

a. A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim;
b. Claims which are submitted fraudulently or that are based upon material misrepresentations;
c. Claims that require information essential for **Us** to administer any applicable preexisting condition; or
d. Claims submitted by a provider more than thirty (30) days after the date of service; if the **provider** does not submit the claim on behalf of the **insured**, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the **Provider** to **You**.

Not later than twenty-five (25) days after the date **We** actually receive an electronic claim, the **We** shall pay the appropriated benefit in full, or any portion of the claim that is clean, and notify your **Provider** (where the claim is owed to the **Provider**) or **You** (where the claim is owed to **You**) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than thirty-five (35) days after the date **We** actually receive a paper claim, **We** shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the **Provider** (where the claim is owed to the **Provider**) or **You** (where the claim is owed to **You**) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiation documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by the insurer shall be paid within twenty (20) days after receipt.

For purposes of this provision, the term "pay" means that the insurer shall either send cash or a cash equivalent by United States mail, or send cash or a cash equivalent by other means such as electronic transfer, in full satisfaction of the appropriate benefit due the **Provider** (where the claim is owed to the **Provider**) or **You** (where the claim is owed to **You**). To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to the last known address of the **Provider** (where the claim is paid to the **Provider**) or to **You** (where the claim is paid to **You**) in a properly addressed, postpaid envelope, or, if not so posted, or not sent by United States mail, on the date of delivery of payment to the **Provider** or **Insured**.

Subject to due written proof of loss, all accrued benefits for loss for which this **Policy** provides periodic payment will be paid at least monthly, and any balance remaining unpaid upon the termination of liability will be paid within thirty (30) days after receipt of due written proof.

If the claim is not denied for a valid and proper reasons by the end of the applicable time period prescribed in this provision, **We** will pay the **Provider** (where the claim is owed to the **Provider**) or **You** (where the claim is owed to **You**) interest on accrued benefits at the rate of three percent (3%) per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest is due pursuant to this provision is less than One Dollar ($1.00), such amount shall be credited to the account of the person or entity to whom such amount is owed.

In the event **We** fail to pay benefits when due, the person entitled to such benefits may bring action to recover such benefits, any interest which may accrue as provided in subparagraph 3 of this paragraph (h) and any other damages as may be allowable by law. If it is determined is such action that **We** acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, the person entitle to such benefits (health care **Provider** or **Insured**) shall be entitled to recover damages in an amount up to three (3) times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

3. The “Physical Examination and Autopsy” provision in the GENERAL PROVISIONS section shall read:

**Physical Examination**
**We**, at **Our** own expense, have the right to have **You** examined as often as **We** may reasonably require while a claim is pending.

**For Montana Residents**

1. References to “**Severe Complications of Pregnancy**” (if included) are replaced by the term “**Other Covered Conditions**.”

2. The term “**Health Screening Benefit**” is added to the “**Riders**” listing in the **SCHEDULE OF BENEFITS** section.

3. Items c. and e. in the definition of **Pre-existing Condition** in the **DEFINITIONS** section are deleted.

4. Items a. and c. in the definition of **Specialist** in the **DEFINITIONS** section are deleted.

5. Any reference to the “first day of the month following the” that may appear in the “**The Date You Are Eligible for Coverage**” and “**The Date a Dependent is Eligible for Coverage**” provisions in the **ELIGIBILITY FOR COVERAGE** section shall not apply to **You**.

6. Items ii. And iii. Under b. “**Clinical Diagnosis**” in the “*Diagnosis Requirements*” part of the **Invasive Cancer Benefit** in the **BENEFITS** section are hereby deleted.

7. The “**Severed Complications of Pregnancy**” benefit (if included) in the **BENEFITS** section is replaced by the following **Benefit**:

**Othered Covered Conditions**
Othered Covered Conditions include the following named health problems (i) that require a distinct Hospitalization at any point from the antepartum period extending through 6 weeks postpartum, for the primary purpose of treating the complication, and (ii) if left untreated, would result in harm to, or death of, the unborn child: acute nephritis; cardiac decompensation; gestational diabetes, placenta previa, placental abruption, toxemia, pre-eclampsia, eclampsia, disease of the endocrine, hemopoietic, puerperal infection, or non-elective caesarean section.

*Diagnosis Requirements*
The Other Covered Condition must be one of the above-named conditions, diagnosed by a Specialist and include clinically accepted diagnostic testing.

*Diagnosis Date*
The date of diagnosis is the date a named Other Covered Condition is diagnosed by a Specialist that satisfies the criteria described above.

