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SELECT BENEFITS
FIXED-PAYMENT INDEMNITY POLICY

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

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

Additional contact information:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104

Main Telephone: (512) 463-6169
Fax: (512) 475-2005
Email: PIO@TDI.STATE.TX.US

INTRODUCTION

This is your Certificate of Coverage. It describes the benefits provided through your **Employer** under the **Policy** issued by Symetra Life Insurance Company (referred to as “we, us or our”).

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

The terms “you, your or yourself” referred to in this Certificate of Coverage mean the **Certificateholder** and/or **Certificateholder’s Dependents**.

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

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

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

This Certificate of Coverage replaces all others previously issued.

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

THIS (CERTIFICATE,) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CERTIFICATE). IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM THE COMPANY.

CERTIFICATE TABLE OF CONTENTS

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

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

➢ **Hospital Inpatient Admission Benefit**	$500 per **Confinement**, up to a maximum of 1 admittance per **Calendar Year** to a **Health Care Facility**
➢ **Inpatient Hospital Benefit**	
Hospital:	$100 per day, up to a maximum of 30 days per **Calendar Year** and 500 days per lifetime
Intensive Care Unit:	$200 per day, up to a maximum of 30 days per **Calendar Year** and 500 days per lifetime
Substance Abuse Facility:	$100 per day, up to a maximum of 30 days per **Calendar Year** and 500 days per lifetime
Mental Health Facility:	$50 per day, up to a maximum of 30 days per **Calendar Year** and 180 days per lifetime
Nursing Facility:	$50 per day, only if following a covered **Hospital** stay of at least 3 consecutive days and the **Insured** is less than age 65 up to a maximum of 60 consecutive days per stay and 500 days per lifetime

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

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**.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DEFINITIONS (CONTINUED)

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

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

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

Dependent: the following persons:

a. Your spouse, as defined by state law.
b. Your child who is under 26 years of age (Limiting Age).
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; grandchildren; 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.

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

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

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

Is not a person who:

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

Durable Medical Equipment: equipment that is made to:

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

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

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

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

DEFINITIONS (CONTINUED)

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

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

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

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

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

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

Health Care Facility:

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

Hospital: a licensed healthcare facility that:

a. Provides acute care;
b. Provides 24-hour nursing services;
c. Provides inpatient therapeutic and diagnostic services for **Illness or Injury**; Provides facilities for major surgery or has a formal arrangement with another healthcare facility for surgical facilities; and
d. 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 primarily for the treatment of Substance Abuse Disorders.
e. A place primarily for the treatment of **Mental Disorders**.

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

DEFINITIONS (CONTINUED)

Illness:

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

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

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

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

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

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

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

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

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

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

Nursing Facility does not include:

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

Observation Services: the use of a **Hospital** bed and periodic monitoring by the **Hospital's** nursing or other staff to observe a person's condition to decide if the person needs to be admitted to or discharged from the **Hospital**.

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

a. Routine preparation and recovery for diagnostic or surgical procedures.
b. Blood administration.
c. Care routinely provided in an **Emergency Room**.

DEFINITIONS (CONTINUED)

d. Routine recovery and post-operative care after outpatient surgery.
e. The use of a bed for the convenience of the **Doctor**, **Insured**, and/or **Insured's** family.

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

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

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

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

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

Provider: any **Doctor**, health professional, **Hospital**, **Nursing Facility**, home health agency or other person or recognized entity licensed to provide hospital or medical services to **Insureds** covered under the **Policy**.

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

Service Waiting Period: the length of time you must wait from your date of employment or if later, the date you become a member of an eligible class before your coverage can begin.

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

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

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

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

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

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.

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 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 on a form approved by us giving the information we require. You may only enroll at the following times:

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

Life Event Changes:

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

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

Effective Date of Your Coverage

Your coverage becomes effective on the latest of the following dates:

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

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

Eligible Dependents

This section applies if the **Schedule of Benefits** shows you are entitled to elect **Dependent** benefits.

