Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Symetra Life Insurance Company
To get information or file a complaint with your insurance company or HMO:

Call: Customer Service Representative at 425-256-8000
Toll-free: 1-800-796-3872
Online: www.symetra.com
Email: https://www.symetra.com/customer-service/how-can-we-help-you/email-us/
Mail: PO Box 34690, Seattle, WA 98124-1690

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance,
PO Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Symetra Life Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Customer Service Representative al 425-256-8000
Teléfono gratuito: 1-800-796-3872
En línea: www.symetra.com
Correo electrónico: https://www.symetra.com/customer-service/how-can-we-help-you/email-us/
Dirección postal: PO Box 34690, Seattle, WA 98124-1690

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance,
PO Box 12030, Austin, TX 78711-2030

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

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

SELECT BENEFITS
FIXED-PAYMENT INDEMNITY POLICY

Employer Name:	Valley View Independent School District
Policy Number:	13178000 - Plan 3
Effective Date of Coverage:	September 1, 2025

CERTIFICATE OF COVERAGE

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

THIS INSURANCE PAYS A FIXED DOLLAR AMOUNT, REGARDLESS OF YOUR EXPENSES, FOR EACH DAY YOU MEET THE POLICY CONDITIONS. IT DOES NOT PAY YOUR MEDICARE DEDUCTIBLES OR COINSURANCE AND IS NOT A SUBSTITUTE FOR MEDICARE SUPPLEMENT INSURANCE.

THIS INSURANCE DUPLICATES MEDICARE BENEFITS WHEN:

• ANY EXPENSES OR SERVICES COVERED BY THE POLICY ARE ALSO COVERED BY MEDICARE MEDICARE GENERALLY PAYS FOR MOST OR ALL OF THESE EXPENSES.

MEDICARE PAYS EXTENSIVE BENEFITS FOR MEDICALLY NECESSARY SERVICES REGARDLESS OF THE REASON YOU NEED THEM. THESE INCLUDE:

• HOSPITALIZATION
• PHYSICIAN SERVICES
• HOSPICE CARE
• OTHER APPROVED ITEMS & SERVICES

BEFORE YOU BUY THIS INSURANCE

• CHECK THE COVERAGE IN ALL HEALTH INSURANCE POLICIES YOU ALREADY HAVE.
• FOR MORE INFORMATION ABOUT MEDICARE AND MEDICARE SUPPLEMENT INSURANCE, REVIEW THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE, AVAILABLE FROM THE INSURANCE COMPANY.
• FOR HELP IN UNDERSTANDING YOUR HEALTH INSURANCE, CONTACT YOUR STATE INSURANCE

DEPARTMENT OR STATE

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** and/or **Certificateholder's Dependents**.

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.

Notice: The Policy is a fixed-payment insurance policy. It provides fixed-payment limited medical benefits. Your coverage under the Policy is not comprehensive medical coverage and is not intended to cover the cost of all hospital or other medical services. The Policy does not satisfy the minimum essential coverage requirements of the Affordable Care Act.

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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 regular full-time **Employees**, as defined by your **Employer**, who have worked and been paid for at least a minimum of 17.5 hours each week at your **Employer's** normal place of business.

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 following the date of employment following the date you become a member of an eligible class.

Annual Enrollment Period

As determined by your **Employer** on a yearly basis.

Employee and Dependent Benefits

*The benefit amounts shown below apply to each person insured under the **Policy***

- **Inpatient Hospital Benefit**

Hospital	$2,000 for the Initial Day of Your **Confinement** and $100 per day beginning on the second day of Your **Confinement**, up to a maximum of 30 days per **Calendar Year** and 500 days per lifetime
Intensive Care Unit	$200 per day, up to a maximum of 30 days per **Calendar Year** and 500 days per lifetime
Substance Abuse Facility	$100 per day, up to a maximum of 30 days per **Calendar Year** and 500 days per lifetime
Mental Health Facility	$100 per day, up to a maximum of 30 days per **Calendar Year** and 180 days per lifetime
Nursing Facility	$100 per day, only if following a covered **Hospital** stay of at least 3 consecutive days up to a maximum of 30 consecutive days per stay and 500 days per lifetime

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.

RIDER

Wellness Screening Test Rider

DEFINITIONS

Accident: a sudden, unforeseen, unexpected and involuntary event definite as to time and place and which is independent 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**.

Ancillary Services: inpatient or outpatient services rendered by a **Doctor** or **Hospital**, which supplement the diagnosis and treatment of **Illness** and **Injury**. These services include but are not limited to:

a. Educational
b. Nutritional
c. Rehabilitative
d. Social
e. Laboratory
f. Radiology

Anesthesia: a drug-induced loss of sensitivity to pain in all or a part of the body during surgery.

Anesthesiologist: a licensed **Doctor** who specializes in the administration of **Anesthesia**.

Anesthetist: a licensed Registered Nurse who specializes in the administration of **Anesthesia**.

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.

Birthing Center: a facility, other than a **Hospital**, that creates a home-like atmosphere for the birth of infants.

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.

Codependency: when a person has difficulty experiencing appropriate levels of self-esteem, setting functional boundaries, owning and expressing his own reality, taking care of his adult needs and wants, and experiencing and expressing his reality moderately.

Compulsive Gambling: gambling behavior that interferes with social or occupational functioning.

DEFINITIONS (CONTINUED)

Confined/Confinement: an inpatient in a **Hospital** or other **Health Care Facility** for greater than 24 consecutive hours.

Custodial Care: services (including room and board) or supplies that:

a. Are provided to an **Insured** primarily to help the **Insured** perform daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
b. Can safely be provided by persons without special occupational skills and experience; and
c. Are not essential for the diagnosis or treatment of the condition;

regardless of where these services or supplies are provided or who recommends them.

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 (a physical impairment or intellectual disability), provided the disabling condition occurs prior to age 26.
d. **Your** unmarried grandchild, who is under the age of 26 and a dependent of **Yours** for federal income tax purposes at the time the application for coverage is made.

A child can include:
a. stepchildren;
b. legally-adopted children;
c. foster children, including any children legally placed with you for adoption or that **You** have filed a petition or suit 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 order 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.

We do not distinguish on the basis of the marital status or lack of marital status between an **Insured** and the other parent in the determination of the dependents or the beneficiaries of the **Insured**, or both.

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, unless it is the only **Doctor** within 50 miles and the **Doctor** is operating within the scope of his license.
b. Is a member of your immediate family.
c. Is employed by or affiliated with your **Employer**.

