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SELECT BENEFITS
CRITICAL ILLNESS POLICY

Employer Name:	The Tarrant County Hospital District dba JPS Health Network
Policy Number:	12379000 - Plan 5
Effective Date of Coverage:	January 1, 2021
Policy Anniversary:	January 1

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 senior insurance counseling program.

IMPORTANT NOTICE	**AVISO IMPORTANTE**
1. To obtain information or make a complaint:	Para obtener informacion o para someter una queja
2. You may call Symetra Life Insurance Company's toll-free number for information or to make a complaint at: 1-800-497-3699	Usted puede Hamar almunero de telefono telephone gratis de Symetra Life Insurance Company's para informacion o a para someter queja al: 1-800-497-3699
3. You may also write to Symetra Life Insurance Company at: 18 Third Street East P.O. Box 440 Ashland, WI 54806	Usted tambien puedo: escribir a Symetra Life Insurance Company: 18 Third Street East P.O. Box 440 Ashland, WI 54806
4. You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at: 1-800-252-3439	Puede comunicarse con el Departamento de Seguros de Texas para obtener infonnacion acerca de companias, coberturas, derechos o quejas al: 1-800-252-3439
5. You may write the Texas Department of Insurance: P. O. Box 149104 Austin, TX 78714-9104 Fax: (512) 475-1771 Web: http://www.tdi.state.tx.us E-mail: ConsumerProtection@tdi.texas.gov	Puede escribir al Departamento de Seguros de Texas: P. O. Box 149104 Austin, TX 78714-9104 Fax: (512) 475-1771 Web: http://www.tdi.state.tx.us E-mail:ConsumerProtection@tdi.state.tx.us
6. PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact Symetra Life Insurance Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.	DISPUTAS SOBRE PRIMAS 0 RECLAMOS: Si tiene una disputa concemiente a su prima o a un reclamo, debe comunicarse con el Symetra Life Insurance Company primero. Si no se resuelve la disputa, duede entonces comunicarse con el departamento (TDI).
7. ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only does not become a part or condition of the attached document.	UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

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

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

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SCHEDULE OF BENEFITS

Eligible Class(es) for Coverage

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

Class	Description
1	All **Active Benefit Eligible Employees**, as defined by your **Employer**, who are regularly scheduled to work at least 40 hours per pay period 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 date of hire.

Annual Enrollment Period

January 1st or as determined by your **Employer** on a yearly basis.

Employee Critical Illness Benefit

- **Critical Illness Benefit** — $20,000 per category of Critical Illness

  The **Employee's** Critical Illness Benefit amount is reduced by 50% on the **Policy** anniversary date that occurs on or follows the **Employee's** 70th birthday.

- **Guaranteed Issue Amount** — $20,000
- **Recurrence Benefit** — 100% of the Critical Illness Benefit paid for the first occurrence of the same condition
- **Health Screening Benefit** — $50 per person, per **Calendar Year**

Spouse Critical Illness Benefit

- **Critical Illness Benefit** — 100% of the **Employee's** benefit per category of critical illness

  The Spouse Critical Illness Benefit amount is reduced by 50% on the **Policy** anniversary date that occurs on or follows the **Employee's** 70th birthday.

- **Guaranteed Issue Amount** — $20,000
- **Recurrence Benefit** — 100% of the Critical Illness Benefit paid for the first occurrence of the same condition
- **Health Screening Benefit** — $50 per person, per **Calendar Year**

SCHEDULE OF BENEFITS (CONTINUED)

Child Critical Illness Benefit

- **Critical Illness Benefit** — 25% of the **Employee's** benefit per category of Critical Illness

  The Child Critical Illness Benefit amount is reduced by 50% on the **Policy** anniversary date that occurs on or follows the **Employee's** 70th birthday.

- **Guaranteed Issue Amount** — $5,000

- **Recurrence Benefit** — 100% of the Critical Illness Benefit paid for the first occurrence of the same condition

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

DEFINITIONS

Accident: a sudden, unforeseen, unexpected and involuntary event definite as to time and place and which is independent of disease or bodily infirmity.

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 work day.

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

Benefit Year: the time, designated by your **Employer**, during which the benefit elections you make during annual enrollment are in effect.

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

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

Dependent: the following persons:

a. Your spouse, as defined by state law.
b. Your child who is under 26 years of age (Limiting Age).
c. Your child, who is incapable of self-support due to a disabling physical or mental impairment, provided the disabling condition occurs prior to age 26.