*Exclusions and Limitations*
A Critical Illness Benefit will not paid for:

c. A normal delivery Hospitalization.
d. A prolonged delivery Hospitalization that is not due to treatment of an above-named Other Covered Condition.

An "Other Covered Condition" Critical Illness Benefit (if included) is only payable up to one time per 10-month period.

8. Items h.ii. and h.vi. in the "**Exclusions**" provision in the **EXCLUSIONS AND LIMITATIONS** section shall read:

ii. Engaging in any activity for which the **Insured** was convicted of a felony:

vi. When convicted of being intoxicated or under the influence of alcohol when operating a motor vehicle, illegal drugs or any narcotic (including overdose) unless as prescribed by a physician.

9. The "**Notice of Claim**" provision in the **GENERAL PROVISIONS** section shall read:

**Notice of Claim**
Written notice of claim must be given to the insurer within 6 months after the occurrence or commencement of any loss covered by the **Policy** or as soon after that date as is reasonably possible. Notice given by or on behalf of the **Insured** or the **Beneficiary** to the insurer at Symetra Claims Administration, PO Box 440, Ashland, WI 54806 or to any authorized insurance producer of the insurer, with information sufficient to identify the **Insured**, is considered notice to the insurer.

10. The last two paragraphs of the "**Proof of Loss**" provision in the **GENERAL PROVISIONS** section shall read:

Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this **Policy** provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss.

Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

11. The "**Time Payment of Claims**" provision in the **GENERAL PROVISIONS** section shall read:

**Time Payment of Claims**
**We** will pay benefits immediately after **We** receive all essential information needed to make a determination on the claim. If additional information is required in order for **Us** to make a determination on the claim, **We** will pay benefits within 20 days of receipt of all information necessary to make that determination.

12. The "**Statements**" provision in the **GENERAL PROVISIONS** is amended by adding the words "In the absence of fraud" to the beginning of the paragraph.

13. The second paragraph of the "**Payment of Benefits**" provisions in the **GENERAL PROVISIONS** section shall read:

In the event **You** die, any death benefits will be payable to **Your Beneficiary**. If, on the date **You** die, there is no living named **Beneficiary**, any benefits due under the **Policy** will be paid to **Your** estate.

14. The "**Time Limit on Certain Defenses**" provision in the **GENERAL PROVISIONS** section shall read:

**Time Limit on Certain Defenses**
After 2 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such 2-year period.

**For New Hampshire Residents**

1. All references to the world “Specialist” are replaced with “Doctor.”

2. The last 3 paragraphs of the INTRODUCTION section are replaced by the following:

THIS IS A LIMITED POLICY - PLEASE READ IT CAREFULLY

**Right to Return this Certificate:** This **Certificate** may, at any time within 30 days after its receipt by the **Primary Insured**, be returned by delivering it or mailing it to the company or the agent through whom it was purchased. Immediately upon such delivery or mailing, the **Certificate** will be deemed void from the beginning, and any **Premium** paid on it will be refunded.

**NOTICE TO BUYER:**
**THIS IS A SPECIFIED DISEASE CERTIFICATE THIS CERTIFICATE PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. READ YOUR CERTIFICATE CAREFULLY WITH THE OUTLINE OF COVERAGE AND THE BUYER’S GUIDE.**

**NOTICE TO BUYER:**
**THIS IS AN ANCILLARY HEALTH CERTIFICATE. THIS CERTIFICATE PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.**

**THIS CERTIFICATE DOES NOT PROVIDE COMPREHENSIVE HEALTH INSURANCE COVERAGE. IT IS NOT INTENDED TO SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT (ACA) OR PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE ACA (OFTEN REFERRED TO AS “MAJOR MEDICAL COVERAGE”). IT DOES NOT PROVIDE COVERAGE FOR HOSPITAL, MEDICAL, SURGICAL, OR MAJOR MEDICAL EXPENSES.**

3. The term “Health Screening Benefit” (if included) shall read “Critical Illness Health Screening Benefit.”

4. The following changes are made to the Table of Contents and in other places where the applicable terms are used:

   - The reference to “Stroke” (if included) shall read “Severe Stroke.”
   - The references to “Occupational Tuberculosis,” “Occupational Hepatitis” and “Occupational Human Immunodeficiency Virus (HIV)” (if included) are hereby deleted.