Durable Medical Equipment: equipment that is made to:

a. Withstand prolonged use;
b. Be used mainly in the treatment of an **Illness** or **Injury**;
c. Be used while not **Confined** as an inpatient; and
d. Be used mainly by persons who have an **Illness** or **Injury**.

DEFINITIONS (CONTINUED)

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**.

Eligible Services or Supplies: those services or supplies received by an **Insured** for treatment of a covered **Illness** or **Injury** that are not excluded under the **Policy**. If a Preventive Care Benefit is shown in the **Schedule of Benefits**, **Eligible Services or Supplies** also include preventive care services or supplies received by an **Insured** to help prevent **Illness** and diagnose a problem early that are not excluded under the **Policy**.

Emergency Room: a staffed and equipped **Hospital** room or **Hospital** area for the reception and treatment of persons with conditions, such as **Illness** or **Injury**, requiring immediate medical care.

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

Experimental/Investigative: a treatment, procedure, facility, equipment, drug, device, or supply which meets one or more of the following criteria as determined by us:

a. The treatment cannot be lawfully marketed without approval of the U.S. Food and Drug Administration, an approval for marketing has not been given at the time it is provided.
b. The treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval.
c. If Reliable Evidence shows that the treatment is the subject of ongoing clinical trials, or is under study to determine its maximum tolerated dose, toxicity, safety, efficacy or its efficacy as compared with a standard means of treatment or diagnosis.
d. If Reliable Evidence shows that the prevailing opinion among experts regarding the treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

"Reliable Evidence" shall mean only published reports and articles in the authoritative medical and scientific literature, the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure, or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Health Care Facility:

a. A **Hospital**.
b. A **Hospital Intensive Care Unit**.
c. A licensed **Nursing Facility**.
d. A licensed substance abuse facility which is primarily for the treatment of a **Substance Abuse Disorder**.
e. A licensed mental health facility which is primarily for the treatment of a **Mental Disorder**.

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 **Health Care facility** for surgical facilities; and
e. Licensed to operate as a **Hospital** pursuant to law.

DEFINITIONS (CONTINUED)

Hospital does not include:

a. A rest home or nursing home, home for the aged, or convalescent home.
b. A **Nursing Facility**.
c. A **Hospice** or a place for **Custodial Care** or a **Birthing Center**.
d. A place primarily for the treatment of **Substance Abuse Disorders**.
e. A place primarily for the treatment of **Mental Disorders**.

Hospice: is a healthcare facility, other than a **Hospital**, providing medical care and support services for terminally ill persons.

Illness:

a. Physical sickness or disease.
b. **Mental Disorder**, as defined under the **Policy**.
c. Complications of pregnancy.
d. Congenital abnormalities.

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.

Intensive Care Unit (ICU): a designated area within a **Hospital** that meets all of the following conditions:

a. Provides continuous specialized or intensive care or services, not regularly provided in a general medical unit, to an **Insured** who is seriously ill or injured.
b. Has immediate access to emergency lifesaving equipment and supplies.
c. Is staffed with nurses and other health care professionals who have the advanced skills and training to care for the seriously ill or injured.

Intensive Care Unit includes coronary care units, neonatal intensive care units, burn intensive care units and other such special care units that meet the above conditions. **Intensive Care Unit** does not include areas primarily used for post-operative or post-anesthesia care.

Lifetime Maximum: the limitation applied to benefits payable during your lifetime while covered under the **Policy**.

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

Mental Disorder: those neuropsychiatric, mental, or personality disorders which are listed in the International Classification of Diseases as psychoses, neuroses, personality disorders, and other non-psychotic mental disorders.

Nursing Facility: a non-**Hospital**, non-acute care facility for patients who need 24-hour nursing supervision in order to ensure that their medical, psychological, or social needs are met. The facilities offer a full range of care including rehabilitation, and specialized nutritional, social service and activity programs.

Nursing Facility does not include:

a. A rest home or nursing home, home for the aged, or convalescent home, to the extent such facility does not satisfy the above definition.
b. A **Hospice** or a place for **Custodial Care** or a **Birthing Center**.
c. A place primarily for the treatment of **Substance Abuse Disorders**.
d. A place primarily for the treatment of **Mental Disorders**.

DEFINITIONS (CONTINUED)

Observation Services: the use of a **Hospital** bed and periodic monitoring for a period less than 24 hours by the **Hospital's** nursing or other staff to observe a person's condition to decide if the person needs to be admitted to the **Hospital**.

The following are not considered **Observation Services**:

a. Routine preparation and recovery for diagnostic or surgical procedures.
b. Blood administration.
c. Care routinely provided in an **Emergency Room**.
d. Routine recovery and post-operative care after outpatient surgery.
e. The use of a bed for the convenience of the **Doctor**, **Insured**, and/or **Insured's** family.

Observation Services do not apply to a **Doctor's** office, an outpatient **Hospital** facility or clinic, **Urgent Care** facility, or a mental health or substance abuse facility.

Policy: the contract between us and the **Policyholder**. The **Policy** is comprised of the Policy Specifications, the **Employer** section 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.

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**, **Nursing Facility**, **Home Health Agency** or other person 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.

Substance Abuse Disorder: the psychological or physical dependence on, or addiction to, alcohol, drugs, and other controlled substances.

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

Temporomandibular Joint Syndrome (TMJ): the symptoms associated with, or exhibited as a malfunction of, the temporomandibular joint. These are frequently caused by, but not exclusive to:

a. Improper or incorrect space between the maxilla and mandible.
b. Improper dental occlusion.
c. Muscular spasm in the **TMJ** area.

Urgent Care: medical treatment for non-life threatening injuries that require immediate medical attention, medical treatment for acute minor **Illness** and general family medical care on a walk-in basis.

ELIGIBILITY FOR COVERAGE

Eligible Employees

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

a. You are performing all the normal duties of your job at the normal place of business of the **Employer**.
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, or filing of a petition or suit for adoption, or 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 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 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**.

ELIGIBILITY FOR COVERAGE (CONTINUED)

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 of the month following the earlier of the date you acquire a **Dependent** such as through marriage, birth, adoption, placement for adoption, or filing a petition or suit 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 same time 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 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 Inpatient Hospital Benefits for 31 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.

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

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

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.

ELIGIBILITY FOR COVERAGE (CONTINUED)

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 all of the following are met:

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 an **Eligible Service or Supply** is provided.

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.