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

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

ELIGIBILITY FOR COVERAGE (CONTINUED)

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

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

a. You are performing all the normal duties of your job at your **Employer's** normal place of business.

b. You make any required contribution or **Premium** payment for the change to take effect.

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

Benefits, payable under the **Policy**, are based on the coverage amounts in effect at the time an **Eligible Service or Supply** is provided.

Change in Amounts of Coverage

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

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

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

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**.

Termination of Dependent Coverage

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

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

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

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

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

ELIGIBILITY FOR COVERAGE (CONTINUED)

See "Continuation of Coverage" and “Extension of Inpatient Hospital Benefits” provisions for any exceptions to the Termination provisions.

Continuation of Coverage

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

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

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

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

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

Leave of Absence
If you are on a documented leave of absence, all of your coverage may be continued for up to 2 months following the date you were last **Actively at Work**. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

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

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

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

In all other respects, the terms of you and your **Dependent** coverage remain unchanged.

Upon written request from your **Employer**, we may agree to continue your coverage for reasons other than those listed above, provided your **Employer** provides a plan of continuation which applies to all **Employees** the same way.

Reinstatement

If you ceased to be eligible for coverage, coverage that terminated may be reinstated if you become eligible again within 90 days from the date you were last eligible. Your reinstated coverage will take effect on the date in which 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**.

Reemployment

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

ELIGIBILITY FOR COVERAGE (CONTINUED)

Survivor Benefit

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

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

BENEFITS

Hospital Inpatient Admission Benefit

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

The Hospital Inpatient Admission Benefit will be paid, as shown in the **Schedule of Benefits**, for the first calendar day that you are **Confined** as a result of a non-occupational **Illness or Injury** and you are:

a. Admitted to a **Health Care Facility** for a minimum of 24 hours.
b. Admitted to a **Hospital** for **Observation Services** for a minimum of 24 hours.

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

Exclusions and Limitations

No Hospital Inpatient Admission Benefit will be paid for admission to:

a. An **Emergency Room**.
b. An outpatient **Hospital** facility or clinic or **Urgent Care** facility.
c. A **Hospital** for **Observation Services** that are less than 24 hours.
d. Any other portion of a **Hospital** which provides services that do not require **Confinement**.

Inpatient Hospital Benefit

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

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

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

a. The **Insured** is **Confined** in a **Health Care Facility** for a minimum of 24 hours or a **Hospital** for **Observation Services** for a minimum of 24 hours.
b. The **Health Care Facility** is operating within the scope of its license.
c. A charge is made for room and board or **Observation Services**.
d. The entire duration of **Confinement** is recommended and approved by a **Doctor**.
e. The **Confinement** is the result of a non-occupational **Illness or Injury**.
f. The services and supplies are not excluded under the Exclusions and Limitations provision of the Certificate.

Extension of Inpatient Hospital Benefits

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

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

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

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

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

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

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

EXCLUSIONS AND LIMITATIONS

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

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

a. For which there is no legal obligation to pay.
b. Received before the **Insured** is covered for the benefit.
c. Received after Termination of Coverage, except as provided under the **Policy**.
d. Which are not furnished or prescribed by a **Doctor**.
e. Received for **Experimental or Investigative** treatment, procedures for research purposes, or practices when not generally recognized as accepted medical practices.
f. That are not approved or accepted as essential to the treatment of an **Illness** or **Injury** by any of the following:

    i. The American Medical Association
    ii. The U.S. Surgeon General
    iii. Department of Public Health
    iv. The National Institute of Health

g. Related to cosmetic surgery or dental care done to beautify an **Insured** without medical or dental indication of **Injury** or **Illness**.
h. Related to elective medical, dental, or surgical procedures done without medical or dental indication of **Illness** or **Injury**.
i. For reversal procedures in connection with previous male or female sterilization.
j. In the nature of educational or vocational testing or training.
k. For outpatient food, food supplements, or vitamins.
l. For radial keratotomies.
m. For physical therapy, occupational therapy, speech therapy or chiropractic manipulations or modalities.
n. In connection with treatment of male or female infertility, in vitro and in vivo fertilization of an ovum, or artificial insemination.
o. For **Durable Medical Equipment**.
p. For **Custodial Care**.
q. For **Ancillary Services** in connection with surgery or other **Illness**, except as stated in the **Schedule of Benefits**.
r. Related to smoking cessation.
s. For the treatment of the following:

    i. **Codependency**
    ii. Social, occupational, or religious maladjustments
    iii. **Compulsive Gambling**
    iv. Chronic marital or family problems when not related to the primary focus of treatment that must be a diagnosable **Mental Disorder**

t. For the treatment of obesity, weight reduction, or dietetic control, except for morbid obesity or disease etiology.
u. For the following, except as specifically stated in the **Schedule of Benefits** section of the **Policy**:

    i. For dental treatment and oral surgery
    ii. For treatment of **Mental Disorders**, except for **Severe Mental Disorders**
    iii. For treatment of **Substance Abuse Disorders**
    iv. For refractions, eyeglasses, or hearing aids or their fitting
    v. For routine physicals or general health exams, routine immunizations and vaccinations

EXCLUSIONS AND LIMITATIONS (CONTINUED)

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

x. For any **Illness** or **Injury** covered by any Worker's Compensation Act or similar law.

GENERAL PROVISIONS

Notice of Claim

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

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

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

Claim Forms

Before the 16th day of receiving a notice of claim, we will send the forms needed to provide **Proof of Loss**. If we do not send the forms within 15 days, any other written proof which fully describes the nature and extent of the claim may be submitted. We will notify a claimant in writing of the acceptance or rejection of a claim not later than the 15th business day after the date that receive all items needed to provide **Proof of Loss**. If we are unable to accept or reject the claim within 15 business days, we will notify the claimant of the reasons that we need additional time. We will accept or reject the claim not later than the 45th day after the date we notify a claimant of the need for additional time. If the claim is accepted, we will pay the claim not later than the fifth business day after the notice is made.

Proof of Loss

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

a. A completed claim form.
b. Documentation of: the date(s) of the services, supplies received and the costs you incurred.
c. The names and addresses of all **Providers**.
d. A certified copy of the death certificate (if applicable).
e. Your **Beneficiary** designation (if applicable).
f. If applicable, documentation of:

    i. The date your disability began;
    ii. The cause of your disability; and
    iii. The prognosis of your disability;

g. Your signed authorization for us to obtain and release medical information.
h. Any additional information required by us to make a determination on the claim.

All proof submitted must be satisfactory to us.

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

a. The date an **Eligible Service or Supply** is provided

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

Time Payment of Claims

We will pay benefits 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 your written direction.
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:
   (1) 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
   (2) 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. Failure to honor an **Assignment** to a **Provider** due to inadvertent error will not subject us to double payment.

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

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

Symetra Select Benefits
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**.

Extension of Coverage
You and your **Dependents** may qualify to temporarily extend coverage, at group rates, for the medical benefits shown in the **Schedule of Benefits** of the **Policy**. This extension of coverage does not apply to benefits for Employee Life, Dependent Life, Disability Income or Accidental Death & Dismemberment, whether or not shown on the **Schedule of Benefits**.

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

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

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

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

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

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

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

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

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

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

Period of Extension
You have the option to continue coverage for yourself and/or your covered **Dependents** for 18 months.

If you chose to extend coverage following termination of employment and you or a covered **Dependent** become disabled, coverage for the disabled person and all covered **Dependents** may be extended for an additional 11 months, up to a total of 29 months. In order to lengthen the extension period, the Social Security Administration must determine that you or a covered **Dependent** became disabled within the first 60 days of an extension of coverage period. You must notify your **Employer** before the end of the first 18-months and provide a copy of the Social Security disability determination letter within 60 days of the determination date.

This same 11-month extension is provided to a disabled child if the child is born or placed for adoption during the extension of coverage period and the child is determined to be disabled within the first 60 days of extension of coverage.

If, during the 18-month extension of coverage period, another qualifying event takes place, coverage may be extended for up to 36 months for any covered Dependents.

In no case will the total extension of coverage period exceed 36 months.

GENERAL PROVISIONS (CONTINUED)

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

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

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