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SCHEDULED BENEFIT ACCIDENT GROUP INSURANCE POLICY

Employer Name:	The Tarrant County Hospital District dba JPS Health Network
Policy Number:	12379000 - Plan 2
Effective Date of Coverage:	January 1, 2021

CERTIFICATE OF COVERAGE

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**.

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 an accident insurance policy. It does not pay benefits for losses caused by sickness. 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.

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

CERTIFICATE TABLE OF CONTENTS

SCHEDULE OF BENEFITS 5

DEFINITIONS 9

ELIGIBILITY FOR COVERAGE 14
Eligible Employees 14
The Date You Are Eligible for Coverage 14
Enrollment 14
Life Event Changes 14
Effective Date of Your Coverage 14
Eligible Dependents 14
The Date a Dependent is Eligible for Coverage 15
Enrollment 15
Effective Date of Dependent Coverage 15
Change in Amounts of Benefits 15
Change in Amounts of Coverage 16
Termination of Your Coverage 16
Termination of Dependent Coverage 16
Continuation of Coverage 17
Illness or Injury 17
Leave of Absence 17
Temporary Layoff 17
Reinstatement 17
Extension of Coverage 18
Qualifying Events 18
Notification and Election 18
Period of Extension 18
Termination 18

BENEFITS 19
Ambulance Transportation Benefit 19
Emergency Room Benefit 19
Major Diagnostic Testing Benefit 19
Pain Management / Epidural Benefit 19
Initial Doctor Visit Benefit 19
X-Ray Benefit 20
Hospital Admission Benefit 20
Intensive Care Unit (ICU) Admission Benefit 20
Hospital Confinement Benefit 20
Intensive Care Unit (ICU) Confinement Benefit 21
Rehabilitation/Skilled Nursing Benefit 21
Blood/Plasma/Platelets Benefit 22
Surgery Benefit 22
Outpatient/Miscellaneous Surgery Benefit 22
Transportation Benefit 22
Family Lodging Benefit 23
Coma Benefit 23
Follow Up Doctor's Visit Benefit 23
Physical Therapy Benefit 23
Chiropractic Visit Benefit 24
Medical Equipment Benefit 24
Prosthetic Device Benefit 24
Burn Benefit 24
Paralysis Benefit 24
Lacerations Benefit 24

CERTIFICATE TABLE OF CONTENTS

Emergency Dental Work Benefit 25
Eye Injury Benefit 25
Specific Injury Benefit 25
Dislocations Benefit 25
Fractures Benefit 25
Accidental Death Benefit 26
Common Carrier Accidental Death Benefit 26
Accidental Dismemberment Benefit 26

EXCLUSIONS AND LIMITATIONS 27

GENERAL PROVISIONS 28
Notice of Claim 28
Claim Forms 28
Proof of Loss 28
Time Payment of Claims 28
Payment of Benefits 28
Physical Examination and Autopsy 29
Right To Appeal a Denied Claim 29
Legal Actions 29
Entire Contract 29
Statements 29
Time Limit on Certain Defenses 29
Workers' Compensation 29

CHILD ORGANIZED SPORT ACTIVITY BENEFIT(S) RIDER 1

WELLNESS SCREENING BENEFIT(S) RIDER 1

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 and Dependent Benefits

Scheduled Accident Benefits

➢ **Emergency Care & Diagnostics**	Employee	Dependent Spouse	Dependent Child
Ambulance – Ground	$250	$250	$250
Ambulance – Air	$1,500	$1,500	$1,500
Emergency Room	$200	$200	$200
Major Diagnostic Testing (MRI, CT Scan, CAT, EEG)	$150	$150	$150
X-Ray	$50	$50	$50
Pain Management/Epidural	$75	$75	$75
Initial Doctor's Visit	$75	$75	$75

➢ **Accident Hospitalization & Surgical Benefits**	Employee	Dependent Spouse	Dependent Child
Hospital Admission	$1,250	$1,250	$1,250
ICU Admission	$2,500	$2,500	$2,500
Hospital Confinement (per day up to 365 days per Accident)	$250	$250	$250
ICU Confinement (per day up to 30 days per Accident)	$500	$500	$500
Rehabilitation/Skilled Nursing Facility (per day up to 90 days per Accident)	$125	$125	$125
Blood/Plasma/Platelets	$400	$400	$400
Surgery			
– open abdominal, thoracic	$2,000	$2,000	$2,000
– cranial	$2,000	$2,000	$2,000
– hernia	$1,000	$1,000	$1,000
– exploratory or without repair	$300	$300	$300
Outpatient/Miscellaneous Surgery	$300	$300	$300
Transportation (per trip)	$400	$400	$400
Family lodging (per night, up to 30	$100	$100	$100