5. The reference to “All regular full-time” in the “Eligible Classes for Coverage” provision in the SCHEDULE OF BENEFITS section shall read:

   - “All regular full-time and part-time”

6. The “Miscellaneous Goods and Services” provision *if included) in the “Riders” part of the SCHEDULE OF BENEFITS shall read:

**Miscellaneous Goods and Services**
From time to time, **We** may offer or provide to **You** noninsurance benefits and services, some examples include: TeleDoc/Telemedicine/Telehealth services; and Health Advocacy, NurseLine, Medical Bill Saver, EAP and Work/Life Balance, and Wellness Programs. 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 nor are **We** liable for the failure of the provision of the same. Further, **We** are not liable to **You** for the negligent provision of such goods and/or services by third party service providers.

7. The definitions of “Amendment,” “Rider,” and “Specialist” in the DEFINITIONS section shall not apply to you.

8. The time period in the definition of “Pre-existing Conditions” in the DEFINITIONS section shall read “6 months.”

9. The 4th paragraph of the “Effective Date of Dependent Coverage” provision in the ELIGIBILITY FOR COVERAGE section shall not apply to you.

10. In the 2nd paragraph of the “Termination of Dependent Coverage” in the ELIGIBILITY FOR COVERAGE” section, the term “unmarried” is deleted.

11. The “**Portability**” provision (if included) in the **ELIGIBILITY FOR COVERAGE** section is deleted.

12. The term “Advanced Alzheimer’s Disease” (if included) in the BENEFITS section shall read “Alzheimer’s Disease.”

13. The “*Diagnosis Requirements*” for Non-Melanoma Skin Cancer (if included) in the BENEFITS section shall be amended by adding:

    If a pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted instead.

14. The 1st paragraph of the “Major Organ Failure” provision (if included) in the BENEFITS section shall read:

Major Organ Failure is defined as the permanent failure or loss of one or more of the following organs:
heart, liver, lung, or pancreas, that requires a partial or full surgical transplant of a human organ.

15. The 1st sentence of the 2nd paragraph of the “*Diagnosis Requirements*” for Alzheimer’s Disease (if included) in the BENEFITS section shall read:

The diagnosis of Alzheimer’s Disease must be confirmed where there is significant reduction in mental and social functioning where the **Insured** is unable to perform independently, at least 2 of the following 6 “Activities of Daily Living” for a continuous period of at least 180 days:…

16. In the 1st 2 paragraphs of the “Pre-existing Conditions Limitation” provision (if included) in the EXCLUSIONS AND LIMITATIONS section, the time period stated shall read “6 months.”

17. The “Benefit Increases” provision in the EXCLUSIONS AND LIMITATIONS section (if included) shall read:

If **Your** benefit amount increases, the amount of the benefit increase will not be paid for any critical illness caused by or resulting from a **Pre-Existing Condition** if it is diagnosed in the first 6 months after **Your** increase in coverage takes effect.

18. In the “Exclusions” provision in the EXCLUSIONS AND LIMITATIONS section:

- In the 1st line, the word “Injury” is deleted.
- In item g., the phrase “Contributed to by” is deleted.
- h. ii. shall read:
    - Voluntary participation in a felony, riot, or insurrection.
- Items h.iii. and h.vi. are deleted.
- Item h.vi. shall read:
    - Voluntary consumption of unprescribed drugs.

19. The last sentence of the “Proof of Loss” provision in the GENERAL PROVISIONS section is deleted.

20. The “Payment of Benefits” provision in the GENERAL PROVISIONS section is amended by adding:

    Benefits may not be assigned to a health care **Provider**.

21. In the “Entire Contract” provision in the GENERAL PROVISIONS section, the phrase “and any Riders” is deleted.

22. In the “Time Limit on Certain Defenses” provision in the GENERAL PROVISIONS section, the phrase “Absent a showing of intentional fraud,” is deleted.

**For Ohio Residents**

1. The INTRODUCTION section is amended by adding:

Notice to Ohio Residents: Holders of Certificates furnished by any insurer to a resident of Ohio in connection with, or pursuant to any provisions of, any group sickness and accident policy which insures residents of Ohio are entitled to all the protections afforded them under Ohio law, including without limitation, Title XXXIX of the Ohio Revised Code.

**For Oklahoma Residents**

1. The INTRODUCTION section is amended by adding:

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

2. Item h.i. in the "Exclusions" provision of the EXCLUSIONS AND LIMITATIONS section is amended by adding:

"when serving in the military or an auxiliary unit thereto"

3. The time period stated in item b. of the "Legal Actions" provision in the GENERAL PROVISIONS section shall read "5 years."

