How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay it's debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.

- **Life Insurance:**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.

- **Individual Annuities:** Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.

- **Individual aggregate limit:** Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.

- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:	For questions about insurance, contact:
Texas Life and Health Insurance Guaranty Association 515 Congress Avenue, Suite 1875 Austin, Texas 78701 800-982-6362 or www.txlifega.org	**Texas Department of Insurance** P.O. Box 12030 Austin, Texas 78711-2023 800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

Have a complaint or need help?

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

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

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

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

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

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

¿Tiene una queja o necesita ayuda?

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

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

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

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

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

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

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

SCHEDULED BENEFIT ACCIDENT GROUP INSURANCE POLICY

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

Notice: This is a group accident insurance Policy. It does not pay benefits for losses caused by sickness. 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 requirements of minimum essential coverage under the Affordable Care Act.

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INTRODUCTION

This **Policy** is divided into three sections:

a. the Policy Specifications section.
b. the **Employer** section.
c. the Certificate of Coverage section.

All sections together form the **Policy** and include all of the benefits available under the plan.

The **Employer** will be responsible for giving the Certificate of Coverage section to the **Certificateholder**.

Whenever **We** use the terms “you or your” in the **Employer** section, **We** mean the **Employer**.

Whenever **We** use the terms “you, your or yourself” in the Certificate of Coverage section, **We** mean the **Certificateholder** and/or **Certificateholder’s Dependents**.

Definitions of terms that appear in bolded print are included in the Certificate of Coverage section.

If there is any conflict between the terms and conditions of this **Policy** and an attachment, this **Policy** shall be controlling.

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

POLICY SPECIFICATIONS

Policyholder:	Vanguard Academy Charter School
Policy Number:	13404000 - Plan 3
Policy Effective Date:	May 1, 2026
Premium Due Date:	**Premium** is due on the Policy Effective Date and the first of each month beginning with June 1, 2026
Policy Anniversary:	May 1 of each year beginning in 2027
Governing Jurisdiction:	This Policy is delivered in and governed by the laws of the state of Texas

This **Policy** has been issued in consideration of the signed master application, the application of the **Employer** and payment of **Premium**. The **Employer**'s coverage under this **Policy** renews on each Policy Anniversary.

Symetra Life Insurance Company issues this **Policy** and agrees to pay the benefits of this **Policy** subject to its terms and conditions.

Symetra Life Insurance Company has, by its President and Secretary, executed this **Policy** as of this Policy Effective Date and caused it to be duly countersigned at Bellevue, Washington.

Margaret Meister
President

Jacqueline M. Veneziani
Secretary

READ YOUR POLICY CAREFULLY.

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SCHEDULED BENEFIT ACCIDENT GROUP INSURANCE POLICY

Employer Name:	Vanguard Academy Charter School
Policy Number:	13404000 - Plan 3
Effective Date of Coverage:	May 1, 2026

EMPLOYER SECTION

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SCHEDULE OF PREMIUM RATES

Rate Guarantee:

A change in the initial **Premium** rate will not take effect prior to 38 months following the Policy Effective Date. However, the **Premium** rate may change prior to this time for reasons that affect the insured risk, which include:

a. A change occurs in the benefits provided under the **Policy**.
b. A division, subsidiary or affiliated company (known as associated entity) is added or deleted.
c. The number of **Employees** insured under the **Policy** changes by 25% or more.
d. A new law or a change in any existing law is enacted which applies to the benefit coverage.

We will notify you in writing at least 60 days before a **Premium** rate change is effective.

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EMPLOYER PROVISIONS

Assignment

The coverage provided under this **Policy** is not assignable, except as otherwise stated in this **Policy**.

Conformity with Law

Any provision of the **Policy** that is in conflict with applicable state statutes, or any federal statutes, is hereby amended to conform to the minimum requirements of such statutes, unless otherwise forbidden by laws of the state where the **Certificateholder** resides.

Inadvertent Error

The **Insured** will not lose the amount of coverage due him because of inadvertent error by you:

a. To provide the name of the **Insured** to **Us**; or
b. To report a change in the amount of the **Insured's** coverage to **Us**.

Failure to report the termination of coverage of any **Insured** to **Us** will not continue the coverage beyond the date it would otherwise end.

You have no authority to pay **Premium** for individuals that are not **Employees** or to continue coverage of terminated **Employees**. Payment of **Premium** will not effect or continue an individual's coverage if it should not be in effect or continue in effect. **Premiums** and benefits will be adjusted based on the true facts.

Misstatement of Age

If the age of an **Insured** has been misstated, the benefit payable will be the benefit to which he is entitled due to actual age.

Policy Changes

The coverage under this **Policy** may be changed at any time by written agreement between Symetra and officers of the **Employer**. Changes will be valid only if approved by an officer of Symetra and endorsed or attached to this **Policy**, and do not require the consent of any **Insured**. No agent has the authority to change this **Policy** or to waive any of its provisions.

Entire Contract

All **Policy** sections, the master application, the application of the **Employer**, all amendments or Riders and, to the extent required by law, the applications, if any, of the **Insured** form the entire contract.