SCHEDULE OF BENEFITS

days per accident)			
Coma (paid after 7 day duration)	$6,000	$6,000	$6,000
➢ **Follow Up Care**	Employee	Dependent Spouse	Dependent Child
Follow up Doctor's Visit	$75	$75	$75
Physical Therapy (up to 10 visits per Accident)	$50	$50	$50
Chiropractic Visit (up to 10 visits per Accident)	$50	$50	$50
Medical Equipment	$250	$250	$250
Prosthetic Device	$2,000	$2,000	$2,000
➢ **Burns – Second Degree**	Employee	Dependent Spouse	Dependent Child
20 – 100 square centimeters	$75	$75	$75
101 – 225 square centimeters	$150	$150	$150
More than 225 square centimeters	$600	$600	$600
➢ **Burns – Third Degree**	Employee	Dependent Spouse	Dependent Child
20 – 100 square centimeters	$650	$650	$650
101 – 225 square centimeters	$4,000	$4,000	$4,000
More than 225 square centimeters	$15,000	$15,000	$15,000
Skin Grafts	25% of burn amount		
➢ **Paralysis**	Employee	Dependent Spouse	Dependent Child
Quadriplegia	$15,000	$15,000	$15,000
Paraplegia	$7,500	$7,500	$7,500
Hemiplegia	$7,500	$7,500	$7,500
Uniplegia	$3,750	$3,750	$3,750
➢ **Lacerations**	Employee	Dependent Spouse	Dependent Child
Lacerations not requiring sutures	$40	$40	$40
Under 3 inches, requiring sutures	$70	$70	$70
3 to 6 inches, requiring sutures	$125	$125	$125
Over 6 inches, requiring sutures	$300	$300	$300
➢ **Emergency Dental Work**	Employee	Dependent Spouse	Dependent Child
Crown Repair	$150	$150	$150
Extraction	$75	$75	$75
➢ **Eye Injuries**	Employee	Dependent Spouse	Dependent Child
Removal of foreign object	$40	$40	$40
Surgical Repair	$200	$200	$200
➢ **Specific Injuries**	Employee	Dependent Spouse	Dependent Child
Ruptured Disc	$400	$400	$400

Tendons/Ligaments			
– one tear with surgical repair	$650	$650	$650
– two or more tears with surgical repair	$900	$900	$900
– arthroscopic surgery with no repair	$200	$200	$200
Torn Knee Cartilage			
– exploratory surgery with no repair	$200	$200	$200
– surgical repair	$650	$650	$650
Concussion	$200	$200	$200

➢ **Dislocations (closed reduction)**	Employee	Dependent Spouse	Dependent Child
Hip	$4,000	$4,000	$4,000
Knee (except patella)	$1,600	$1,600	$1,600
Shoulder	$1,600	$1,600	$1,600
Foot/Ankle (except toes)	$1,600	$1,600	$1,600
Wrist	$1,600	$1,600	$1,600
Lower Jaw	$1,600	$1,600	$1,600
Elbow	$1,600	$1,600	$1,600
Bones of the Hand (except fingers)	$800	$800	$800
Collarbone	$800	$800	$800
Two or more fingers	$300	$300	$300
Two or more toes	$300	$300	$300
One finger or toe	$125	$125	$125

Open Reduction Dislocation Benefit	200% of dislocation benefit
Partial Dislocation Benefit	25% of dislocation benefit

➢ **Fractures (closed reduction)**	Employee	Dependent Spouse	Dependent Child
Skull (depressed)	$4,000	$4,000	$4,000
Skull (non-depressed)	$4,000	$4,000	$4,000
Hip/Thigh	$4,000	$4,000	$4,000
Vertebral Body (excluding vertebral processes)	$4,000	$4,000	$4,000
Pelvis	$4,000	$4,000	$4,000
Arm (upper, includes elbow)	$2,500	$2,500	$2,500
Shoulder Blade	$2,500	$2,500	$2,500
Leg	$2,500	$2,500	$2,500
Vertebral Processes	$1,600	$1,600	$1,600
Knee Cap	$1,600	$1,600	$1,600
Collarbone	$1,600	$1,600	$1,600
Forearm (below elbow)	$1,600	$1,600	$1,600
Foot/Ankle (except toes)	$1,600	$1,600	$1,600
Hand/Wrist	$1,250	$1,250	$1,250
Lower Jaw	$1,250	$1,250	$1,250
Upper Jaw	$1,600	$1,600	$1,600
Ribs (two or more)	$750	$750	$750
Facial Bones or Nose	$750	$750	$750
One rib, finger, or toe	$300	$300	$300
Coccyx	$300	$300	$300

Open Reduction Fracture Benefit	200% of fracture benefit
Bone Chip Fracture Benefit	25% of fracture benefit

SCHEDULE OF BENEFITS

Catastrophic Accident Benefits	Employee	Dependent Spouse	Dependent Child
Accidental Death	$50,000	$25,000	$12,500
Common Carrier Accidental Death	$100,000	$50,000	$25,000

- **Dismemberment Benefits**

Double Dismemberment (loss of both hands, both feet, or sight in both eyes)	$50,000	$25,000	$12,500
Loss of Speech or Hearing in both ears	$25,000	$12,500	$6,250
Loss of one hand and one foot	$50,000	$25,000	$12,500
Loss of one eye	$25,000	$12,500	$6,250
Loss of one hand or one foot	$25,000	$12,500	$6,250
Loss of two or more fingers or toes	$10,000	$5,000	$2,500
Loss of one finger or toe	$2,500	$1,250	$625

RIDER(S)

Wellness Screening Test Benefit
Child Organized Sport Activity Benefit

Miscellaneous Goods and Services

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

DEFINITIONS

Accident: a sudden, unforeseen, unexpected and involuntary event definite as to time and place and which is independent of disease or bodily infirmity. In order for benefits under the **Policy** to be payable, the **Accident** must occur while the **Insured's** coverage is inforce.