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

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**.

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

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

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.

Employer: the entity, named in this Certificate, who has obtained coverage under the **Policy**.

DEFINITIONS (CONTINUED)

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.

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

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

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

Provider: any doctor, health professional, hospital, 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.

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

Specialist: a person who:

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

Examples of a **Specialist** are:

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

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

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

ELIGIBILITY FOR COVERAGE

Eligible Employees

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

a. Are performing all the normal duties of your job at the normal place of business of the **Employer**.
b. 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 date on which you complete the **Service Waiting Period**.
c. 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 and submit 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 qualified life event change.

Life Event Changes:

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

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

Effective Date of Your Coverage

Your coverage becomes effective on the 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 life event change).
c. The date the next **Benefit Year** begins (if you enroll during an Annual Enrollment Period).
d. The date **Premium** is received.

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

If you have any questions about your eligibility or enrollment, contact your **Employer**.

ELIGIBILITY FOR COVERAGE (CONTINUED)

Eligible Dependents

This section applies if the **Schedule of Benefits** shows you are entitled to elect a Spouse or Child Critical Illness Benefit.

A family member is eligible for coverage under the **Policy** if all of the following conditions are met:

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

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

The Date a Dependent is Eligible for Coverage

A **Dependent** first becomes eligible to be an **Insured** on the later of:

a. The date you become eligible.
b. The date you acquire a **Dependent** such as through marriage, birth, adoption, or placement for adoption.

Enrollment

In order for a **Dependent** to become an **Insured**, you must first enroll the **Dependent** in writing and submit 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 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** child 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.

ELIGIBILITY FOR COVERAGE (CONTINUED)

If a **Dependent**, other than a newborn child, is confined to a hospital or other healthcare 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 the **Dependent** was confined for more than 31 days following the date he would otherwise become an **Insured**, you will be required to provide new evidence of the **Dependent's** insurability.

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

Continuity with Prior Coverage

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

Effective Date of Coverage

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

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

Change in Amounts of Benefits

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

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

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

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

Change in Amounts of Coverage

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

Effective Date of Change

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

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

a. You are 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.

ELIGIBILITY FOR COVERAGE (CONTINUED)

Termination of Your Coverage
Your coverage will cease on the earlier of:

a. The date the **Policy** is canceled.
b. The date your **Employer's** coverage ceases under the **Policy**.
c. The date the first of the following events occurs:

    i. Your membership in an eligible class ceases.
    ii. Your employment with your **Employer** ceases.
    iii. You are no longer **Actively at Work**.
    iv. You or your **Employer** cease to make contributions or **Premium** payments for your coverage.
    v. You are pensioned or retired, as defined by your **Employer**.
    vi. The date you begin full-time active duty as a member of the armed forces (land, water, air) of any country or international authority, except as provided under the Continuation of Coverage provision.

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

a. The date the **Policy** is canceled.
b. The date your coverage ceases.
c. The date all **Dependent** coverage ceases under the **Policy**.
d. The date the first of the following occurs:

    i. You are no longer in a class eligible for **Dependent** coverage.
    ii. The family member ceases to be an eligible **Dependent**.

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

Proof of the disabling impairment must be given to us no later than 31 days after the date your child attains the limiting age. Subsequently, we have the right to require proof of your child's impairment, but not more often than once per year after two years from the date the limiting age is attained.

Continuation of Coverage During Temporary Absence
Coverage may continue beyond the day it would otherwise cease under the Termination provisions if you are absent from work due to any of the following reasons. Any continued coverage:

a. Is subject to payment of the required **Premium**.
b. Must be requested, in writing, by your **Employer**.
c. Terminates if:

    i. The **Policy** terminates.
    ii. Your **Employer** ceases to be an **Employer** under the **Policy**.
    iii. You begin work for pay or profit with another employer.

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

ELIGIBILITY FOR COVERAGE (CONTINUED)

Illness or Injury:
If you are absent from work due to illness or **Injury**, all of your coverage may be continued for up to three consecutive months from the date you were last **Actively at Work**.

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

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

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

Sabbatical:
If you are on an employer-approved sabbatical, all of your coverage may be continued for up to one month following the date you were last **Actively at Work**. If the sabbatical terminates prior to the agreed upon date, this continuation will cease immediately.