Statements Not Warranties

In the absence of fraud, all statements made by you or by any **Insured** will be deemed representations and not warranties. These statements will not be used to reduce or deny benefits unless the statements are in a written application signed by you or the **Insured**, and a copy 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.

Pronouns

Masculine pronouns used in this **Policy** will apply to both genders.

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Records of the Employer

You will give such data as may be required by **Us** to provide the coverage. This includes data on persons who are eligible to become covered, changes in the amount of coverage, and terminations of coverage.

You may add eligible **Employees** and/or **Dependents** periodically in accordance with the terms of the **Policy**.

Your records that **We** believe have a bearing on coverage under the **Policy** are open for **Our** review at any reasonable time.

Personnel and other records pertaining to coverage under this **Policy** will be open for review by **Us** at any reasonable time. Any additional records of **Yours** as may have a bearing on the coverage shall also be open for review by **Us** at any reasonable time.

Certificate

We will give individual Certificates of Insurance to the **Policyholder**, in electronic or paper form, for delivery to persons covered under this **Policy**, which will explain the important features of this **Policy**, who is covered under this **Policy**, and to whom benefits are payable. **We** will give new or amended Certificates of Insurance to the **Policyholder** for delivery to persons covered under this **Policy** when amendments require the Certificates of Insurance to be modified.

You will be solely responsible for delivering the appropriate Certificates of Insurance to persons covered under this **Policy**, and for informing such persons when the Certificates of Insurance have been modified by amendment.

You agree to defend and hold **Us** harmless from any liability resulting from your failure to deliver the appropriate Certificates of Insurance to persons covered under this **Policy**, or to inform such persons when the Certificates of Insurance have been modified by amendment.

Incontestability of Policy

We will not contest this **Policy** after it has been in force for two years with respect to you, except for:

a. Nonpayment of **Premium**; or
b. Fraudulent misstatements by you.

No statement made by an **Insured** relating to his insurability will be used to contest his coverage:

a. After his coverage has been in force during his lifetime for two years; and
b. Unless such statement is in writing and signed by him.

Workers' Compensation

This **Policy** is not in lieu of and does not affect any requirements for coverage by **Workers' Compensation** Insurance.

Payment of Premiums

The first **Premium** will be due on your **Effective Date of Coverage** under this **Policy**. After that, **Premium** will be due monthly, unless you and Symetra agree in writing to some other method of **Premium** payment. If you instruct or allow any third party to pay **Premium** on your behalf, such third party is your agent, and you remain liable for the payment of all **Premium** due to **Us**. You will defend and hold **Us** harmless from any liability resulting from any act or omission of such third party.

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Grace Period

If you have not given written notice to **Us** before the Premium Due Date to terminate coverage under this **Policy**, a grace period of 31 days will be given in which to pay the **Premium** then due. Coverage will continue in force during this grace period. If the **Premium** is not paid before the end of the grace period, coverage will cease on the last day of the grace period and you will be liable to **Us** for any unpaid **Premium** for the time coverage was in force.

If, before the end of the grace period, you give written notice to **Us** that coverage is to be terminated, coverage will terminate on the later of the date contained in the notice or the date such notice is received by **Us**. A pro rata **Premium** will be due for the period between the date the **Premium** was due and the date coverage ends.

Reinstatement

If your coverage ceases, **We** may reinstate such coverage, if requested in writing by you, and:

a. All past due **Premiums**, including the grace period **Premium** are paid; and
b. The current **Premium** is paid.

Change in Premium Rates

We may change the **Premium** rate for any coverage by giving you 60 days written notice. **We** may change the rates on:

a. The first Policy Anniversary;
b. The end of any applicable rate guarantee period;
c. Any **Premium** due date after the first Policy Anniversary; or
d. Any **Amendment** or **Rider** effective date.

Premium Adjustment

Premium adjustment will be made when necessary. Refunds and credits are limited to **Premiums** received during the three month period prior to receipt of request for adjustment.

Termination by the Employer

You may terminate your coverage provided under this **Policy** by mailing to **Us** 31 days prior written notice stating when such termination will be effective.

Termination by Symetra

We may terminate your coverage under this **Policy** by giving at least 45 days prior written notice, when:

a. You fail to comply with the minimum participation and contribution rules;
b. Fraud upon **Us** has occurred; or
c. You do not duly perform in good faith your obligations under this **Policy**.

We may terminate your coverage under this **Policy** by giving at least 10 days prior written notice, when you do not pay all **Premiums** that are due by the end of the grace period.

We may also terminate your coverage under this **Policy** at any time for any reason after it has been in force for 12 months, provided **We** give 45 days prior written notice.

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All written notices will be delivered to you, or mailed to your last known address as shown on our records and **We** will indicate in that notice the reason for the termination.

Renewal

We may renew your coverage under this **Policy** on each Policy Anniversary by giving you 20 days prior written notice, indicating in that notice the amount of **Premium** due.