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.

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.

Coma: a state of profound unconsciousness with no evidence of appropriate responses to stimulation. **Coma** does not include a medically induced **Coma**.

Common Carrier: any air, land or water motorized conveyance operated under a license for the transportation of fare-paying passengers, including ridesharing programs. **Common Carrier** does not include courtesy transportation for which a charge is not made or cruise ships at sea more than 12 consecutive hours or any conveyance, regardless of whether the conveyance is licensed that is hired or used for a sport, gamesmanship, contest, or recreational activity. These conveyances can include, but are not limited to, race cars, bobsleds, hunting vehicles, sightseeing vehicles, helicopters, fishing boats, parasails, paragliders, and boat cruises operating beyond 12 hours.

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

Confinement: the period of time between admission and discharge.

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.

DEFINITIONS

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** unmarried child, who is incapable of self-support due to a disabling physical or mental impairment, provided the disabling condition occurs prior to age 26.

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

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

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

Is not a person who:

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

Durable Medical Equipment: equipment that is made to:

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

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 a **Employer** and for any eligible **Employees** and **Dependents**.

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

Eligible Services or Supplies: those services or supplies received by an **Insured** for treatment of a covered **Injury** 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:

a. Employed by, and paid by, the **Employer**;
b. Working under exclusive contract with, and paid by, the **Employer**;
c. An individual proprietor or partner of the **Employer**.

DEFINITIONS

Health Care Facility:

a. A **Hospital**.
b. A **Hospital Intensive Care Unit**.
c. A licensed **Nursing Facility**.

Hospital: a licensed healthcare facility that:

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

Hospital does not include:

a. A rest home or nursing home, home for the aged, or convalescent home.
b. A **Nursing Facility**.
c. A **Hospice** or a place for **Custodial Care** or a **Birthing Center**.
d. A place, including a section or wing/ward of a **Hospital**, primarily for the treatment of **Substance Abuse Disorders**.
e. A place, including a section or wing/ward of a **Hospital**, 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, including any condition, whether or not a pregnancy is terminated, that requires **Hospital Confinement** and whose diagnosis is distinct from pregnancy but is adversely affected or caused by 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.

DEFINITIONS

Loss: with regard to:

a. Hands and feet, means actual severance through or above wrist or ankle joints;
b. Speech and hearing, means entire and irrecoverable loss thereof;
c. Eye, means total and irrevocable loss of sight that cannot be medically or surgically treated by artificial means;
d. Thumb or finger, actual severance through or above the metacarpophalangeal joints.

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**.

Observation Services: services provided in a **Hospital** and given by a member of the **Hospital** medical staff to help determine the severity of the patient's condition.

Paralysis: the complete and permanent loss of use of one or more limbs through neurological **Injury** due to an **Accident** for a continuous period of at least 180 days, confirmed by a **Doctor**. **Paralysis** as a result of stroke is excluded.

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

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

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

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**.

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.

DEFINITIONS

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

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.

We, Us, Our: Symetra Life Insurance Company.

Workers' Compensation: insurance against liability imposed on certain employers to pay insurance benefits and furnish care to **Employees** injured, and to pay benefits to **Dependents** of **Employees** killed in the course of or arising out of their employment.

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

ELIGIBILITY FOR COVERAGE

Eligible Employees

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

a. **You** are 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 or a domestic partner.
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, other than a change of residence or not being claimed as a **Dependent** on **Your** last filed income tax return.
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 date of employment 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 from the date **You** first become eligible).
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**.

ELIGIBILITY FOR COVERAGE

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

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

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

Enrollment
In order for a **Dependent** to become an **Insured**, **You** must first enroll the **Dependent** in writing on a form approved by **Us** giving the information **We** require. **You** may enroll a **Dependent** at the 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 date of employment 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).
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.

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

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 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 or a **Loss** occurs.

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 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 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 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.

ELIGIBILITY FOR COVERAGE

See "Continuation of Coverage" provision 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 a **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 an **Illness** or **Injury**, all of **Your** coverage may be continued for a period of up to six 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 two 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 two 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 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 90 days from the date **You** were last eligible. **Your** reinstated coverage will take effect on the first day of the calendar month following the date in **You** become eligible again. If **You** do not qualify for reinstatement within 90 days from the date **You** were last eligible, **You** will be treated as a new **Employee**.

ELIGIBILITY FOR COVERAGE

Extension of Coverage

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

Qualifying Events

You qualify for extension of coverage if **You** would otherwise lose group coverage for accident 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 accident benefits because of any of the following events:

a. **You** lose group coverage for accident 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 accident 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 accident benefits with your **Employer** will end.

Period of Extension

You have the option to continue coverage for **Yourself** and/or **Your** covered **Dependents** for 18 months, 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 accident 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 accident 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.