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

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

Labor Strike/Labor Dispute:
If you are not at work due to a labor strike or dispute, all of your coverage may be continued for up to one month following the date you were last **Actively at Work**. If the labor strike or dispute ends earlier, this continuation will cease immediately.

If any of the reasons for absence above apply to you, **Dependent** coverage may continue until your coverage ends.

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 temporary absences above, provided your **Employer** provides a plan of continuation which applies to all **Employees** the same way.

ELIGIBILITY FOR COVERAGE (CONTINUED)

Post-Termination Continuation of Coverage

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

a. You were **Actively at Work** on the date your employment ceases.
b. You had been continuously covered under the **Policy** for at least 6 months prior to the date your coverage would have terminated.
c. You are under 70 years of age.
d. You are not pensioned or retired, as defined by your **Employer**.
e. You are not scheduled for immediate deployment as a full-time member of the armed services of any country.

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

Coverage may be continued up to the last day of the month in which the first of the following events occurs:

a. You have been covered under this Continuation of Coverage provision for eighteen months.
b. You begin work for pay or profit with another employer.
c. You attain 70 years of age.
d. You are pensioned or retired, as defined by your **Employer**.
e. You enter full-time active duty as a member of the armed forces (land, water, air) of any country or international authority.
f. You request, in writing, to cancel coverage.

Any continued coverage:

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

    i. The **Policy** terminates.
    ii. Your **Employer** ceases to be an **Employer** under the **Policy**.
    iii. After you have been covered under this Continuation of Coverage provision for 31 days, we terminate your coverage.

Reinstatement

If you ceased to be eligible for coverage, coverage that terminated may be reinstated if you become eligible again within 90 days from the date you were last eligible. Your reinstated coverage will be identical to the coverage you and your **Dependents** had immediately prior to termination. It will take effect on the first day of the calendar month following the date you become eligible again.

Evidence of insurability will not be required to reinstate coverage.

If you do not qualify for reinstatement within 90 days from the date you were last eligible, you will be treated as a new **Employee**.

Reemployment

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

BENEFITS

Critical Illness Benefit

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

Covered Critical Illness

Category 1 Covered Critical Illness	Percentage of Benefit Amount Payable
Invasive Cancer	100%
Minor Cancer	25%

Category 2 Covered Critical Illness	Percentage of Benefit Amount Payable
Heart Attack	100%
Stroke	100%
Coronary Artery Disease Needing Surgery or Angioplasty	25%

Category 3 Covered Critical Illness	Percentage of Benefit Amount Payable
Coma Due to Accident	100%
Occupational HIV Infection	100%
Loss of Sight	100%
Loss of Speech	100%
Loss of Hearing	100%
Major Organ Failure	100%
End Stage Renal Failure	100%
Paralysis Due to Accident	100%
Severe Burns	100%

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

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

A benefit may be payable for a different Covered Critical Illness if the dates when each of the conditions is diagnosed are separated by at least 6 months:

a. 6 months for a critical illness in the same category.
b. 6 months for a critical illness in another category.

Any benefit payable for a critical illness in the same category is limited to the difference between the following amounts:

a. 100% of the benefit amount in effect on the date when the new critical illness was diagnosed.
b. the amount of the benefit previously paid.

Covered Critical Illness Descriptions

Invasive Cancer
Invasive Cancer is defined as a malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissue. The term cancer includes leukemia, lymphoma, sarcoma, and Hodgkin's disease unless excluded below.

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

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

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

We will accept a Clinical Diagnosis of Invasive Cancer only if the following conditions are met:

i. A Pathological Diagnosis cannot be made because it is medically inappropriate or life threatening;
ii. There is medical evidence to support the diagnosis; and
iii. A **Specialist** is treating the **Insured** for Invasive Cancer.

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

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

a. All tumors which are histologically described as benign, non-malignant, pre-malignant, borderline, low malignant potential, or dysplasia (all grades) or intraepithelial neoplasia.
b. Any lesion described as carcinoma in-situ (cancer which has not spread to neighboring tissue) that is classified as (Tis) by the AJCC Staging System.
c. Any lesion classified as Ta by the AJCC Staging System.
d. All non-melanoma skin cancers unless there are distant metastases.
e. Prostate cancer that is classified as T1 by the AJCC Staging System and has a Gleason Score that is less than or equal to 6, without lymph node or distant metastasis.
f. Any skin melanoma that is less than or equal to 1.0 mm in maximum Breslow thickness, without lymph node or distant metastasis.
g. Thyroid cancer that is classified as T1 by the AJCC Staging System and is less than or equal to 2 cm in diameter, without lymph node or distant metastasis.