We may refuse to renew your coverage under this **Policy** by giving you 45 days prior written notice indicating in that notice the reason for nonrenewal of your coverage under this **Policy**.

ERISA

This **Policy** is delivered in and is governed by the laws of the state of Texas and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments to ERISA.

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

Mailing Address: Symetra Life Insurance Company
PO Box 674419 | Houston, TX 77267-4419
Phone 1-800-796-3872 | Fax (715) 682-5919 www.symetra.com

SCHEDULED BENEFIT ACCIDENT GROUP INSURANCE POLICY

Policyholder:
Employer Name: Vanguard Academy Charter School
Policy Number: 13404000 - Plan 3
Effective Date of Coverage: May 1, 2026

CERTIFICATE OF COVERAGE

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

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INTRODUCTION

This is **Your** Certificate of Coverage. It describes the benefits provided through **Your Employer** under the **Policy** issued by Symetra Life Insurance Company (referred to as "**We**, **Us** or **Our**").

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

The terms "**You**, **Your** or **Yourself**" referred to in this Certificate of Coverage mean the **Certificateholder** and/or **Certificateholder's Dependents**.

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

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

This Certificate of Coverage replaces all others previously issued.

Notice: The Policy is an accident insurance policy. It does not pay benefits for losses caused by sickness. Your coverage under the Policy is not comprehensive medical coverage and is not intended to cover the cost of all hospital or other medical services. The Policy does not satisfy the minimum essential coverage requirements of the Affordable Care Act.

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

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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 working a minimum of 30 hours per week.

Service Waiting Period

If **You** are in an eligible class on **Your Employer**'s **Effective Date of Coverage**, there is no **Service Waiting Period**. Otherwise, the **Service Waiting Period** is the first of the month following the date of employment.

Annual Enrollment Period

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

Employee and Dependent Benefits

Scheduled Accident Benefits

➢ **Emergency Care & Diagnostics**	Employee	Dependent Spouse	Dependent Child
Ambulance – Ground	$400	$400	$400
Ambulance – Air	$2,500	$2,500	$2,500
Emergency Room	$200	$200	$200
Major Diagnostic Testing (MRI, CT Scan, CAT, EEG)	$350	$350	$350
X-Ray	$100	$100	$100
Pain Management/Epidural	$150	$150	$150
Initial Doctor's Visit	$200	$200	$200

➢ **Accident Hospitalization & Surgical Benefits**	Employee	Dependent Spouse	Dependent Child
Hospital Admission	$1,500	$1,500	$1,500
ICU Admission	$3,000	$3,000	$3,000
Hospital Confinement (per day up to 365 days per Accident)	$350	$350	$350
ICU Confinement (per day up to 30 days per Accident)	$1,000	$1,000	$1,000
Rehabilitation/Skilled Nursing Facility (per day up to 90 days per Accident)	$200	$200	$200
Blood/Plasma/Platelets	$500	$500	$500
Surgery – open abdominal, thoracic	$2,000	$2,000	$2,000
Surgery – cranial	$2,000	$2,000	$2,000
Surgery – hernia	$1,000	$1,000	$1,000
Surgery – exploratory or without repair	$300	$300	$300
Outpatient/Miscellaneous Surgery	$300	$300	$300
Transportation (per trip)	$400	$400	$400
Family lodging (per night, up to 30 days per accident)	$300	$300	$300
Coma (paid after 7-day duration)	$20,000	$20,000	$20,000

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SCHEDULE OF BENEFITS (continued)

➢ **Follow Up Care**	Employee	Dependent Spouse	Dependent Child
Follow up Doctor's Visit	$100	$100	$100
Physical Therapy (up to 10 visits per Accident)	$50	$50	$50
Chiropractic Visit (up to 10 visits per Accident)	$50	$50	$50
Medical Equipment	$300	$300	$300
Prosthetic Device	$2,000	$2,000	$2,000

➢ **Burns – Second Degree**	Employee	Dependent Spouse	Dependent Child
20 – 100 square centimeters	$150	$150	$150
101 – 225 square centimeters	$400	$400	$400
More than 225 square centimeters	$1,500	$1,500	$1,500

➢ **Burns – Third Degree**	Employee	Dependent Spouse	Dependent Child
20 – 100 square centimeters	$1,500	$1,500	$1,500
101 – 225 square centimeters	$4,000	$4,000	$4,000
More than 225 square centimeters	$16,000	$16,000	$16,000
Skin Grafts	50% of burn amount		

➢ **Paralysis**	Employee	Dependent Spouse	Dependent Child
Quadriplegia	$20,000	$20,000	$20,000
Paraplegia	$10,000	$10,000	$10,000
Hemiplegia	$10,000	$10,000	$10,000
Uniplegia	$5,000	$5,000	$5,000

➢ **Lacerations**	Employee	Dependent Spouse	Dependent Child
Lacerations not requiring sutures	$75	$75	$75
Under 3 inches, requiring sutures	$150	$150	$150
3 to 6 inches, requiring sutures	$400	$400	$400
Over 6 inches, requiring sutures	$800	$800	$800