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

BENEFITS

Ambulance Transportation Benefit
We will pay the Ambulance Transportation Benefit, as shown in the **Schedule of Benefits**, if the **Insured** requires transportation by a licensed ground or air ambulance service from the place where he is **Injured,** or from where **Injury** necessitates transport, to the nearest accredited **Hospital** where adequate facilities for treatment are available. Benefits are also payable for ambulance transportation between medical facilities if necessary for appropriate treatment of **Injuries** received in an **Accident**. Air ambulance transportation must be within 96 hours of the **Accident**. Ground ambulance transportation must be within 90 days of the **Accident**. This benefit is payable for one trip per **Accident** per **Insured**.

Emergency Room Benefit
We will pay the Emergency Room Benefit, as shown in the **Schedule of Benefits**, for if the **Insured** is treated in an **Emergency Room** for an **Injury** that occurs while the **Insured** is covered for this benefit. **Emergency Room** services must be incurred within 30 days from the date of the **Accident**. The **Emergency Room** Benefit is payable one time per **Accident** per **Insured**.

Major Diagnostic Testing Benefit
We will pay the Major Diagnostic Testing Benefit, as shown in the **Schedule of Benefits**, if the **Insured** undergoes any of the following major diagnostic tests as the result of **Injury**. Such test must be administered or performed by a **Provider** within 365 days of the **Accident**. The benefit is payable for any one of the following tests:

a. Magnetic Resonance Imaging (MRI)
b. Computed Tomography (CT, Cat Scan)
c. Electrocardiogram (EKG)
d. Electroencephalogram (EEG).

This benefit is payable one time per **Accident** per **Insured**.

Pain Management / Epidural Benefit
We will pay the Pain Management / Epidural Benefit, as shown in the **Schedule of Benefits** if the **Insured** receives medical pain management services, including the application of epidural injections, for treatment of **Injury**. Services must be administered or performed by a **Provider** within 365 days of the **Accident**. Services may be provided at the **Doctor's** office, an outpatient **Hospital** clinic or **Urgent Care** facility. This benefit is payable once per **Accident** per **Insured**.

Initial Doctor Visit Benefit
We will pay the Initial Doctor Visit Benefit, as shown in the **Schedule of Benefits**, for the first day an **Insured** received treatment from a **Doctor** for an **Injury**. The initial visit must occur within 365 days of the **Accident**. Services may be provided at the **Doctor's** office, an outpatient **Hospital** clinic or **Urgent Care** facility.

Exclusions and Limitations
No Initial Doctor Visit Benefit will be paid for:

a. Care received in an **Emergency Room**.
b. **Inpatient** or **Outpatient** surgical procedures.
c. Diagnostic X-ray and laboratory tests.

This benefit is payable only once per **Accident** per **Insured**. This benefit is not payable on any day for which the **Emergency Room** benefit is also payable for the same **Insured**.

BENEFITS

X-Ray Benefit
We will pay the X-Ray Benefit shown in the **Schedule of Benefits** if the Insured requires an x-ray as a result of an **Injury**. Such test must be administered or performed by a **Provider** within 365 days of the **Accident**. This benefit is payable only once a day, up to one day per **Accident** per **Insured**.

Hospital Admission Benefit
We will pay the Hospital Admission Benefit, as shown in the **Schedule of Benefits**, for the first calendar day that the **Insured** is **Confined** as the result of an **Injury** and the **Insured** is admitted to a **Hospital** for **Observation Services** or for any other reason for a minimum of 24 consecutive hours or a charge is made for room and board. **Hospital** admission must occur within 365 days from the date of the **Accident**. This benefit is payable one time per **Accident** per **Insured**.

The Hospital Admission Benefit is a separate benefit and will be paid regardless of any other Hospital Benefits available.

Exclusions and Limitations
No Hospital Admission Benefit will be paid for admission to:

a. An **Emergency Room**.
b. An outpatient **Hospital** facility or clinic or **Urgent Care** facility.
c. Any other portion of a **Hospital** which provides services that do not require **Confinement**.

Intensive Care Unit (ICU) Admission Benefit
We will pay the Intensive Care Unit (ICU) Benefit, as shown in the **Schedule of Benefits**, for the first calendar day that the **Insured** is **Confined** to an **ICU** as the result of an **Injury** and the **Insured** is admitted for **Observation Services** or for any other reason for a minimum of 24 hours, or a charge is made for room and board. **ICU** admission must occur within 365 days from the date of the **Accident**. This benefit is payable one time per **Accident** per **Insured**.

The Intensive Care Unit (ICU) Admission Benefit is a separate benefit and will be paid regardless of any other Intensive Care Unit (ICU) benefits available.

Exclusions and Limitations
No Intensive Care Unit (ICU) Admission Benefit will be paid for admission to:

a. An **Emergency Room**.
b. An outpatient **Hospital** facility or clinic or **Urgent Care** facility.
c. Any other portion of a **Hospital** which provides services that do not require **Confinement**.

Hospital Confinement Benefit
We will pay the Hospital Confinement Benefit, as shown in the **Schedule of Benefits**, if the **Insured** is **Confined** in a **Hospital** for treatment of an **Injury**.