**For South Carolina Residents**

1. The "Physical Examination and Autopsy" provision in the GENERAL PROVISIONS section shall read:

**We**, at **Our** own expense, have the right to have **You** examined as often as **We** may reasonably require while a claim is pending, and to require an autopsy in the case of death during the period of contestability, unless it is forbidden by law. The autopsy must be performed in the State of South Carolina.

**For South Dakota Residents**

1. The time period in the definition of "Pre-existing Conditions" in the DEFINITIONS section shall read "6 months."

2. The "Enrollment" part of the "Eligible Dependents" provision in the ELIGIBILITY FOR COVERAGE section is amended by adding:

This enrollment period will be waived when a parent is required to enroll a child due to a court or administrative order.

3. The 2nd paragraph of the "Pre-existing Conditions Limitation" part of the "Continuity with Prior Coverage" provision in the ELIGIBILITY FOR COVERAGE section shall read:

If either the **Pre-existing Conditions** Limitation of the **Policy** or that of the **Prior Coverage** applies, no benefit will be paid for the first twelve (12) months.

4. The first paragraph of the "Pre-existing Condition Limitation" (if included) in the EXCLUSIONS AND LIMITATIONS section shall read:

No benefit will be paid for a **Pre-existing Condition** during the first 12 months after the **Insured's** coverage takes effect.

5. The "Benefit Increases" part (if included) of the "Pre-existing Condition Limitation" in the EXCLUSIONS AND LIMITATIONS section shall read:

**Benefit Increases**
If **You** increase the amount of **Your** benefit during an Annual Enrollment Period, no benefits will be paid for the first 12 months of any critical illness caused by or resulting from a **Pre-Existing Condition** if it is diagnosed in the first 12 months after **Your** increase in coverage takes effect.

6. The "Exclusions" provision in the EXCLUSIONS AND LIMITATIONS section shall be amended as follows:

- The 1st line shall read: "No benefit will be paid when the **Insured** has a critical illness that is: …."
- Items h.vi. and h.vii. are deleted.

7. The time periods stated in items a. and b. of the "Notice of Claim" provision in the GENERAL PROVISIONS section shall read "30 days."

**For Vermont Residents**

1. Page 1 of the Certificate is amended by adding:

**THIS POLICY DOES NOT MEET THE MINIMUM COVERAGE REQUIREMENTS OF THE AFFORDABLE CARE ACT. YOU SHOULD NOT PURCHASE THIS POLICY UNLESS YOU ARE ALREADY COVERED BY COMPREHENSIVE MAJOR MEDICAL INSURANCE.**

**THIS CERTIFICATE IS DELIVERED IN AND IS GOVERNED BY THE LAWS OF THE STATE OF VERMONT.**

2. The following paragraph in the INTRODUCTION section is deleted:

**YOU SHOULD NOT PURCHASE THIS POLICY UNLESS YOU ARE ALREADY COVERED BY COMPREHENSIVE MAJOR MEDICAL INSURANCE.**

3. References to "**Portability**" in the **Table of Contents** and other sections (if included) are deleted and are not part of **your** certificate. None of the **Portability** provisions (if included) shall apply to **you** or **your dependents**.

4. The "**Portability**" provision (if included) in the **ELIGIBILITY FOR COVERAGE** section is deleted.

5. The words "sudden, unforeseen," in the definition of "Accident" in the DEFINITIONS section are deleted.

6. The word "unmarried" in the definition of "Dependent" in the DEFINITIONS section is deleted.

7. Items h.vi. and h.vii. in the "Exclusions" provision in the EXCLUSIONS AND LIMITATIONS section are deleted.

**For West Virginia Residents**

1. The following notice shall appear on page 1 of **Your** Certificate:

Notice: The **Policy** is a fixed-payment insurance policy. It provides fixed-payment limited medical and other 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.

2. The **CERTIFICATE TABLE OF CONTENTS** is amended as follows:

"**Assignment of Benefits**" is changed to "**Assignment of Life Insurance Benefits**" under the **BENEFITS** section.

"**Assignment of Benefit Payments**" is added under the **GENERAL PROVISIONS** section.

3. The "**Portability**" provision (if included) in the **ELIGIBILITY FOR COVERAGE** section is deleted.

4. The "**Time Payment of Claims**" provision in the **GENERAL PROVISIONS** section shall read:

**Time Payment of Claims**
**We** will pay benefits as soon as **We** receive, or no more than 15 days after, all essential information need to make a determination on the claim.