➢ **Emergency Dental Work**	Employee	Dependent Spouse	Dependent Child
Crown Repair	$300	$300	$300
Extraction	$150	$150	$150

➢ **Eye Injuries**	Employee	Dependent Spouse	Dependent Child
Removal of foreign object	$200	$200	$200
Surgical Repair	$400	$400	$400

➢ **Specific Injuries**	Employee	Dependent Spouse	Dependent Child
Ruptured Disc – with surgical repair	$800	$800	$800
Tendons/Ligaments – one tear with surgical repair	$800	$800	$800
Tendons/Ligaments – two or more tears with surgical repair	$1,600	$1,600	$1,600

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SCHEDULE OF BENEFITS (continued)

Tendons/Ligaments – arthroscopic surgery with no repair	$300	$300	$300
Torn Knee Cartilage – exploratory surgery with no repair	$300	$300	$300
Torn Knee Cartilage – surgical repair	$800	$800	$800
Concussion	$300	$300	$300

➢ **Dislocations (closed reduction)**	Employee	Dependent Spouse	Dependent Child
Hip	$5,000	$5,000	$5,000
Knee (except patella)	$2,500	$2,500	$2,500
Shoulder	$1,600	$1,600	$1,600
Foot/Ankle (except toes)	$1,600	$1,600	$1,600
Wrist	$1,600	$1,600	$1,600
Lower Jaw	$1,600	$1,600	$1,600
Elbow	$1,600	$1,600	$1,600
Bones of the Hand (except fingers)	$1,000	$1,000	$1,000
Collarbone	$1,000	$1,000	$1,000
Two or more fingers	$750	$750	$750
Two or more toes	$750	$750	$750
One finger or toe	$500	$500	$500
Open Reduction Dislocation Benefit	200% of dislocation benefit		
Partial Dislocation Benefit	25% of dislocation benefit		

➢ **Fractures (closed reduction)**	Employee	Dependent Spouse	Dependent Child
Skull (depressed)	$5,000	$5,000	$5,000
Skull (non-depressed)	$5,000	$5,000	$5,000
Hip/Thigh	$5,000	$5,000	$5,000
Vertebral Body (excluding vertebral processes)	$3,000	$3,000	$3,000
Pelvis	$3,000	$3,000	$3,000
Arm (upper, includes elbow)	$1,600	$1,600	$1,600
Shoulder Blade	$1,600	$1,600	$1,600
Leg	$2,500	$2,500	$2,500
Vertebral Processes	$1,600	$1,600	$1,600
Knee Cap	$1,600	$1,600	$1,600
Collarbone	$1,600	$1,600	$1,600
Forearm (below elbow)	$1,600	$1,600	$1,600
Foot/Ankle (except toes)	$1,600	$1,600	$1,600
Hand/Wrist	$1,250	$1,250	$1,250
Lower Jaw	$1,250	$1,250	$1,250
Upper Jaw	$1,600	$1,600	$1,600
Ribs (two or more)	$750	$750	$750
Facial Bones or Nose	$750	$750	$750
One rib, finger, or toe	$300	$300	$300
Coccyx	$700	$700	$700
Open Reduction Fracture Benefit	200% of fracture benefit		
Bone Chip Fracture Benefit	25% of fracture benefit		

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SCHEDULE OF BENEFITS (continued)

Catastrophic Accident Benefits	Employee	Dependent Spouse	Dependent Child
Accidental Death	$100,000	$50,000	$25,000
Common Carrier Accidental Death	$200,000	$100,000	$50,000

- **Dismemberment Benefits**

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

RIDER(S)

Enhanced Scheduled Benefit Accident Benefits
Enhanced Catastrophic Accident Benefits
Continuation of Coverage
Wellness Screening Benefits
Organized Sport Activity Benefit
Family Care Benefits
Parental Caregiver Benefits

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DEFINITIONS

Accident: a sudden, unforeseen, unexpected and involuntary event definite as to time and place. In order for benefits under the **Policy** to be payable, the **Accident** must occur while the **Insured's** coverage is in force.

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

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

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

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

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

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

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

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

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

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

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

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

Confinement: the period of time between admission and discharge.

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

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

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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.
d. **Your** unmarried grandchild, who is under the age of 26 and a dependent of **Your** for federal income tax purposes at the time the application for coverage is made.

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

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

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

Durable Medical Equipment: equipment that is made to:

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

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

Effective Date of Coverage: the date coverage under the **Policy** goes into effect for 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**.

Eligible Services or Supplies: those services or supplies received by an **Insured** for treatment of a covered **Injury** that are not excluded under the **Policy**.

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

Employee: a person who is:

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

Health Care Facility:

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

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Hospital: a licensed healthcare facility that:

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

Hospital does not include:

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

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

Illness:

a. Physical sickness or disease.
b. **Mental Disorder**, as defined under the **Policy**.
c. Complications of pregnancy, including any condition, whether or not a pregnancy is terminated, that requires **Hospital Confinement** and whose diagnosis is distinct from pregnancy but is adversely affected or caused by pregnancy.
d. Congenital abnormalities.