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

a. You are performing all the normal duties of your job at your **Employer's** normal place of business; 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 last day of the month in which 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.
    v. You are pensioned or retired, as defined by your **Employer**.
    vi. The date you begin active duty in the armed forces.

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 last day of the month in which the first of the following occurs:

    i. You are no longer in a class eligible for **Dependent** coverage.
    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. If it was not possible to give **Us** proof by the time it is due, then **You** must give **Us** proof as reasonably possible. 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 "Extension of Inpatient Hospital Benefits" provisions for any exceptions to the Termination provisions.

Continuation of Coverage

Coverage may continue, as described below, beyond the day it would otherwise cease under the Termination provisions. Any continued coverage:

a. Is subject to payment of the required contribution or **Premium**.
b. 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.

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 **Illness** or **Injury**, all of your coverage may be continued for a period of 6 consecutive months from the date you were last **Actively at Work**.

Leave of Absence
If you are on a documented Leave of Absence, all of your coverage may be continued for up to 2 months following the date you were last **Actively at Work**. If the leave 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 months following the date you were last **Actively at Work**. If the layoff becomes permanent, 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 thirty (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.

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 month following the date in which 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**.

ELIGIBILITY FOR COVERAGE (CONTINUED)

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

Survivor Benefit
Upon your death, coverage may be continued for insured **Dependents**, with no **Premium** due, for all benefits, excluding the Dependent Life Insurance Benefit, covered under the **Policy**. All **Dependent** coverage will cease on the earliest date below:

a. The date the **Insured** no longer qualifies as a **Dependent** as defined in the **Policy**.
b. The date your spouse remarries.
c. The date the **Dependent** becomes eligible for any other plan that includes inpatient hospital benefits.
d. The date your spouse qualifies for **Medicare**.
e. The termination date of the **Policy**.
f. Two years from the date of your death.

BENEFITS

Inpatient Hospital Benefit

This benefit applies only if it is shown in the **Schedule of Benefits**.

The Inpatient Hospital Benefit will be paid when costs are incurred for **Eligible Services or Supplies** received while you are covered for this benefit. We will pay the specified **Health Care Facility** benefit as shown in the **Schedule of Benefits**.

Inpatient Hospital Benefits will be paid only if all of the following are met:

a. The **Insured** is **Confined** in a **Health Care Facility** for a minimum of 24 hours.
b. The **Health Care Facility** is operating within the scope of its license.
c. The entire duration of **Confinement** is recommended and approved by a **Doctor**.
d. The services and supplies are not excluded under the Exclusions and Limitations provision of the Certificate.

Extension of Inpatient Hospital Benefits

Inpatient Hospital Benefits will continue to be paid under the **Policy** when your coverage terminates, if, on the date coverage would otherwise terminate you:

a. Are **Totally Disabled**; and
b. Are **Confined** to a **Hospital** for the disabling **Illness** or **Injury**.

Benefits paid under this extension will continue to be paid until the earliest of these dates:

a. The date which is 90 days from the date coverage would have otherwise terminated.
b. The date on which the disabled **Insured's Inpatient Hospital Benefit** has reached the maximum amount as shown in the **Schedule of Benefits**.
c. The date **Total Disability** ceases.
d. The date you become covered under another group policy.

This extension of benefits applies only to the disabled **Insured** and no **Premium** is due during this extension.

Exclusions and Limitations

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

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

EXCLUSIONS AND LIMITATIONS

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

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

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

EXCLUSIONS AND LIMITATIONS (CONTINUED)

w. For an **Illness** or **Injury** caused wholly or partly, directly or indirectly by:
   i. Declared or undeclared war or act of war when serving in the military or an auxiliary unit thereto.
   ii. Committing or attempting to commit an assault or felony.
   iii. Inciting or taking part in any form of public violence.
   iv. Intentionally self-inflicted **Injury**, while sane or insane.

GENERAL PROVISIONS

Notice of Claim
You must give **us** or an authorized agent of Ours written notice of claim within the following time period:

a. 30 days after the date an **Eligible Service or Supply** is received.
b. 20 days after the date of death.

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
Before the 16th day 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. **We** will notify a claimant in writing of the acceptance or rejection of a claim not later than the 15th business day after the date that receive all items needed to provide **Proof of Loss**. If **we** are unable to accept or reject the claim within 15 business days, **we** will notify the claimant of the reasons that **we** need additional time. **We** will accept or reject the claim not later than the 45th day after the date **we** notify a claimant of the need for additional time. If the claim is accepted, we will pay the claim not later than the fifth business day after the notice is made.

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

a. A completed claim form.
b. Documentation of: the date(s) of the services, supplies received and the costs **you** incurred.
c. The names and addresses of all **Providers**.
d. A certified copy of the death certificate (if applicable).
e. Your **Beneficiary** designation (if applicable).
f. If applicable, documentation of:
    i. The date **your** disability began;
    ii. The cause of **your** disability; and
    iii. The prognosis of **your** disability;
g. **Your** signed authorization for **us** to obtain and release medical information.
h. 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 an **Eligible Service or Supply** 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 one year after it is due.

Time Payment of Claims
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.

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;
c. A **Provider** of medical treatment or services upon **your** written direction; or

d. The Texas Department of Human Services if:
   (a) Benefits for the child or children covered under this **policy** have been paid under financial and medical assistance programs administered pursuant to the Human Resources Code, and
   (b) The parent who is covered under this policy has possession of or access to the child(ren) pursuant to a court order, or is not entitle to access or possession of the child but is required by the court to pay child support, and
   (c) **We** have received notification that the benefits must be paid to the Texas Department of Human Services.

In the event **you** die and, 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.

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 Life Insurance Company
P.O. Box 674419
Houston, TX 77267-4419
1-800-497-3699

Your written request should include:

a. A statement of the reason(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 6 years from the end of the time within which **Proof of Loss** is required by the **Policy**.

Extension of Coverage
You and your **Dependents** may qualify to extend coverage, at group rates, for the medical benefits shown in the **Schedule of Benefits** of the **Policy**.

GENERAL PROVISIONS (CONTINUED)

Qualifying Events
You qualify for extension of coverage if you would otherwise lose group coverage for medical benefits because of a reduction in work hours or termination of employment (for reasons other than gross misconduct).

A covered **Dependent** also qualifies for extension of coverage if he would otherwise lose group coverage for medical benefits because of any of the following events:

a. You lose group coverage for medical benefits because of a reduction in work hours or termination of employment (for reasons other than gross misconduct);
b. Your death;
c. You and your spouse divorce or legally separate;
d. You become entitled to **Medicare**.