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

a. The **Insured** is **Confined** in a **Hospital** for **Observation Services** or for any other reason for a minimum of 24 consecutive hours;
b. The **Hospital** is operating within the scope of its license;
c. A charge is made for room and board;
d. **Hospital Confinement** begins within 365 days from the date of the **Accident**;
e. The entire duration of **Confinement** is recommended and approved by a **Doctor**;
f. The **Confinement** is the result of an **Injury**.

Exclusions and Limitations
Hospital Confinement Benefits will not be paid for:

a. Care received in an **Emergency Room**;
b. Care received in an outpatient **Hospital** facility or clinic or **Urgent Care** facility;
c. Care in any other portion of a **Hospital** which provides services that do not require **Confinement**;
d. **Inpatient** or **Outpatient** surgical procedures.

Intensive Care Unit (ICU) Confinement Benefit

We will pay the ICU Confinement Benefit, as shown in the **Schedule of Benefits**, if the **Insured** is **Confined** in an **ICU** for treatment of an **Injury**.

ICU Confinement Benefits will be paid only if all of the following are met:

a. The **Insured** is **Confined** in an **ICU** for a minimum of 24 consecutive hours;
b. The **ICU** is operating within the scope of its license;
c. A charge is made for room and board;
d. **ICU Confinement** begins within 365 days from the date of the **Accident**;
e. The entire duration of **Confinement** is recommended and approved by a **Doctor**;
f. The **Confinement** is the result of an **Injury**.

Exclusions and Limitations
ICU 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 in any other portion of a **Hospital** which provides services that do not require **Confinement**.

Rehabilitation/Skilled Nursing Benefit

We will pay the Rehabilitation/Skilled Nursing Benefit, as shown in the **Schedule of Benefits**, when the **Insured** is **Confined** in a **Rehabilitation Facility** or **Skilled Nursing Facility** for treatment of an **Injury**. Rehabilitation/Skilled Nursing Benefits will be paid only if all of the following are met:

a. The **Insured** is **Confined** in a **Rehabilitation Facility** or **Skilled Nursing Facility** for a minimum of 24 hours;
b. The **Rehabilitation Facility** or **Skilled Nursing Facility** is operating within the scope of its license;
c. A charge is made for room and board;
d. **Confinement** begins within 365 days from the date of the **Accident**;
e. The entire duration of **Confinement** is recommended and approved by a physician;
f. The **Confinement** is the result of an **Injury**.

Exclusions and Limitations
Rehabilitation Facility Extension or Skilled Nursing Facility 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 in any other portion of a **Hospital** which provides services that do not require **Confinement**;
d. **Inpatient** or **Outpatient** surgical procedures.

BENEFITS

Blood/Plasma/Platelets Benefit

We will pay the Blood/Plasma/Platelets Benefit as shown in the **Schedule of Benefits** for each day an **Insured** receives a transfusion of blood, plasma, or platelets during a surgical procedure for which a benefit is payable under this **Policy**. This benefit is payable once per **Injury**. This benefit is only payable once per day, even if more than one surgical procedure involving a transfusion occurs.

Surgery Benefit

We will pay the Surgery Benefit, as shown in the **Schedule of Benefits** based on the type of surgical procedure that is performed. It will be paid for the calendar day an **Insured** undergoes an **Inpatient** surgical procedure performed in connection with an **Injury** while the **Insured** is covered under this benefit. Such surgical procedure must be performed within 365 days from the date of the **Accident**.

If more than one type of surgical procedure is performed on the same calendar day, the benefit paid will be based on the surgical procedure that provides the largest benefit amount.

Outpatient/Miscellaneous Surgery Benefit

We will pay the Outpatient/Miscellaneous Surgery Benefit, as shown in the **Schedule of Benefits** for each day an **Insured** undergoes **Outpatient** surgical procedure or an **Inpatient** surgical procedure not otherwise covered by the **Policy**. Surgery must be required due to an **Injury** and must be performed within 365 days from the date of the **Accident**.

If more than one type of surgical procedure is performed on the same calendar day, the benefit paid will be based on the surgical procedure that provides the largest benefit amount. This benefit is payable only one time per **Accident** per **Insured**.

Transportation Benefit

We will pay the Transportation Benefit, as shown in the **Schedule of Benefits** for each day an **Insured** must travel to or from a **Health Care Facility** more than 50 miles away from the **Insured's** primary residence for medical treatment of an **Injury**.

The travel must occur within 365 days after the date of the **Accident**. This benefit is payable for three trips per **Accident** for each **Insured**.

Mileage is measured as the shortest distance from the **Insured's** primary residence to the **Health Care Facility**. This benefit will not be paid for any form of ambulance transportation, nor will it be paid for any day for which an Ambulance Transportation Benefit is payable.

BENEFITS

Family Lodging Benefit

We will pay the Family Lodging Benefit as shown in the **Schedule of Benefits** for each day an expense is incurred for lodging by an adult family member or adult companion accompanying an **Insured** who is **Confined**, as the result of an **Injury**, more than 50 miles away from the **Insured's** primary residence.