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

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

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

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

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

Loss: with regard to:

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

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

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

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

Nursing Facility does not include:

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

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

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

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

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

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

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

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

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

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

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

We, Us, Our: Symetra Life Insurance Company.

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

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

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ELIGIBILITY FOR COVERAGE

Eligible Employees

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

a. **You** are performing all the normal duties of **Your** job at the normal place of business of the **Employer**.
b. **You** are a member of an eligible class as described in the **Schedule of Benefits**.

The Date You Are Eligible for Coverage

You first become eligible for coverage on the later of:

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

Enrollment

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

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

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 **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 date **You** acquire a **Dependent** such as through marriage, birth, adoption or placement for adoption, or the date on which **You** become a party to a suit seeking to adopt the child.
c. The first day of the month following the date **You** acquire a spouse or domestic partner.

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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).
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, **Dependent** coverage will be provided for the first 31 days following the birth or adoption of such child. Coverage will continue beyond the first 31 day period for that child if:

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

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

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

Change in Amounts of Benefits

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

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

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

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

Change in Amounts of Coverage

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

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

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

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

Termination of Your Coverage

Your coverage will cease on the earliest of:

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

    i. **Your** membership in an eligible class ceases.
    ii. **Your** employment with **Your Employer** ceases.
    iii. **You** are no longer **Actively at Work**.
    iv. **You** or **Your Employer** cease to make contributions or **Premium** payments for **Your** coverage.
    v. **You** are pensioned or retired, as defined by **Your Employer**.
    vi. The date **You** begin active duty in the armed forces.

Termination of Dependent Coverage

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

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

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

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

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

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

Reinstatement

If **You** ceased to be eligible for coverage, coverage that terminated may be reinstated if **You** become eligible again within 31 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 **You** become eligible again. If **You** do not qualify for reinstatement within 31 days from the date **You** were last eligible, **You** will be treated as a new **Employee**.

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Portability
Coverage may continue for **You** and any **Dependent(s)** when coverage ends under the **Policy**. **Your** portable coverage will be provided under an insurance policy **We** make available for this purpose. Coverage under **Your** portable insurance may not be identical to coverage under this **Policy**.

If **You** are age **65** or younger, **You** may request portability coverage for **You** and any **Dependent(s)** when:

a. **You** are no longer **Actively at Work** and are not eligible for coverage under any other Continuation of Coverage provision in this Certificate;
b. **You** are no longer employed by the **Policyholder**, including retirement; or
c. the **Policy** terminates and the **Policyholder** does not obtain a replacement policy with another insurance carrier within 31 days.

If **You** are eligible to request portability coverage, then **You** must elect insurance under the portability policy in order for any **Dependent(s)** to be eligible for coverage under the portability policy.

A **Dependent** who is **Your** spouse who is age 65 or younger may request portability coverage for him/herself and any insured **Dependent** child(ren):

a. in the event of **Your** death;
b. in the event of divorce, dissolution of partnership or legal separation from **You**; or
c. when **You** enter active duty service or training in any military for a period of 31 days or more and are no longer eligible under the **Policy** as an **Employee**.

If a **Dependent** spouse elects coverage under the portability policy, the **Dependent** spouse will become the **Insured** under the portability policy. Any **Dependent** child(ren) may only be covered under one portability policy.

When coverage under the **Policy** ends, notice of the right to request portability coverage will be given. To elect coverage under a group portability policy, **You** or **Your Dependent** spouse must send a request to **Us**. The benefits and premium rates of the portability policy are described on **Our** portability request form, which can be obtained by contacting the **Policyholder** or **Us**.

The request and the initial **Premium** due must be received within 31 days after insurance under the **Policy** ends. If timely notice is not given, an extension of the period of time in which to request portability coverage will be allowed. **You** or **Your Dependent** spouse will have 15 days from the date notice is received to submit his/her request and initial **Premium**. However, in no event will a request be accepted by **Us** if received more than 91 days after the date coverage under the **Policy** would otherwise end, even if notice is not received.

The continued group insurance coverage under the portability policy is available as a result of portability rights that arise solely from the **Policy**, as arranged for the **Employee** as an employee welfare benefit subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

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

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

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ELIGIBILITY FOR COVERAGE (continued)

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

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

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

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

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

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

a. the date **You** lose coverage due to the event.
b. the date **Your Employer** informed **You** that **You** may choose extension of coverage.

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

If **You** do not choose to extend coverage, **Your** group coverage for accident benefits with your **Employer** will end.

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

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

a. **Your Employer** no longer provides group coverage for accident benefits to any **Employees**.
b. **You** do not pay the **Premium** for your extension of coverage on time.
c. **You** become covered under another group policy for accident benefits that does not include a preexisting condition exclusion or limitations on preexisting conditions you may have after the date of your extension of coverage election.
d. **You** become entitled to **Medicare** after the date of your extension of coverage election.

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

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BENEFITS

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

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

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

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

This benefit is payable one time(s) per **Accident** per **Insured**.