Minor Cancer
Minor Cancer is defined as a diagnosis of one of the following four (4) malignant cancers:

1. Carcinoma in-situ (cancer which has not spread to neighboring tissue) that is classified as (Tis) by the AJCC Staging System, of all organs except skin.
2. Malignant prostate cancer that is classified as T1 by the AJCC Staging System and has a Gleason Score that is less than or equal to 6, without lymph node or distant metastasis.

3. Malignant melanoma of that is less than or equal to 1.0 mm in maximum Breslow thickness, without lymph node or distant metastasis.
4. Malignant thyroid cancer that is classified as T1 by the AJCC Staging System and is less than or equal to 2 cm in diameter, without lymph node or distant metastasis.

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

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

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

a. All tumors which are histologically described as benign, non-malignant, pre-malignant, borderline, low malignant potential, dysplasia (all grades) or intraepithelial neoplasia;
b. Non-melanoma skin cancer;
c. Carcinoma in-situ of the skin;
d. Melanoma in-situ.

Heart Attack (Myocardial Infarction)
Heart Attack (Myocardial Infarction) is defined as the ischemic death of a portion of the heart muscle due to a blockage of one or more coronary arteries. Heart Attack is a Covered Critical Illness when it is due to: coronary artery disease, hypertension, dissection or similar disease.

Diagnosis Requirements
The diagnosis must be made by a **Specialist** and based on all three of the following criteria:

1. New clinical presentation.
2. Electrocardiographic changes consistent with an evolving Heart Attack (Myocardial Infarction).
3. Serial measurement of cardiac biomarkers in the blood showing a pattern and to a level consistent with a diagnosis of Heart Attack (Myocardial Infarction).

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

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

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

Stroke
Stroke is defined as a cerebrovascular incident resulting in irreversible death of brain tissue due to intra-cranial hemorrhage or cerebral infarction due to embolism or thrombosis in an intra-cranial vessel. Stroke is a Covered Critical Illness when it is due to: athlerothrombosis, cardioembolic disease or hypertension or similar disease.

Diagnosis Requirements
This event must result in permanent neurological functional impairment with objective neurological abnormal signs on physical examination by a **Specialist** at least 30 days after the event. The diagnosis must also be supported by findings on brain imaging and must be consistent with the diagnosis of a new Stroke.

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

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

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

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

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

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

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

Coma Due to Accident
Coma Due to Accident is defined as a coma that results from an accidental **Injury** that occurred while covered under the **Policy**.

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

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

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

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

a. Coma resulting from non-accident related causes including, but not limited to, stroke and alcohol or drug abuse.
b. Medically induced coma.

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

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

Diagnosis Requirements
All of the following conditions must be satisfied:

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

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

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

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

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

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

Diagnosis Date
The date of diagnosis is the date the diagnosis of blindness is confirmed by a **Specialist**.

Exclusions and Limitations
A Critical Illness Benefit will not be paid if the blindness is correctable by aides or surgical procedures.

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

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

Diagnosis Date
The date of diagnosis is the date the diagnosis of speech loss is confirmed by a **Specialist**.

Exclusions and Limitations
A Critical Illness Benefit will not be paid for loss of speech resulting from the following:

a. Stroke or Invasive Cancer.
b. All psychiatric causes.

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

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

Diagnosis Date
The date of diagnosis is the date the diagnosis of hearing loss is confirmed by a **Specialist** meeting the **Policy** description of Loss of Hearing.

Exclusions and Limitations
A Critical Illness Benefit will not be paid for hearing loss that is correctable with aids or surgery.

Major Organ Failure
Major Organ Failure is defined as the failure of bone marrow, heart, liver, lung, pancreas, or small bowel. The organ failure is a Covered Critical Illness when it is due to: Hypertensive Nephropathy, Cardiomyopathy or Cirrhosis or similar disease.

Diagnosis Requirements
A **Specialist** must determine that a transplant of one or a combination of the above mentioned organs is necessary to treat organ failure in the **Insured**. The **Insured** must be included on an official USA transplant waiting list such as the United Network for Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP).