This benefit is payable up to 30 nights per **Accident** for each **Insured**. This benefit is only payable once per day, even if the **Confinement** is the result of more than one **Injury**.

This benefit is only payable:

a. If the adult family member or adult companion is providing care for the **Insured** or is acting as an advocate on the behalf of an **Insured** while the **Insured** is receiving care;
b. The place where the companion is lodging is a hotel, motel or similar place that provides lodging for travelers for a charge;
c. For a **Confinement** for which a benefit is payable for an **Insured** under the **Policy**;
d. If the same or similar **Confinement** is not available within 50 miles of the **Insured's** primary residence; and
e. Lodging occurs within 365 days from the date of the **Accident**.

Mileage is measured as the shortest distance from the **Insured's** primary residence to the facility at which the **Confinement** occurs.

Coma Benefit

We will pay the Coma Benefit as shown in the **Schedule of Benefits** if an **Insured** lapses into a **Coma** as the result of and within 365 days of the **Injury**, and such **Coma** has lasted for a minimum of seven days. The **Insured** must be **Confined** in a **Health Care Facility** and must be under the care of a **Doctor**.

Follow Up Doctor's Visit Benefit

We will pay the Follow up Doctor's Visit Benefit, as shown in the **Schedule of Benefits**, for each day the **Insured** has a follow up visit with a **Doctor** for treatment of an **Injury**. Services may be provided at the **Doctor's** office, an outpatient **Hospital** clinic or **Urgent Care** facility and occur after initial treatment in a **Doctor's** office or **Emergency Room**. Benefits are payable for no more than one follow up visit for the same **Injury**. Follow up **Doctor** visits must begin within 365 days from the date of the **Accident** and must be complete within 1 year from the date of the **Accident**.

Exclusions and Limitations
No Follow up Doctor's Visit Benefit will be paid for:

a. Care received in an **Emergency Room**.
b. Physical therapy.
c. Chiropractic care.
d. **Inpatient** or **Outpatient** surgical procedures.
e. Diagnostic X-ray and laboratory tests.

Physical Therapy Benefit

We will pay the Physical Therapy Benefit as shown in the **Schedule of Benefits**, for any calendar day the **Insured** receives physical therapy in a **Health Care Facility** as the result of an **Injury** that occurs while the **Insured** is covered for this benefit. Physical therapy must begin within 365 days after the date of the **Accident**.

BENEFITS

Chiropractic Visit Benefit
We will pay the Chiropractic Visit Benefit as shown in the **Schedule of Benefits**, for any calendar day the **Insured** receives chiropractic care as the result of an **Injury** that occurs while the **Insured** is covered for this benefit. Chiropractic care must begin within 365 days after the date of the **Accident** and must be ordered by a **Doctor**.

Medical Equipment Benefit
We will pay the Medical Equipment Benefit as shown in the **Schedule of Benefits** if the **Insured** rents or buys **Durable Medical Equipment** as the result of an **Injury**. The medical equipment must be prescribed by a **Doctor** within 365 days after the **Injury** occurs. This benefit is payable up to one time per **Accident** per **Insured**.

Prosthetic Device Benefit
We will pay the Prosthetic Device Benefit as shown in the **Schedule of Benefits** for a prosthetic device the **Insured** purchases as the result of an **Injury**. The prosthetic device must be prescribed by a **Doctor** within 365 days after the **Injury** occurs. This benefit is payable once per **Accident** per **Insured**, regardless of the number of prostheses the **Insured** requires.

Exclusions and Limitations
No Prosthetic Device Benefit will be paid for:

a. Hearing aids.
b. Wigs.
c. Dental aids, including false teeth.
d. The repair or replacement of prosthetic devices unless the prosthetic device is damaged during an **Accident**.

Burn Benefit
We will pay the Burns Benefit, as shown in the **Schedule of Benefits** if the **Insured** sustains second or third degree burns due to an **Accident**. Benefits are based on the severity of the burn and the area of the body indicated. Only one Burn Benefit is payable for each **Accident** per **Insured**. If the **Insured** sustains multiple burns as the result of the same **Accident**, **We** will pay the highest benefit for which the **Insured** is eligible.

Paralysis Benefit
We will pay the Paralysis Benefit, as shown in the **Schedule of Benefits**, if the **Insured** becomes **Paralyzed** due to an **Accident**. The benefit amount is based on the type of **Paralysis** indicated. The Paralysis Benefit is payable only once per **Insured**. **Paralysis** must be diagnosed by a **Doctor** within 365 days from the date of the **Accident**.

Lacerations Benefit
We will pay the Lacerations Benefit, as shown in the **Schedule of Benefits**, if the **Insured** sustains a laceration as the result of an **Accident**. The benefit amount is based on the type of laceration indicated. Lacerations Benefit amount paid will be per laceration. Only one Laceration Benefit is payable per **Accident**, per **Insured**; however, if the **Insured** sustains multiple lacerations, the benefit amount applicable to the total length of all lacerations will be paid. The lacerations must be repaired by a **Doctor** within 96 hours after the **Accident**.