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

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

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

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

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

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

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Hospital Admission Benefit

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

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

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

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

Intensive Care Unit (ICU) Admission Benefit

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

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

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

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

Hospital Confinement Benefit

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

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

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

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

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

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Intensive Care Unit (ICU) Confinement Benefit

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

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

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

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

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

Rehabilitation/Skilled Nursing Benefit

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

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

Exclusions and Limitations
Rehabilitation Facility Extension or Skilled Nursing Facility Benefits will not be paid when services or supplies are received for:

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

Blood/Plasma/Platelets Benefit

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

Surgery Benefit

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

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

Outpatient/Miscellaneous Surgery Benefit

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

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

Transportation Benefit

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

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

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

Family Lodging Benefit

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

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

This benefit is only payable:

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

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

Coma Benefit

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

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Follow Up Doctor's Visit Benefit

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

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

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

Physical Therapy Benefit

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

Chiropractic Visit Benefit

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

Medical Equipment Benefit

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

Prosthetic Device Benefit

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

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

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

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Burn Benefit

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

Paralysis Benefit

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

Lacerations Benefit

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

Emergency Dental Work Benefit

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

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

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

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

Eye Injury Benefit

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

Specific Injury Benefit

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

Dislocations Benefit

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

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

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

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

Fractures Benefit

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

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

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

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

Accidental Death Benefit

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

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

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

Common Carrier Accidental Death Benefit

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

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

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

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Accidental Dismemberment Benefit

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

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

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EXCLUSIONS AND LIMITATIONS

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

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

a. Suicide or attempted suicide, whether sane or insane, or intentionally self-inflicted **Injury**;
b. Declared or undeclared war or act of war;
c. Voluntary intoxication (as defined by the law of the jurisdiction in which the **Injury** occurred) or while under the influence of any narcotic, drug or controlled substance, unless administered by or taken according to the instruction of a **Physician** or medical professional;
d. Voluntary intoxication through use of poison, gas or fumes, whether by ingestion, injection, inhalation or absorption;
e. Committing or attempting to commit an assault or felony or voluntary participation in a riot or insurrection;
f. Travel in or descent from any vehicle or device for aviation or aerial navigation, except as a fare-paying passenger in a commercial aircraft (other than a charter airline) on a regularly scheduled passenger flight, or a method of transportation that meets the definition of a **Common Carrier**;
g. Ride in or on any motor vehicle or aircraft engaged in acrobatic tricks/stunts (for motor vehicles), acrobatic/stunt flying (for aircraft), endurance tests, or racing;
h. Participation in any organized sport in a professional or semi-professional capacity;
i. Participation in bungee jumping, hang gliding, parachuting, parakiting, parasailing, sail gliding, or skydiving;
j. Active duty service or training in the military (naval force, air force or National Guard/Reserves or equivalent) for service/training extending beyond 31 days of any state, country or international organization, unless specifically allowed by a provision of this **Certificate**; or
k. Disease or bodily/mental illness or degenerative process, or any related medical/surgical treatment or diagnostic procedures for such disease, illness or degenerative process.

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

l. Any **Loss** treated outside the United States, Canada or Mexico, except in emergency or urgent situations while traveling.
m. Services rendered by a person who ordinarily resides in **Your** household, is a member of **Your** immediate family, or is employed by or affiliated with **Your Employer**.

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GENERAL PROVISIONS

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

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

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

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

a. A completed claim form.
b. Documentation of: the date(s) of the services or supplies received.
c. The names and addresses of all **Providers**.
d. A certified copy of the death certificate (if applicable).
e. **Your** beneficiary designation (if applicable).
f. **Your** signed authorization for **Us** to obtain and release medical information.
g. Any additional information required by **Us** to make a determination on the claim.

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

Written **Proof of Loss** must be given to **Us** within 90 days after the date a **Loss** occurs.

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

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

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

a. **You**;
b. **Your** legally appointed guardian if **You** are not legally able to accept such benefits;
c. A **Provider** of medical treatment or services upon **Your** written direction; or
d. The Texas Department of Human Services if:
    1. Benefits for the child or children covered under this policy have been paid under financial and medical assistance programs administered pursuant to the Human Resources Code, and
    2. The parent who is covered under this policy has possession of or access to the child(ren) pursuant to a court order, or is not entitled to access or possession of the child but is required by the court to pay child support, and
    3. We have received notification that the benefits must be paid to the Texas Department of Human Services.

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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.

Failure to honor an **Assignment** to a **Provider** due to inadvertent error will not subject **Us** to double payment.

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

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

Symetra Life Insurance Company
PO Box 674419
Houston, TX 77267-4419
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 3 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.

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Time Limit on Certain Defenses

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

Workers' Compensation

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

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

ENHANCED SCHEDULED BENEFIT ACCIDENT RIDER

Policyholder:
Name: Vanguard Academy Charter School
Master Policy Number: 13404000 - Plan 3
Master Policy Effective Date: 05/01/26

Eligible Group:
Name: Employees of Vanguard Academy Charter School
Policy Number: 13404000 - Plan 3
Effective Date of Coverage: 05/01/26
Rider Effective Date: May 1, 2026

This Rider is attached to and made a part of your Certificate as of the Rider Effective Date. It is subject to all of the terms, conditions, provisions, limitations and exclusions of the Certificate except as they are expressly modified by this Rider.