In addition, a covered **Dependent** child further qualifies for extension of coverage if he would otherwise lose coverage because he ceases to be an eligible **Dependent** under the **Policy**.

Notification and Election
You or your **Dependent** are responsible for notifying your **Employer** when a qualifying event, as specified above, occurs. Your **Employer** must be notified within 60 days of the later of:

a. The event.
b. The date coverage would end because of the event.

You have 60 days to elect extension of coverage from the later of:

a. The date you lose coverage due to the event.
b. The date your **Employer** informed you that you may choose extension of coverage.

If you choose to extend coverage, you must pay the full cost of coverage each month. The coverage for medical benefits will be identical to the coverage you and/or your **Dependents** had immediately prior to the date coverage ended.

If you do not choose to extend coverage, your group coverage for medical benefits with your **Employer** will end.

Period of Extension
You have the option to continue coverage **Yourself** and/or **Your** covered **Dependents** for as long as the **Policy** remains in force.

Termination
Extension of coverage may be terminated for any of the following reasons:

a. Your **Employer** no longer provides group coverage for medical benefits to any **Employees**.
b. You do not pay the **Premium** for your extension of coverage on time.
c. You become covered under another group policy for medical benefits that does not include a preexisting condition exclusion or limitations on preexisting conditions you may have after the date of your extension of coverage election.
d. You become entitled to **Medicare** after the date of your extension of coverage election.
e. The person whose Social Security disability enabled the extended coverage is determined to have recovered.

If you have any questions about extension of coverage, contact your **Employer**.

Symetra Life Insurance Company
777 108th Avenue NE, Suite 175
Bellevue, WA 98004-5135
1-800-796-3872
TTY/TDD 1-800-833-6388

WELLNESS SCREENING BENEFIT(S) RIDER

This Rider is part of the Certificate to which it is attached. It takes effect on September 1, 2025. It is part of and subject to the other terms and conditions of the Certificate, except as noted below. If the terms of this Rider and the Certificate conflict, then this Rider's provisions will control. Terms in bold used in this Rider have the meanings assigned to them in this Rider or in the Definitions section of the Certificate.

This Rider provides an **Insured** with a benefit if the **Insured** incurs an expense as a result of receiving any of the screening tests described in this Rider.

Benefit(s)

We will pay the benefit amount indicated in the table below for each day **You** or **Your Dependent(s)** undergo any of the screening tests listed in this Rider during a calendar year. The benefit(s) listed in this Rider will be limited to 1 screening tests per calendar year per **Insured**. Services for any of the screening tests must be provided under the supervision of and in the place of business of a **Provider**. Benefits listed in this Rider will be paid for the calendar day while the **Insured** is covered under this Rider. Only one screening test benefit per day is payable, regardless of the number of screening tests received on that day.

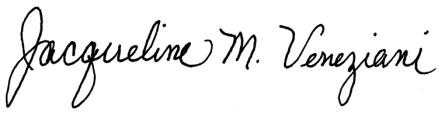
Screening Tests	**Benefit Amount**
Abdominal aortic aneurysm ultrasonography	$50
Blood test for lipids, including total cholesterol, LDL, HDL and triglycerides	$50
Bone Density screening	$50
Bone Marrow testing	$50
Breast MRI	$50
Breast Ultrasound	$50
CA 15-3 blood test for breast cancer	$50
CA 125 blood test for ovarian cancer	$50
Carotid Doppler	$50
CEA blood test for colon cancer	$50
Chest X-ray	$50
Child sports physicals	$50
Colonoscopy or virtual colonoscopy	$50
CT angiography	$50
Electrocardiogram	$50
Fasting blood glucose test	$50
Flexible sigmoidoscopies	$50
Mammograms	$50
Pap smears	$50
Prostate-specific antigen (PSA) test	$50
Serum cholesterol test to determine level of HDL and LDL	$50
Stress test on a bicycle or treadmill	$50
Testicular ultrasound	$50
Thermography	$50
ThinPrep Pap Test	$50

Exclusions

All exclusions as stated in the Exclusions and Limitations section of the Certificate are applicable to the benefits under this Rider.

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
Phone 1-800-796-3872 | www.symetra.com
Domiciled in Iowa

RESIDENCE STATE AMENDMENT

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

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

For Arkansas Residents

2. 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 reasonably possible, at **Our** expense, 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.

3. The 2nd to last paragraph of the "**Portability**" provision (if included) in the **ELIGIBILITY FOR COVERAGE** section shall read:

The request and the initial **Premium** due must be received by **Us** within 31 days after insurance under the **Policy** ends, or within 15 days from the date on which **You** or **Your Dependent** spouse receive notice of the right to request portability. If timely notice is not given, an extension of the period of time in which to request portability coverage will be allowed. 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.

For Connecticut Residents

1. The top of the 1st page of the **Certificate of coverage** shall read:

SELECT BENEFITS
HOSPITAL CONFINEMENT INDEMNITY POLICY

2. The 1st page of the **certificate of coverage** is amended by adding:

THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR LIMITED BENEFITS POLICY AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSE. THIS PLAN IS NOT DESIGNED TO COVER THE COSTS OF SERIOUS OR CHRONIC ILLNESS. IT CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS THOSE

LIMITS, THE BENEFICIARY AND NOT THE INSURER IS RESPONSIBLE FOR PAYMENT OF THE EXCESS AMOUNTS. THE SPECIFIC DOLLAR LIMITS ARE SET FORTH IN THE SCHEDULE OF BENEFITS.

3. The "**BENEFITS**" section of the **CERTIFICATE TABLE OF CONTENTS** is amended by adding:

Home Health Care Benefit

4. The **SCHEDULE OF BENEFITS** is amended by adding:

Home Health Care Benefit $10 per day, up to a maximum of 10 days per **Calendar Year**

5. The "**Termination of Coverage**" provision in the **ELIGIBILITY FOR COVERAGE** section is amended by adding:

Upon termination or cancellation of the **Policy/Certificate**, the **Employer** is responsible for providing each **Insured** employee with a 15 day notice.

6. Item a. in the "**Continuation of Coverage**" provision in the **ELIGIBILITY FOR COVERAGE** section shall read:

a. Temporary Layoff

If **You** are temporarily laid off by the **Employed** 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**.

7. The following paragraph is added to the end of the "**Continuation of Coverage**" provision in the **ELIGIBILITY FOR COVERAGE** section:

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 XVIII of the Social Security Act.