BENEFITS

Emergency Dental Work Benefit
We will pay the Emergency Dental Work Benefit, as shown in the **Schedule of Benefits**, if the **Insured** requires the following emergency dental treatment as the result of an **Accident**:

a. Repair of a broken sound, natural tooth with a crown; or
b. Extraction of a broken sound, natural tooth.

The benefit amount is based on the type of procedure indicated.

The dental work must occur within 365 days after the **Accident**. Only one Emergency Dental Benefit Amount is payable per **Accident** per **Insured** regardless of the number of teeth involved. Emergency dental work does not include false teeth such as dentures, bridges, veneers, partials, or implants.

Eye Injury Benefit
We will pay the Eye Injury Benefit, as shown in the **Schedule of Benefits**, if the **Insured** sustains an eye **Injury** as the result of an **Accident**. The **Injury** must require surgery or removal of a foreign object by a **Doctor** within 365 days after the **Accident**. Only one Eye Injury Benefit is payable per **Accident** per **Insured**. The benefit amount is based on the type of procedure indicated.

Specific Injury Benefit
We will pay the Specific Injury Benefit, as shown in the **Schedule of Benefits** if the **Insured** sustains one of the specific **Injuries** listed in the **Schedule of Benefits** as the result of an **Accident**. Benefit amounts are based on the type of **Injury** sustained. The **Injury** must require surgery or medical treatment within 365 days after the **Accident**. Only one Specific Injury Benefit is payable per **Accident** per **Insured**.

Dislocations Benefit
We will pay the Dislocations Benefit, as shown in the **Schedule of Benefits**, if the **Insured** sustains a dislocation as the result of an **Accident**. Benefit amounts are based on the type of dislocation sustained by the **Insured** as indicated in the **Schedule of Benefits**. The dislocation must be treated by a **Doctor** within 365 days after the **Accident**.

If a dislocation is diagnosed by a **Doctor** as partial or incomplete, **We** will pay a reduced benefit equal to the applicable percentage shown in the **Schedule of Benefits** multiplied by the dislocation amount for the appropriate body part.

If a dislocation is diagnosed by a **Doctor** as an open reduction dislocation, **We** will pay an increased benefit equal to the applicable percentage shown in the **Schedule of Benefits** multiplied by the dislocation amount for the appropriate body part.

If an **Insured** sustains a fracture and a dislocation due to the same **Accident**, **We** will pay both benefits.

Fractures Benefit
We will pay the Fractures Benefit, as shown in the **Schedule of Benefits**, if an **Insured** sustains a fracture as the result of an **Accident**. Benefit amounts are based on the type of fracture sustained by the **Insured** as indicated in the **Schedule of Benefits**. The fracture must be treated by a **Doctor** within 365 days after the **Accident**. **We** will pay no more than three fracture benefits per **Accident** per **Insured**.

If a fracture is diagnosed by a **Doctor** as a bone chip fracture, **We** will pay a reduced benefit equal to the applicable percentage shown in the **Schedule of Benefits** multiplied by the fracture amount for the appropriate body part.

If a fracture is diagnosed by a **Doctor** as an open reduction fracture, **We** will pay an increased benefit equal to the applicable percentage shown in the **Schedule of Benefits** multiplied by the fracture amount for the appropriate body part.

If an **Insured** sustains a fracture and a dislocation due to the same **Accident**, **We** will pay both benefits.

Accidental Death Benefit

We will pay the benefit as shown in the **Schedule of Benefits** if the **Injury** sustained by the **Insured** results in a loss of life. **We** must receive proof that the **Insured** sustained a loss of life as the result of an **Accident** that occurred while covered under this benefit, and the **Loss**:

a. Was the direct result of an **Accident**;
b. Was independent of all other causes; and
c. Occurred within 365 days of the **Accident**.

Benefits for loss of life will be paid in accordance with the beneficiary designation provisions of this Certificate.

Common Carrier Accidental Death Benefit

We will pay the benefit, as shown in the **Schedule of Benefits**, if the **Injury** sustained by the **Insured** results in a loss of life while on or occupying a **Common Carrier**. **We** must receive proof that the **Insured** sustained a loss of life as the result of an **Accident** that occurred while covered under this benefit, and the **Loss**:

a. Was the direct result of an **Accident**;
b. Was independent of all other causes; and
c. Occurred within 365 days of the **Accident**.

This benefit is payable in in lieu of the **Accidental Death** benefit.

Accidental Dismemberment Benefit

We will pay the benefit as shown in the **Schedule of Benefits** if the **Injury** sustained by the **Insured** results in a **Loss** as defined in this benefit. **We** must receive proof that the **Insured** sustained the **Loss** as the result of an **Accident** that occurred while covered under this benefit, and the **Loss**:

a. Was the direct result of an **Accident**;
b. Was independent of all other causes; and
c. Occurred within 365 days of the **Accident**.