The Certificate is hereby amended to include additional benefits as provided by this rider:

Enhanced Scheduled Accident Benefits

	Employee	Dependent Spouse	Dependent Child
➢ **Emergency Care & Diagnostics**			
Hospital Observation Initial	$150	$150	$150
Second Opinion Benefit	$300	$300	$300
➢ **Accident Hospitalization & Surgical Benefits**			
Initial Accident	$70	$70	$70
Anesthesiology Services	$200	$200	$200
Joint Replacement Surgery	$1,000	$1,000	$1,000
➢ **Follow-Up Care**			
Telemedicine Visit	$40	$40	$40
Home Health Care Services	$150	$150	$150
Enhanced Outpatient Therapies (Vocational, Occ, Speech, or Respty.)	$50	$50	$50
Acupuncture	$50	$50	$50
➢ **Lacerations**			
Puncture Wound	$30	$30	$30
➢ **Specific Injuries**			
Sprain	$200	$200	$200
PTSD due to Covered Accident	$750	$750	$750
Electric Shock/ Electrocution	$500	$500	$500
➢ **Brain Injuries**			
Moderate TBI	$750	$750	$750
Severe TBI	$1,000	$1,000	$1,000
Intracranial hemorrhage	$1,500	$1,500	$1,500
➢ **Accidental Poisoning**			
Carbon Monoxide	$750	$750	$750
Lead/ Hazardous chemical	$750	$750	$750

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➢ **Crime Victim Benefits**			
Carjacking	$300	$300	$300
Robbery/ Aggravated Assault	$400	$400	$400
Gunshot Victim	$1,500	$1,500	$1,500
➢ **Bite Would Benefits**			
Animal Bite Wound	$200	$200	$200
Bite Treatment Tetanus/ Rabies/Anti-Venom	$200	$200	$200
➢ **Assistive Modifications (home/ vehicle)**			
Home/ vehicle modifications	$2,000	$2,000	$2,000

Definitions

First Responder(s): paid law enforcement (sheriff or police), firefighters, EMTs, paramedics.

Gunshot: a ballistic wound caused by a discharge of a gun, typically a man-portable firearm, producing a visible flash, a powerful and loud shockwave and often chemical gunshot residue. **Gunshot** does not include a shot from a spring-loaded ball bearing (BB) gun, compressed air pellet gun, paint ball gun, or catapult-type gun, including, but not limited to, a crossbow, dart, or bolt.

Hazardous Chemical: includes heavy metals (such as lead), fumes (excluding Carbon Monoxide), household and industrial cleaners, propellants, cosmetics, acids, pesticides, fertilizers, paint, paint-stripping agents, adhesives, craft supplies, chlorine, cosmetics, eCigarettes, tobacco, batteries, automobile fluids, deodorizers, air fresheners, fire extinguishers, and mushrooms.

Puncture Wound: A puncture wound is usually caused by a sharp pointy object such as a nail or a tack, that pierces the full thickness of the skin.

Benefit Descriptions

Emergency Care & Diagnostics

Hospital Observation

This benefit applies only if it is shown in the **Enhanced Scheduled Accident Benefits**.

We will pay the Observation Unit benefit amount as shown in the **Enhanced Scheduled Accident Benefits** for the **Initial day** of observation you have in an observation unit as the result of an **Accident** or **Injury**. The initial day of observation must begin within 24 hours after your accident.

If your period of observation leads to a hospital stay, then:

a. The Observation unit benefit amount will not be paid.
b. The applicable Inpatient Hospital Admission or the Inpatient Hospital daily Benefits amounts are payable.

If your period of observation lasts greater than 24 consecutive hours, then:

a. The applicable Inpatient Hospital Admission or the Inpatient Hospital daily Benefit amounts are payable.
b. The Observation unit benefit amount will not be paid.

We will pay the greater of the Observation Unit, Emergency room or Physician visit Office/Urgent care facility benefit amount for the initial treatment of an **Accident** or **Injury**.

This benefit will not be paid to you for pre-operative and post-operative care.

Second Opinion Benefit

This benefit applies only if it is shown in the **Enhanced Scheduled Accident Benefits**.

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We will pay the applicable Second Opinion Benefit shown in the **Enhanced Scheduled Accident Benefits** for **Hospital** or ICU Confinement if:

a. an **Insured** is admitted to a **Hospital** due to Injuries sustained in a covered **Accident**;
b. the **Hospital**'s utilization review program requires a second opinion from a **Physician**; and
c. the second opinion is provided within 180 days after the covered **Accident**.

The Second Opinion Benefit is payable only once per period of confinement, even if there are multiple Injuries for which a second option is sought. This benefit does not pay if the **Insured** seeks an elective second opinion.