8. The **BENEFITS** section is amended by adding:

Home Health Care
We will pay the **Home Health Care Benefit** for each day **You** or **Your Insured Dependent** receive(s) **Home Health Care** as a result of **Illness** or **Injury**.

We will pay the **Home Health Care Benefit** only if **You** or **Your Insured Dependent** were confined in a **Hospital** as a result of **Illness** or **Injury**, and continued **Hospital** confinement would otherwise be required if **Home Health Care** is not provided. **You** or **Your Insured Dependent's Home Health Care** plan, for the same **Illness** or **Injury** for which the hospitalization occurred, must be approved in writing by a **Physician** or advanced practice registered nurse, and must be provided by a **Home Health Agency**. The **Home Health Care** plan must be approved and begin within 7 days of the date of discharge. The **Home Health Care** must begin within 180 days of the **Illness** or **Injury**. This benefit is payable for up to 180 days per person per **Covered Accident**.

This **Home Health Care Benefit** will not be paid for the same day as an **Inpatient Hospital Benefit** or **Therapy Services**.

9. The "**Emergency Room Benefit**" in the **BENEFITS** section is amended by adding:

Coverage is also provided for isolation care and emergency services provided by the state's mobile field hospital, subject to and **Policy** provisions that apply to other services covered by the **Policy**.

10. Item e. in the **EXCLUSIONS AND LIMITATIONS** section shall read:

b. Received for **Experimental or Investigative** treatment, procedures for research purposes, or practices when not generally recognized as accepted medical practices or have not successfully completed a phase III clinical trial of the Federal Food and Drug Administration.

For Indiana Residents

1. The following notice is added to the 2nd page of the **CERTIFICATE OF COVERAGE section:**

If **You**: (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint **You** have been unable to resolve with **Your** insurer, **You** may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395
Complaints can be filed electronically at www.in.gov/idoi

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

a. The date **You** acquire a **Dependent** such as through marriage, birth, the earlier of adoption or placement for adoption, or the date of an entry of the order granting the adoptive parents custody of the child for purposes of adoption. NOTE: Newborn children are covered from the moment of birth.

3. The time period for giving **Us** proof of **Your** child's disabling condition stated in the 2nd to last paragraph of the "**Termination of Dependent Coverage**" provision in the **ELIGIBILITY FOR COVERAGE** section shall read "120 days."

For Kansas Residents

1. The definition of "**Pregnancy Limitation Period**" in the **DEFINITIONS** section and all other references to the "**Pregnancy Limitation Period**" in the **Certificate** are deleted.

2. The 1st paragraph of 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 all essential information needed to make a determination on the claim.

For Louisiana Residents

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

2. The top of the 1st page of the **CERTIFICATE OF COVERAGE section** shall read:

SELECT BENEFITS
FIXED-PAYMENT INDEMNITY CERTIFICATE

3. The following sentence (if included) in the definition of "**Dependent**" in the **DEFINITIONS** section shall be deleted:

All references to spouse, or any other term that denotes a spousal relationship, used in this **Certificate** will apply to a civil union partner or domestic partner.

4. Item i. in the "**Exclusions**" part of the "**Accidental Death and Dismemberment Benefit**" provision in the **BENEFITS** section shall read:

i. Operating a motor vehicle while legally intoxicated as defined by the laws of the state in which the **Accident** occurred, or under the influence of any excitant, hallucinogen, or narcotic unless administered or prescribed by a **Doctor** and taken in conformance with the prescribed dosage and warnings.

For Maine Residents

1. The time period stated in item a. in the 2nd paragraph of the "**Extension of Inpatient Hospital Benefits**" part of the "**Inpatient Hospital Benefit**" provision in the **BENEFITS** section shall read "180 days."
2. The time period in item a. of the "**Legal Actions**" provision in the **GENERAL PROVISIONS** section shall read "60 days."

For Maryland Residents

1. All references to "Disability Income," "Total and permanent disability benefits," and "Pregnancy Elimination Period" are deleted.

2. In the **SCHEDULE OF BENEFITS**, the "**Dependent Life Insurance Benefit**" provision shall read:

   - **Dependent Life Insurance Benefit**

     Spouse: $2,500
     Child:
     - **14 days to 19 years (*to 26 years if full-time student*)** $1,250

3. In the "**Surgical Benefits**" part of the **SCHEDULE OF BENEFITS**, the "**Surgical Procedure Benefit**" for "**Inpatient Hospital**" provision is amended by adding:

Second Opinion Benefit $75 per each **Confinement**

4. In the definition of "**Dependent**" in the **DEFINITIONS** section and wherever else found in the **Certificate**, the phrase "a physical impairment or intellectual disability" is changed to "an incapacitating physical or mental impairment."

5. In the "**Life Event Changes**" part of the "**Eligible Employees**" provision in the **ELIGIBILITY FOR COVERAGE** section, item b. is amended by adding the phrase "or court-ordered coverage" to the end of the item and item d. shall read:

d. A change in employment status or involuntary termination of employment which causes **your** spouse to become ineligible for group coverage.

6. Item c. in the "**Enrollment**" part of the "**The Date a Dependent is Eligible for Coverage**" provision in the **ELIGIBILITY FOR COVERAGE** section shall read:

c. Within 31 days of the date **You** have a qualified life event change, or within 6 months from the date **Dependent** coverage terminates if the termination is due to **Your** spouse's involuntary termination of employment.

8. Item c. iv. In the "**Termination of Your Coverage**" provision in the **ELIGIBILITY FOR COVERAGE** section shall read:

iv. The last day of the **Grace Period** if **You** or **Your Employer** do not make contributions or **Premium** payments for **Your** coverage prior to the end of the **Grace Period**.

9. The "**Settlement Provision**" part of the "**Employee Life Insurance Benefit**" provision in the **BENEFITS** section shall read:

Settlement Provision
Death benefits may be paid under a settlement option elected by the **Beneficiary**. Any option offered by **Us**, including a lump sum payment, may be chose by the **Beneficiary**. Benefits will not be paid under a settlement option to: an executor, an administrator, a trustee, a corporation, a partnership, or an association. The interest rate will be **our** current option rate for the year of death. The minimum rate is 3% per year.

10. The "**Life Insurance Conversion Rights**" part of the "**Employee Life Insurance Benefit**" provision in the **BENEFITS** section shall read:

You may convert **Your Life Insurance Benefit** to an individual **policy**, without evidence of insurability, as explained below. **You** must apply to convert, by written application, within 31 days of the date **your** coverage under the **Policy** ceases. **You** will be provided a written notice of **your** conversion rights at least 15 days prior to the expiration of the 31 day conversion period.