Diagnosis Date
The date of diagnosis is the date the **Insured** is placed on an official transplant list or listed with the National Marrow Donor Program.

Exclusions and Limitations
If an **Insured** is on the UNOS list for a combined transplant (example: heart and lung), a single benefit will be paid.

A Critical Illness Benefit will not be paid when an **Insured**:

a. Needs a transplant of any other organs, parts of organs, tissues or cells.
b. Is registered on an official transplant list as a donor.

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

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

a. The **Insured** must undergo regular renal dialysis at least weekly.
b. The **Insured** needs a kidney transplant and is included on an official USA transplant waiting list such as the United Network for Organ Sharing (UNOS)

Diagnosis Date
The date of diagnosis is the date a **Specialist** determines that permanent regular renal dialysis is necessary or the date the **Insured** is placed on an official transplant list.

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

Paralysis Due to Accident
Paralysis Due to Accident is defined as paralysis with quadriplegia, paraplegia, hemiplegia, or diplegia, as the result of an **Accident** that occurred while covered under the **Policy.**

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

Diagnosis Date
The date of diagnosis is the date of the **Accident** that has caused the paralysis as confirmed by a **Specialist.**

Exclusions and Limitations
A Critical Illness Benefit will not be paid for paralysis resulting from causes not related to an **Accident**, including but not limited to, stroke, cancer, coma, multiple sclerosis, Parkinson's disease, ALS and other motor neuron diseases.

Severe Burns
Severe Burns is defined as having sustained third degree burns.

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

Diagnosis Date
The date a **Specialist** diagnoses the **Insured** with severe burns satisfying the Severe Burns description.

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

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

The Recurrence Benefit will be paid, as shown in the **Schedule of Benefits**, if a benefit has been paid under the **Policy** and the **Insured** is diagnosed again for the same Covered Critical Illness. All of the following conditions must be satisfied:

a. The subsequent condition is one of the Covered Critical Illnesses that qualifies for a recurrence benefit.
b. The subsequent condition satisfies the requirements as stated in the Covered Critical Illness Description and any additional conditions stated below.
c. The subsequent condition occurred and is diagnosed at least 365 days after the date of diagnosis for the paid Critical Illness Benefit.
d. The subsequent diagnosis must be made while the **Insured** is covered under the **Policy**.

The Recurrence Benefit is payable only one time for each **Insured**.

BENEFITS (CONTINUED)

Covered Critical Illness for Recurrence Benefit
The following conditions are Covered Critical Illnesses that may qualify for a Recurrence Benefit:

Invasive Cancer
Major Organ Failure
Heart Attack
Paralysis Due to Accident
Stroke
Severe Burns
Coma Due to Accident

Conditions
To qualify for a recurrence benefit the following additional conditions must be satisfied:

Invasive Cancer
If an **Insured** was paid a Critical Illness Benefit for Invasive Cancer, a Recurrence Benefit may be paid if a **Specialist** reports that the **Insured** was cancer-free and had no evidence of cancer at least 365 days since the date of diagnosis of the first cancer.

This cancer-free state must be supported with clinical, radiological, histological and laboratory evidence to confirm there was no evidence of cancer for at least 365 days after diagnosis of the first Invasive Cancer.

This recurrence benefit will pay out if the second cancer is either a recurrence of the same cancer or a new cancer that meets the description of Invasive Cancer as stated in the **Policy**.

Major Organ Failure
If an **Insured** was paid a Critical Illness Benefit for Major Organ Failure, then the Recurrence Benefit will only pay out for a second Major Organ Failure if a **Specialist** reports that the originally-claimed Major Organ Failure was no longer present at least 365 days from the date of diagnosis of the first Major Organ Failure.

This Recurrence Benefit for Major Organ Failure will pay out if the **Insured** had a transplant that was functioning well at least 365 days after the transplant, but the transplanted organ subsequently fails again meeting the diagnosis requirements of Major Organ Failure as stated in the **Policy**.

This Recurrence Benefit will not cover failure of a second different major organ if a **Specialist** says that the first organ failure was still present 365 days after diagnosis of the first Major Organ Failure.