EXCLUSIONS AND LIMITATIONS

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

In addition, no Accident benefits are payable under the **Policy** for any **Injury** that results from or is caused by:

a. Suicide or attempted suicide, whether sane or insane, or intentionally self-inflicted **Injury**;
b. Declared or undeclared war or act of war;
c. Voluntary intoxication (as defined by the law of the jurisdiction in which the **Injury** occurred) or while under the influence of any narcotic, drug or controlled substance, unless administered by or taken according to the instruction of a **Physician** or medical professional;
d. Voluntary intoxication through use of poison, gas or fumes, whether by ingestion, injection, inhalation or absorption;
e. Committing or attempting to commit an assault or felony or voluntary participation in a riot or insurrection;
f. Incarceration or imprisonment following conviction for a crime;
g. Travel in or descent from any vehicle or device for aviation or aerial navigation, except as a fare-paying passenger in a commercial aircraft (other than a charter airline) on a regularly scheduled passenger flight, or a method of transportation that meets the definition of a **Common Carrier**;
h. Ride in or on any motor vehicle or aircraft engaged in acrobatic tricks/stunts (for motor vehicles), acrobatic/stunt flying (for aircraft), endurance tests, off-road activities (for motor vehicles), or racing;
i. Participation in any organized sport in a professional or semi-professional capacity;
j. Participation in base jumping, bungee jumping, cave diving, cliff jumping, free climbing, freediving, freerunning, hang gliding, ice climbing, kite surfing, kiteboarding, luging, mixed climbing, mountain biking, mountain climbing, mountaineering, parachuting, paragliding, parakiting, paramotoring, parasailing, Parkour, rock climbing, sail gliding, sandboarding, scuba diving, ski jumping, skydiving, sky surfing, speed flying, speed riding, train surfing, tricking, wingsuit flying, zip lining or other similar extreme sports or high risk activities;
k. Cosmetic or other elective surgery, other than reconstructive surgery required due to **Injury** resulting from an **Accident** ;
l. Active duty service or training in the military (naval force, air force or National Guard/Reserves or equivalent) for service/training extending beyond 31 days of any state, country or international organization, unless specifically allowed by a provision of this **Certificate**; or
m. Disease or bodily/mental illness or degenerative process, or any related medical/surgical treatment or diagnostic procedures for such disease, illness or degenerative process.

In addition, **We** will not pay benefits for:

a. Any **Loss** treated outside the United States, Canada or Mexico;
b. For any **Injury** covered by any Worker's Compensation Act or similar law; or
c. Dental treatment except as a result of **Accident**.

GENERAL PROVISIONS

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

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

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

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

a. A completed claim form.
b. Documentation of: the date(s) of the services or supplies received.
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. **Your** signed authorization for **Us** to obtain and release medical information.
g. 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 date a **Loss** occurs.

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

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

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

a. **You**;
b. **Your** legally appointed guardian if **You** are not legally able to accept such benefits; or
c. A **Provider** of medical treatment or services upon **You**r written direction.

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

a. **Your** spouse
b. **Your** children
c. **Your** parents
d. **Your** siblings
e. **Your** estate.

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

GENERAL PROVISIONS

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

Your written request should include:

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

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

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

a. Until 60 days have elapsed after **Proof of Loss** has been filed; or
b. After 2 years from the end of the time within which **Proof of Loss** is required by the **Policy**.

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

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

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

Workers' Compensation
The **Policy** does not replace **Workers' Compensation** or affect any requirement for **Workers' Compensation** coverage.

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

CHILD ORGANIZED SPORT ACTIVITY BENEFIT(S) RIDER

This Rider is part of the Certificate to which it is attached. It takes effect on January 1, 2021. 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.

Benefit(s)

This Rider provides an additional 25%, up to $5,000 for benefits payable under the **Policy** if the **Accident** occurred while an **Insured Dependent** child is participating in an organized sport. The child must be insured by the **Policy** on the date the **Accident** occurred.

Definition(s)

Organized Sport: *a competition or supervised organized practice for a competition at the amateur level. The competition must be governed by a set of written rules, be officiated by someone certified to act in that capacity and overseen by a legal entity such as a public school system, sports conference or sports league. The legal entity must have a set of by-laws, and competition must be on a regulation playing surface.*

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

WELLNESS SCREENING BENEFIT(S) RIDER

This Rider is part of the Certificate to which it is attached. It takes effect on January 1, 2021. 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 test 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 when costs related to the screening test are incurred while the **Insured** is covered under this Rider.

Screening Tests	**Benefit Amount**
Abdominal aortic aneurysm ultrasonography	$100
Baseline testing for Concussion	$100
Blood test for lipids, including total cholesterol, LDL, HDL and triglycerides	$100
Bone density screening	$100
Bone marrow testing	$100
Breast MRI	$100
Breast ultrasound	$100
CA 15-3 blood test for breast cancer	$100
CA 125 blood test for ovarian cancer	$100
Carotid Doppler	$100
CEA blood test for colon cancer	$100
Chest X-ray	$100
Child sports physicals.	$100
Colonoscopy or virtual colonoscopy	$100
CT angiography	$100
Electrocardiogram	$100
Fasting blood glucose test	$100
Flexible sigmoidoscopies	$100
Mammograms	$100
Pap smears	$100
Prostate-specific antigen (PSA) test	$100
Serum cholesterol test to determine level of HDL and LDL	$100
Stress test on a bicycle or treadmill	$100
Testicular ultrasound	$100
Thermography	$100
ThinPrep Pap Test	$100

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

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