11. The following "**Second Opinion Benefit**" provision is added to the **Hospital Confinement Benefit** (if included) in the **BENEFITS** section:

Second Opinion Benefit
We will pay the applicable "**Second Opinion Benefit**" shown in the **SCHEDULE OF BENEFITS** for **Hospital** or **ICU Confinement** if:
a) An **Insured** is admitted to a **Hospital** due to an **Accident, Illness** or **Injury**;
b) The **Hospital's** utilization review program requires a second opinion from a **Physician**.

For Minnesota Residents

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

2. The 2nd paragraph of the **INTRODUCTION** section is amended by adding:

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

3. The **INTRODUCTION** section is amended by adding:

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 misstatements 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**.

4. The "**GENERAL PROVISIONS**" section of the **CERTIFICATE TABLE OF CONTENTS** is amended by adding:

Change of Beneficiary
Examination of Policy

5. The 3rd paragraph of the "**Designated Beneficiary**" part of the "**Employee Life Insurance Benefit**" provision in the **BENEFITS** section shall read:

If, on the date you die, there is no named **Beneficiary** or no living named **Beneficiary** for any part of the benefit amount, **We** will pay the proceeds to **Your** estate.

6. In the "**Legal Actions**" provision in the **GENERAL PROVISIONS** section, the time period in a. shall read "60 days" and the time period in b. shall read "3 years."

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

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 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.

For Mississippi Residents

1. In the **GENERAL PROVISIONS** section of the "**CERTIFICATE TABLE OF CONTENTS**," the heading "**Physical Examination and Autopsy**" is amended to read "**Physical Examination**."

2. The "**Notice of Claim**" provision in the **GENERAL PROVISIONS** section is amended to read:

Notice of Claim
You must give us, or an authorized agent of Ours, written notice of claim within the following time period at the address shown below:

a. 30 days after the date an Eligible Service or Supply is received.
b. 180 days after the date of death.
c. 30 days after the date of disability for Disability Income benefits.
d. 30 days after a Prescription is filled or refilled.

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, or information sufficient enough to identify the **Insured** person for whom a claim is submitted.

Symetra
P.O. Box 674419
Houston, TX 77267-4419
1-800-497-3699

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

Time Payment of Claims
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 format. Benefits due under the polices 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 preexisting condition provisions, if they are included in your plan. A "clean claim" means a claim received by **Us** for adjudication and which requires 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 from being made on the claim under this provision. 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 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, then **We** shall pay the appropriate 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 substantiating 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 to 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 owed to the **Provider**) or **You** (where the claim is owed to **You**) in a properly address, postpaid envelope, or, if not so posted or not sent by United States mail, on the date 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 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 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 in 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 entitled 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.

4. 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.

5. The time period in a. of the "**Legal Actions**" provision in the **GENERAL PROVISIONS** section shall read "60 days."

For New Hampshire Residents

1. The top of page 1 of the **Certificate** is amended to read:

HOSPITAL INDEMNITY POLICY

2. Page 1 if the **Certificate** is amended by adding:

RIGHT TO EXAMINE: THIS POLICY MAY, AT ANY TIME WITHIN 30 DAYS AFTER ITS RECEIPT BY THE POLICYHOLDER, 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 POLICY WILL BE DEEMED VOID FROM THE BEGINNING, AND ANY PREMIUM PAID ON IT WILL BE REFUNDED.

Notice to Buyer: This is a hospital indemnity certificate. This certificate provides limited benefits. Benefits are supplemental and are not intended to cover all medical expenses and does not pay benefits from loss from sickness, Review your certificate carefully.

This policy 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. Reference to "**Calendar Year**" shall be replaced with "**Policy Year**."

4. In the **DEFINITIONS** section, the definition of "**Actively at Work**" is deleted and the following terms are amended to read:

Confined/Confinement: an inpatient in a **Hospital** or other **Health Care Facility** for greater than 24 consecutive hours. **Confinement** does not include that period of time during which a **Covered Person** is in a **Hospital** emergency room, an observation room, a freestanding surgical facility or an outpatient facility.

Employee: a person who is:
a. Employed by, and paid by, the **Policyholder**.
b. An individual proprietor or partner of the **Policyholder**.

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. Primarily and continuously engaged in providing or operating either in its premises or in facilities available to the hospital on prearranged basis and under the supervision of a staff or licensed physicians, medical, diagnostic and major surgical facilities for the medical care and **Treatment** of sick or injured persons on an in-patient basis for which a charge is made;
e. Provides facilities for major surgery or has a formal arrangement with another healthcare facility for surgical facilities; and
f. Licensed to operate as a **Hospital** pursuant to law.

Hospital does not include:
a. A rest home or nursing home, home for the aged, or a convalescent home.
b. A **Nursing Facility**.
c. A **Hospice** or a place for **Custodial Care** or a **Birthing Center**.
d. A place primarily for the treatment of Substance Abuse Disorders.

Illness:
a. Physical sickness, disease or medical condition including pregnancy.
b. **Mental Disorder**, as defined under the **Policy**.
c. **Normal pregnancy and childbirth (subject to the Pregnancy Limitation Period).**
d. Complications of pregnancy.
e. Congenital abnormalities.

Mental Disorder: those neuropsychiatric, mental, or personality disorders which are listed in the International Classification of Disease as psychoses, neuroses, personality disorders, or mental and emotional disorders.

Nursing Facility does not include:
a. A facility used primarily for rest or convalescence, or a home for the aged.
b. A **Hospice** or a place for **Custodial Care** or a **Birthing Center**.
c. A place primarily for the treatment of Substance Abuse Disorders.
d. A place primarily for the treatment of **Mental Disorders**.

5. Item a. of the "**Eligible Employees**" provision in the **ELIGIBILITY FOR COVERAGE** section is deleted.

6. The 2nd to last paragraph of the "**Effective Date of Dependent Coverage**" provision in the **ELIGIBILITY FOR COVERAGE** section is deleted.

7. Item a. of the "**Change in Amounts of Benefits**" provision in the **ELIGIBILITY FOR COVERAGE** section is deleted.

8. Items a. and c. of the "**Change in Amount of Coverage**" provision in the **ELIGIBILITY FOR COVERAGE** section are deleted.