Heart Attack, Stroke, Coma Due to Accident, Paralysis Due to Accident, Severe Burns
If an **Insured** was paid a Critical Illness Benefit for any of the other critical illnesses listed under this Recurrence Benefit, then the second diagnosis must be a new acute event with a new diagnosis of the same critical illness and again meets the diagnosis requirements of the same critical illness.

Exclusions and Limitations
A Recurrence Benefit will not be paid when:

a. An **Insured** has already received payment for one Recurrence Benefit.
b. A subsequent diagnosis is made for Minor Cancer, Coronary Artery Disease Needing Surgery or Angioplasty, or any other critical illness that does not qualify for a recurrence benefit.

Health Screening Benefit

This benefit applies to you and your spouse only if it is shown in the **Schedule of Benefits**. The Health Screening Benefit does not apply to a dependent child.

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

Tests to screen for Cancer

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

Tests to screen for Heart-related Disease

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

Tests to screen for Organ-related Disease

a. Fasting blood glucose test

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

EXCLUSIONS AND LIMITATIONS

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

Exclusions

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

a. Diagnosed before the **Insured** is covered under the **Policy**.
b. Diagnosed after the **Insured's** coverage terminates, except as provided under the **Policy**.
c. Not diagnosed by a **Specialist**.
d. Diagnosed by a physician outside the United States.
e. Diagnosed more than once while covered under the **Policy**, except as provided under the Recurrence Benefit.
f. Contributed to or caused by: another Covered Critical Illness, a complication of another critical illness, or treatment of another critical illness for which the **Insured** has been paid a benefit under the **Policy**.
g. Caused wholly or partly, directly or indirectly by:

    i. Declared or undeclared war or act of war.
    ii. Committing or attempting to commit an assault or felony.
    iii. Inciting or taking part in any form of public violence.
    iv. Intentionally self-inflicted **Injury**, while sane or insane.
    v. Full-time active duty as a member of the armed forces (land, water, air) of any country or international authority.
    vi. Being intoxicated or under the influence of alcohol, drugs or any narcotic (including overdose) unless as prescribed by or administered by a physician.
    vii. Alcoholism or drug addiction.

GENERAL PROVISIONS

Notice of Claim
You must give us written notice of claim within the following time period:

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

If you are not able to notify us within the applicable time period, then you must notify us as soon as reasonably possible. Your notice must include the claimant's name, address and the Policy Number.

Claim Forms
Within 15 days of receiving a notice of claim, we will send you 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 we 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:

    i. The date the Covered Critical Illness began.
    ii. The cause of the Covered Critical Illness.
    iii. Satisfaction of the diagnosis requirements for the Covered Critical Illness.

c. The names and addresses of all **Specialists** and other health care **Providers** for the Covered Critical Illness.
d. Your signed authorization for us to obtain and release medical information.
e. Any additional information required by us to make a determination on the claim.

All proof submitted must be satisfactory to us.

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

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

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

Time Payment of Claims
We will pay benefits within 5 business days after we receive all essential information needed to make a determination on the claim.

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

a. You.
b. Your legally appointed guardian if you are not legally able to accept such benefits.
c. Your estate, in the event any payment is owed at the time of your death.
d. "All benefits paid on behalf of the child or children under the policy must be paid to the Texas Department of Human Services" whenever:

   i. the Texas Department of Human Services is paying benefits under the Human Resources Code, Chapter 31 or Chapter 32, i.e., financial and medical assistance service programs administered pursuant to the Human Resources Code; and
   ii. the parent who is covered by the group policy has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support.

Any payment made in good faith fully discharges us to the extent of that payment.

Physical Examination and Autopsy
We, at our own expense, have the right to have you examined as often as we may reasonably require while a claim is pending, and to require an autopsy in the case of death, unless it is forbidden by law.

Examination of Specialist's Records
We may, at our expense, examine your **Specialist's** or other **Provider's** records as often as reasonably necessary while a claim pending.

Right to Appeal a Denied Claim
If you disagree with a decision on a claim, you or your representative may, within 180 days of receiving an initial denial notice appeal the decision by submitting a written request to:

Symetra Life Insurance Company
118 Third Street East
P.O. Box 440
Ashland, WI 54806
1-800-497-3699

Your written request should include:

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

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

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

a. Until 180 days have elapsed after **Proof of Loss** has been filed; or
b. After 3 years from the end of the time within which **Proof of Loss** is required by the **Policy**.

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: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿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 sucompañía 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: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091