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

Select Benefits

Critical Illness Policy

Employer:

Name:	EMR (USA Holdings) Inc.
Policy Number:	12940000 - Plans 2-3
Effective Date of Coverage:	January 1, 2025

For inquiries, to obtain information about this coverage or for assistance in resolving complaints, please call Symetra Life Insurance Company at 1-800-497-3699.

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**.

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

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

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

This Certificate of Coverage replaces all others previously issued.

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

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

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

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SCHEDULE OF BENEFITS

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

Class	Description
1	All Active Full-time employees excluding employees in CIMU and IRPU who are members of Teamsters Local 676..

Service Waiting Period
If **You** are in an Eligible Class on **Your Employer**'s **Effective Date of Coverage**, there is no **Service Waiting Period**. Otherwise, the **Service Waiting Period** is the first of the month following 60 days of continuous employment following the date **You** become, at hiring or later, a member of an Eligible Class.

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

Employee and Dependent Benefits

Employee Critical Illness Benefit

Critical Illness Benefit	**Plan 2:** $10,000 **Plan 3:** $20,000
Guaranteed Issue Amount	up to $20,000
Recurrence Benefit	100% of the Critical Illness Benefit paid for the initial occurrence of the same condition
Health Screening Benefit	$50 per person, per **Calendar Year**

Spouse Critical Illness Benefit

Critical Illness Benefit	50% of the **Employee**'s benefit
Guaranteed Issue Amount	up to $10,000
Recurrence Benefit	100% of the Critical Illness Benefit paid for the initial occurrence of the same condition
Health Screening Benefit	$50 per person, per **Calendar Year**

Child Critical Illness Benefit

Critical Illness Benefit	25% of the **Employee**'s benefit
Guaranteed Issue Amount	up to $5,000
Recurrence Benefit	100% of the Critical Illness Benefit paid for the initial occurrence of the same condition
Health Screening Benefit	$50 per person, per **Calendar Year**

Miscellaneous Goods and Services

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

Dependent: the following persons:

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

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

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

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

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

Is not a person who:

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

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

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

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

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

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

Hospital: a licensed healthcare facility that:

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

Hospital does not include:

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

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

Illness: physical sickness or disease.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Specialist: a person who:

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

Examples of a **Specialist** are:

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

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

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

We, Us, Our: Symetra Life Insurance Company.

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

ELIGIBILITY FOR COVERAGE

Eligible Employees

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

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

The Date You Are Eligible for Coverage

You first become eligible for coverage on the later of:

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

Enrollment

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

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

Life Event Changes

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

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

Effective Date of Your Coverage

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

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

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

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

Eligible Dependents

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

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

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

The Date a Dependent is Eligible for Coverage

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

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

Enrollment

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

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

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

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

Effective Date of Dependent Coverage

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

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

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

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

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

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

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

Continuity with Prior Coverage

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

Effective Date of Coverage

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

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

Change in Amounts of Benefits

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

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

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

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

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

Change in Amounts of Coverage

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

Effective Date of Change

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

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

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

Termination of Your Coverage

Your coverage will cease on the earliest of:

a. The date the **Policy** is canceled.
b. The date **Your Employer**'s coverage ceases under the **Policy**.
c. The date the first of the following events occurs:
    i. **Your** membership in an eligible class ceases.
    ii. **Your** employment with **Your Employer** ceases.
    iii. **You** are no longer **Actively at Work**.
    iv. **You** or **Your Employer** cease to make contributions or **Premium** payments for **Your** coverage subject to the 45 day Grace Period. Coverage will terminate on the last day of the grace period if the premium due is not paid by the end of the grace period.
    v. **You** are pensioned or retired, as defined by **Your Employer**.
    vi. The date **You** begin active duty as a member of the armed forces (land, water, air) of any country or international authority, except as provided under the Continuation of Coverage provision.

Termination of Dependent Coverage

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

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

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

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

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

Continuation of Coverage During Temporary Absence

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Post-Termination Continuation of Coverage

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

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

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

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

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

Any continued coverage:

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

Reinstatement

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

Evidence of insurability will not be required to reinstate coverage.

Reemployment

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

BENEFITS

Critical Illness Benefit

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

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

Covered-Critical Illness

Core Benefits Covered Critical Illness	Percentage of Benefit Amount Payable
Invasive Cancer	100%
Minor Cancer (In Situ)	50%
Heart Attack (Myocardial Infarction)	100%
Coronary Artery Disease Needing Surgery or Angioplasty	100%
Stroke	100%
Major Organ Failure	100%
End Stage Renal Failure	100%
Loss of Sight	100%
Loss of Speech	100%
Loss of Hearing	100%
Paralysis	100%

Neurological Conditions Covered Critical Illness	Percentage of Benefit Amount Payable
ALS and Other Motor Neuron Diseases	100%
Advanced Alzheimer's Disease	100%
Parkinson's Disease	100%

Autoimmune Diseases Covered Critical Illness	Percentage of Benefit Amount Payable
Type II Diabetes	100%

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

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

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

Covered Critical Illness Descriptions

Core Benefits

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

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

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

a. Pathological Diagnosis

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

b. Clinical Diagnosis

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

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

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

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

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

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

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

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

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

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

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

Heart Attack (Myocardial Infarction)

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

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

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

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

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

Coronary Artery Disease Needing Surgery or Angioplasty

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

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

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

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

Stroke

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

Diagnosis Requirements
This event must result in:

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

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

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

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

Major Organ Failure

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

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

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

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

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

End Stage Renal Disease

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

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

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

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

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

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

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

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

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

Loss of Speech

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

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

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

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

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

Loss of Hearing

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

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

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

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

Paralysis

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

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

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

Neurological

Amyotrophic Lateral Sclerosis (ALS) and other Motor Neuron Diseases

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

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

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

Advanced Alzheimer's Disease

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

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

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

Activities of Daily Living are defined as:

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

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

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

i. Psychiatric illnesses.
ii. Alcohol or other drug related brain damage.
iii. Stroke and vascular dementia.
iv. Parkinson's disease.
v. Huntington's disease.
vi. Coma.

Parkinson's Disease

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

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

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

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

Autoimmune Diseases

Type II Diabetes

Type II Diabetes is defined as a chronic condition that develops when the body becomes resistant to insulin or when the pancreas is unable to produce enough insulin.

Diagnosis Requirements
The diagnosis of Type II Diabetes must be made by a **Specialist** according to diagnostic criteria of the American Diabetes Association (ADA).

Diagnosis Date
The date of diagnosis is the date a **Specialist** confirms the diagnosis of Type II Diabetes that satisfies the diagnostic requirements above.

Exclusions and Limitations
A Critical Illness Benefit will not be paid for a diagnosis of:

a. Type I Diabetes.
b. Prediabetes.
c. Metabolic syndrome.
d. Gestational diabetes.

A Type II Diabetes Critical Illness benefit is only payable up to one time per eligible **Insured** per lifetime.

Recurrence Benefit

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

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

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

Health Screening Benefit

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

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

Tests to screen for Cancer

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

Tests to screen for Heart-related Disease

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

Tests to screen for Organ-related Disease

a. Fasting blood glucose test

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

EXCLUSIONS AND LIMITATIONS

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

Exclusions

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

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

GENERAL PROVISIONS

Notice of Claim

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

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

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

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

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

Claim Forms

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

Proof of Loss

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

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

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

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

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

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

Time Payment of Claims

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

Payment of Benefits

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

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

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

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

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

Physical Examination and Autopsy

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

Examination of Specialist's Records

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

Right To Appeal a Denied Claim

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

Symetra Life Insurance Company
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 5 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**.