9. Item c. iii. of the "**Termination of Your Coverage**" provision in the **ELIGIBILITY FOR COVERAGE** section is deleted.

10. The "**Illness or Injury**," "**Disability**," "**Leave of Absence**," and "**Temporary Layoff**" parts of the "**Continuation of Coverage**" provision in the **ELIGIBILITY FOR COVERAGE** section are replaced by the following:

Illness or **Injury**:
If you are absent from work due to **Illness** or **Injury**, or any reason other than termination of employment due to gross misconduct or carrier termination, all of your coverage may be continued for a period of 18

consecutive months from the date your coverage otherwise would have ceased under the **Termination** provisions.

Disability:
If **You** are absent from work due to a disability, **Your** coverage may be continued for a period of 29 consecutive months from the date your coverage otherwise would have ceased under the **Termination** provisions.

Cessation of Employer Coverage:
If loss of coverage is due to termination of coverage for **Your** entire **Eligible Group**, **Your** coverage may be continued for up to 39 weeks following the date of termination of coverage for the entire **Eligible Group**.

Leave of Absence:
If you are on a documented leave of absence, all of your coverage may be continued for up to 2 months following the date your coverage otherwise would have ceased under the **Termination** provision. If the leave terminates prior to the agreed upon date, the 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 months following the date your coverage otherwise would have ceased under the **Termination** provision. If the layoff becomes permanent, this continuation will cease immediately.

Your coverage will not be continued for any Absence that occurs within thirty (30) days after another Absence for which coverage is always being continued.

Your coverage will not be continued for any Absence occurring within thirty (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.

11. The "**Termination of Dependent Coverage**" provision in the **ELIGIBILITY FOR COVERAGE** section is amended by adding:

Continuation of Coverage for Dependents
If you die while insured, **Your Dependent** may continue his or her coverage for 36 months from the date of **Your** death.

If **You** and **Your** spouse divorce or legally separate, **Your Dependent** may continue his or her coverage under the **Certificate**. Continuation for **Your Dependent** will continue for 36 months or until one of the earliest of the following occurrences:

a) The date **Your** coverage under the group **Policy** ends;
b) The third anniversary of the final divorce decree or legal separation;
c) The remarriage of the **Spouse**;
d) The death of the **Spouse**;
e) An earlier date if specified in the divorce decree or legal separation;
f) **Your** child ceases to be a **Dependent** child; or
g) Failure to pay premium within 30 days after it is due.

12. Item a. in the 2nd paragraph of the "**Portability**" provision in the **ELIGIBILITY FOR COVERAGE** section shall read:

a. **You** are no longer a member of an eligible class and are not eligible for coverage under any other "**Continuation of Coverage**" provision in this **Certificate**;

13. In the **BENEFITS** section, the "**Extension of Inpatient Hospital Benefit**" part of the "**Inpatient Hospital Benefit**" is deleted.

14. In the **BENEFITS** section, the "**Life Insurance Conversion Rights**" part of the "**Employee Life Insurance Benefit**" is deleted.

15. In the **BENEFITS** section, the "**Dependent Life Insurance Conversion Rights**" part of the "**Dependent Life Insurance Benefit**" is deleted.

16. The "**Survivor Benefit**" (if included) in the **BENEFITS** section shall read:

Survivor Benefit
Upon **Your** death, coverage may be continued for insured **Dependents**, with no **Premium** due, for all benefits, covered under the **Policy**. All **Dependent** coverage will cease on the earlies date below;

a. The date the **Insured** no longer qualifies as a **Dependent** as defined in the **Policy**.
b. The date your spouse remarries.
c. The date the **Dependent** becomes eligible for any other plan that includes inpatient hospital benefits.
d. The date **Your** spouse qualifies for **Medicare**.
e. The termination date of the **Policy**.
f. Three years from the date of **Your** death.

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

18. In the **EXCLUSIONS AND LIMITATIONS** section, items a. and x.iii. are deleted.

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

Time Payment of Claims
For claims that are submitted electronically, **We** will pay benefits within 15 days after **We** receive all essential information needed to make a determination on the claim, For claims that are submitted in paper format, **We** will pay benefits within 30 days after **We** receive all essential information **We** need to make a determination on the claim.

20. The "**Payment of Benefits**" provision in the **GENERAL PROVISIONS** section shall read:

Payment of Benefits
Benefits cannot be assigned or paid to a health care provider and must be paid directly to the insured employee. 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.

For Ohio Residents

The following is added to the face page of **Your** certificate:

Notice to Ohio Residents: Holders of Certificates furnished by any insurer to a resident of Ohio in connection with, or pursuant to any provision 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.

1. The beginning of item a. in the definition of "**Dependent**" in the **DEFINITIONS** section shall read:

a. **Your** spouse, as defined by state or federal law.

2. The definition of "**Pregnancy Limitation Period**" in the **DEFINITION** section and all other references to the "**Pregnancy Limitation Period**" in the **Certificate** are deleted.

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

4. The 2nd paragraph of the "**Employee Life Insurance Benefit**" provision in the **BENEFITS** section shall read:

If **You** die while covered for this benefit, the amount of Life Insurance, shown in the **Schedule of Benefits**, will be paid when **We** receive adequate proof of **Your** death. The proceeds will be paid, with applicable interest, to the named **Beneficiary**.

5. The 1st paragraph of the "**Life Insurance Conversion Rights**" part of the "**Employee Life Insurance Benefit**" provision in the **BENEFITS** section is amended by adding:

You will be provided a written notice of **Your** conversion rights at least 15 days prior to the expiration of the 31-day conversion period. If **You** don't receive this notice at least 15 days prior to the expiration of the conversion period, **You** will have 15 days from the date on which **You** received the notice to apply to convert **Your Life Insurance Benefit** to an individual **Policy**.

6. The "**Inpatient Hospital Benefit**" provision in the **BENEFITS** section is amended by adding:

The **Inpatient Hospital Benefit** will be paid for each day that an **Insured** that is confined to a **Hospital** for the delivery of a child, regardless if the benefits paid for the **Insured** exceeds the maximum 500 days per lifetime.

7. The "**Exclusions and Limitations**" part of the "**Preventive Care Benefit**" provision in the **BENEFITS** section is deleted.

8. The 2nd paragraph of the "**Outpatient Doctor Office Visit**" benefit provision in the **BENEFITS** section is amended by adding:

An **Outpatient Doctor Visit Benefit** will be paid for medically necessary follow-up care for a mother and newborn regardless if the benefits paid for the **Insured** or **Dependent** exceeds the number of days allowed per **Calendar Year**.