5. The **GENERAL PROVISIONS** section is amended by adding:

**Assignment of Benefit Payments**
**You** may assign payment of **Benefits**, other than **Life Insurance Benefits**, under the **Policy** to be paid directly to **Your Provider**. An assignment will transfer **Your** interest for any designated payment to the assignee.

**For Wyoming Residents**

1. The INTRODUCTION section is amended by adding:

## THIS CERTIFICATE DOES NOT CONTAIN COMPREHENSIVE ADULT WELLNESS BENEFITS.

2. Item b. in the 1st paragraph of "The Date a Dependent is Eligible for Coverage" provision in the ELIGIBILITY FOR COVERAGE section shall read:

b. The date **You** acquire a **Dependent** such as through marriage, birth, adoption, or the earlier of the date a petition to adopt was filed or the date of placement in the home for adoption. If the adoptive child is in the custody of the state, coverage will become effective on the date the date of entry of the final decree of adoption.

3. The 3rd paragraph of the “Effective Date of Dependent Coverage” provision in the ELIGIBILITY FOR COVERAGE section shall read:

However, **Your** child will be covered for Critical Illness Benefits for 31 days following the date of birth, adoption, or the earlier of the date a petition to adopt was filed or the date of placement for adoption in the home without paying **Premium** or authorizing **Your** Employer to deduct any amounts from **Your** pay.

Signed for Symetra Life Insurance Company at Bellevue, Washington.

Margaret Meister
President

Jacqueline M. Veneziani
Secretary

**Symetra Life Insurance Company**
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
1-800-796-3872 | www.symetra.com
Domiciled in Iowa

RESIDENCE STATE AMENDMENT

Governing Jurisdiction: The **Policy** is delivered in and governed by the laws of the state of **Ohio**

If **You** do not reside in the Governing Jurisdiction state shown above, **Your** Certificate is hereby amended as stated below to comply with the laws of **Your** state of residence.

Only those references in this amendment to benefits, provisions or terms actually included in **Your** Certificate will apply to **You**. In addition, any reference made herein to **Dependent** coverage will only apply if **Dependent** coverage is provided in **Your** Certificate.

This amendment is attached to and made part of the Certificate that forms part of the **Policy**. All other provisions of **Your** Certificate remain unchanged.

**For Minnesota Residents**

1. The following is added to the second paragraph of the INTRODUCTION section:

The **Certificateholder** has the right to inspect the **Policy** or a copy thereof during business hours of the Eligible Group at the **Policyholder**'s place of business.

2. The following is added to the end of the INTRODUCTION section:

**Incontestability of Certificate**
**We** will not contest this **Certificate** after it has been in force for two years with respect to **You**, except for fraudulent misstatements made by **You**. No misstatement made by an **Insured** relating to his insurability will be used to contest his coverage:

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

3. The second paragraph of the "Effective Date of Dependent Coverage" provision in the ELIGIBILITY FOR COVERAGE section shall read:

If **You** did not elect **Dependent** coverage before the birth or adoption of a child, coverage will take effect for that child on the date of birth or adoption, if within 60 days of the date of birth or adoption, **You** authorize **Your** employer to deduct **Your** required contribution toward the cost of **Your Dependent** coverage from **Your** pay.

See the "Continuation of Coverage" provision for any exceptions to the Termination provisions.

4. The "**Portability**" provision (if included) in the **ELIGIBILITY FOR COVERAGE** section shall not apply to you.

5. The second paragraph of the "Payment of Benefits" provision in the BENEFITS section shall read:

In the event **You** die, any death benefits will be payable to **Your Beneficiary**. If, on the date **You** die, there is no living named **Beneficiary**, **We** will pay any benefits due under the **Policy** to **Your** estate.

6. The following provisions are added to the GENERAL PROVISIONS section:

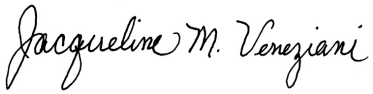
**Change of Beneficiary**
Unless **You** make an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to **You** and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this **Policy**.

**Examination of Policy**
**We** will issue a master policy to the employer and **We** shall also issue to the **Employer**, for delivery to the **employee** who is insured under the **Policy**, an individual certificate setting forth a statement as to the insurance protection to which the **employee** is entitled and to whom payable. **You** may inspect the master **Policy** at the **employer**'s home office during normal business hours upon request.

7. The time frame specified in the "Reinstatement" provision in the ELIGIBILITY FOR COVERAGE section shall read "6 years."

Signed for Symetra Life Insurance Company at Bellevue, Washington.





Margaret Meister
President

Jacqueline M. Veneziani
Secretary