9. The **"Proof of Loss"** provision is the **GENERAL PROVISIONS** section shall read:

Proof of Loss
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. Except for **Life Insurance Benefits** (if included), 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 one year after it is due.

10. The time period in item a. of the "**Legal Actions**" provision in the **GENERAL PROVISIONS** section shall read "60 days."

For South Carolina Residents

1. The time period in a. of the "**Legal Actions**" provision in the **GENERAL PROVISIONS** section shall read "60 days."

2. The "**Physical Examination and Autopsy**" provision in the **GENERAL PROVISIONS** section is amended by adding:

The autopsy must be performed in the State of South Carolina.

For South Dakota Residents

1. In the **DEFINITIONS** section, the following terms are amended to read:

Confined: an **Inpatient** in a **Hospital** or other **Health Care Facility**.

Confinement: the period of time between admission as an inpatient and discharge.

Dentist: a person who is:
a. Licensed to practice dentistry and is operating within the scope of that license.
b. Any other **Doctor** furnishing any dental services he is licensed to perform.

Is not a person who:
a. Ordinarily resides in your household or is a member of your immediate family, unless it is the only dentist within 50 miles and the dentist is operating within the scope of his license.
b. Is employed by or affiliated with **Your Employer**.

Dental prophylaxis performed by a hygienist employed and directly supervised by a **Dentist** will be considered the same as if performed by a **Dentist**.

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 or is a member of **your** immediate family, unless it is the only dentist within 50 miles and the dentist is operating within the scope of his license.
b. Is employed by or affiliated with **your Employer**.

Inpatient: a person continued to a **Hospital** or other **Health Care Facility** for the treatment of **Illness** or **Injury**, other than **Observation Services**.

2. Items a. and g. of the "**Exclusions and Limitations**" part of the "**Disability Income Benefit**" provision in the **BENEFITS** section shall read:

a. **Illness** or **Injury** arising out of, or in the course of, any employment for wage or profit for which benefits are paid under Worker's Compensation.

g. Attempt or commission of an assault or felony at the time of loss.

3. In the "**Exclusions and Limitations**" part of the "**Accidental Death & Dismemberment Benefit**" provision in the **BENEFITS** section, item i. is deleted and items a. and e. shall read:

a. Participation in a riot, insurrection, or rebellion, or the commission of or attempting to commit an assault, battery, felony, or act of aggression at the time of loss, or illegal profession.

4. In the 3rd paragraph of the "**Inpatient Hospital Benefit**" in the **BENEFITS** section, item a. shall read:

a. The **Insured** is **Confined** in a **Health Care Facility** as an **Inpatient**.

5. Item q. in the "**Exclusions and Limitations**" part of the "**Outpatient Prescription Drug Benefit**" provision in the **BENEFITS** section shall read:

q. Drugs that can be obtained without charge under local, state or federal programs, excluding Medicaid, or which are paid for by Workers' Compensation.

6. Items x.ii and y. in the **EXCLUSIONS AND LIMITATIONS** section shall read:

x. ii. Committing or attempting to commit an assault or felony at the time of loss.

For Vermont Residents

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

THIS POLICY DOES NOT MEET THE MINIMUM ESSENTIAL 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 "**Portability**" provision (if included) in the **ELIGIBILITY FOR COVERAGE** section is deleted.

3. 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.

4. The "**Home Health Care Benefit**" (if included) in the **BENEFITS** section shall read:

Home Health Care Benefit
This benefit applies only if it is shown in the **Schedule of Benefits**.

We will pay the **Home Health Care Benefit** for each day **You** or **Your Insured Dependent** receive(s) **Home Health Care** as a result of **Illness** or **Injury**.

We will pay the **Home Health Care Benefit** only if **You** or **Your Insured Dependent** were confined in a **Hospital** as a result of **Illness** or **Injury**, and continued **Hospital** confinement would otherwise be required if **Home Health Care** is not provided. **You** or **Your Insured Dependent's Home Health Care** plan, for the same **Illness** or **Injury** for which the hospitalization occurred, must be approved in writing by a **Physician** or advanced practice registered nurse, and must be provided by a **Home Health Agency**. The **Home Health Care** must begin within 180 days of the **Illness** or **Injury**. This benefit is payable for up to 180 days per person per **Covered Accident**.

This **Home Health Care Benefit** will not be paid for the same day as an **Inpatient Hospital Benefit** or **Therapy Services Benefit**.

5. The "**Therapy Services Benefit**" (if included) in the **BENEFITS** section shall read:

Therapy Services Benefit
This benefit applies only if it is shown in the **Schedule of Benefits.**

We will pay the **Therapy Services Benefit** shown in the **Schedule of Benefits** for each day the **Insured** receives **Therapy Services** from a **Therapist** as the result of an **Illness** or **Injury**.

The therapy must be prescribed by a **Physician** or **Medical Professional**, or recommended by a **Physician** or **Medical Professional** for acupuncture, chiropractic care, occupational therapy, physical therapy, cardiac rehabilitation therapy or speech therapy. **Treatment** must begin within 30 days, and be rendered within 365 days after the **Illness** or **Injury** occurs. This benefit is payable up to 10 days per **Calendar Year** for each **Covered Person**. This benefit is only payable once per day, even if **Treatment** received for more than one **Illness** or **Injury**.

6. The "**Durable Medical Equipment Benefit**" (if included) in the **BENEFITS** section shall read:

Durable Medical Equipment
This benefit applies only if it is shown in the **Schedule of Benefits**.

We will pay the **Durable Medical Equipment Benefit** as shown in the **Schedule of Benefits** if the **Insured** rents or buys **Durable Medical Equipment** as the result of an **Illness** or **Injury**. The medical equipment must be prescribed by a **Doctor** within 180 days after the **Illness** or **Injury** occurs. This benefit is payable up to 1 time per **Calendar Year** per **Insured**.

7. The first paragraph of the **Time Payment of Claims** provision in the **GENERAL PROVISIONS** section shall read:

We will pay benefits immediately, or no more than 30 days after, all essential information needed to make a determination on the claim.

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, no more than 15 days after, all essential information needed 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

21. The 1st page of the **Certificate** is amended by adding:

THIS CERTIFICATE DOES NOT CONTAIN COMPREHENSIVE ADULT WELLNESS BENEFITS.

22. Item b. in the "**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 of entry of the final decree of adoption.

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

However, **your** child will be covered for **Inpatient Hospital 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