Accident Hospitalization & Surgical Benefits

Initial Accident

This Benefit applies only if it is shown in the **Enhanced Scheduled Accident Benefits.**

We will pay the **Initial Accident** Benefit, as shown in the **Enhanced Scheduled Accident Benefits** if the **Insured** sustains any covered **Injury**(ies) as the result of a covered **Accident**. The Initial Accident Benefit is payable 1 time per **Accident** per **Insured**. This benefit may be used any way the **Insured** desires but was designed with the intent of defraying incidental costs associated with an **Accident**, such as over the counter and prescription medications, medical supplies, local transportation, parking, fuel, short-term childcare costs.

Anesthesiology Services

This benefit applies only if it is shown in the **Enhanced Scheduled Accident Benefits**.

We will pay the Anesthesiology Services Benefit, as shown in the **Enhanced Scheduled Accident Benefits** once per calendar day that an **Insured** undergoes an **Inpatient** or **Outpatient** surgical procedure requiring Anesthesiology that's performed in connection with an **Injury** while the **Insured** is covered under this benefit. Such surgical procedure must be performed within 180 days from the date of the **Accident**.

Joint Replacement Surgery

This benefit applies only if it is shown in the **Enhanced Scheduled Accident Benefits**.

We will pay the Joint Replacement Surgery Benefit, as shown in the **Enhanced Scheduled Accident Benefits** for each day an **Insured** undergoes **Inpatient** or **Outpatient** Surgery procedure to replace one of the following named joints: shoulder, elbow, wrist, hip, knee, or ankle due to an **Accident**, and must be performed within 365 days from the date of the **Accident**. Other joints not named here are not covered. This benefit is payable only one time per **Accident** per **Insured**, regardless of the number of joints that require replacement.

Follow-Up Care

Follow-Up TeleMedicine Visit

This benefit applies only if it is shown in the **Enhanced Scheduled Accident Benefits**.

We will pay the Follow-up TeleMedicine Visit Benefit, as shown in the **Enhanced Scheduled Accident Benefits**, for each day the **Insured** has a follow-up TeleMedicine visit with a **Doctor** for treatment of an **Injury**. The TeleMedicine visit must occur after initial treatment in a **Doctor's** office, **Emergency Room** or **Urgent Care facility** for a covered **Accident**. Benefits are payable for no more than 1 follow-up visit for the same **Injury**. Follow-up TeleMedicine visits must occur within 180 days from the date of the **Accident**.

Exclusions and Limitations

No Follow-up TeleMedicine Visit Benefit will be paid for:

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

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Home Health Care Services
This benefit applies only if it is shown in the **Enhanced Scheduled Accident Benefits**.

We will pay the Home Health Care Benefit for each Day **You** or **Your Insured Dependent** receives Home Health Care as the result of **Injuries** sustained in a Covered **Accident**. **We** will pay the Home Health Care benefit if **You** or **Your Insured Dependent** were confined in a **Hospital** as a result of **Injuries** sustained in a covered **Accident**, and continued **Hospital** confinement would otherwise be required if home health care is not provided. **You** or **Your Insured Dependent's** home health care plan, for the same **Injury** for which the hospitalization occurred, must be approved in writing by a **Physician** or advanced practice registered nurse, and must be provided by a **Home Health Agency**. The home health care plan must be approved and begin within 7 Days of the date of discharge. The home health care must begin within 180 days of a covered **Accident**. This benefit is payable for up to 80 days per person per covered **Accident**.

This Home Health Care Benefit will not be paid for the same day as a Hospital Confinement Benefit, a Physical Therapy Benefit, Enhanced Outpatient Therapy Benefit, Acupuncture Benefit or the Rehabilitation Unit Benefit.

Enhanced Outpatient Therapy Benefits
This benefit applies only if it is shown in the **Enhanced Scheduled Accident Benefits**.

We will pay the Vocational, Speech, Occupational, or Respiratory Therapy Benefit as shown in the **Enhanced Scheduled Accident Benefits**, for any calendar day the **Insured** receives Vocational, Speech, Occupational, or Respiratory therapy in a **Health Care Facility** as the result of an **Accidental Injury** that occurs while the **Insured** is covered for this benefit. The therapy must begin within 90 days after the date of the **Accident**. The Vocational, Speech, Occupational, or Respiratory Therapy Benefit will be paid only 1 time per day, regardless of the number of therapy modalities completed on a single day and is not payable for the same days that a Home Health Care, Follow-Up Doctor's Visit Benefit, Follow Up TeleMedicine Benefit, Acupuncture Therapy, or a Rehabilitation/Skilled Nursing Benefit is paid. Benefit maximum is 10 day(s) per person, per **Accident**.

Acupuncture Therapy
This benefit applies only if it is shown in the **Enhanced Scheduled Accident Benefits**.

We will pay the Acupuncture Therapy Benefit as shown in the **Enhanced Scheduled Accident Benefits**, for any calendar day the **Insured** receives Acupuncture therapy in a **Health Care Facility** as the result of an **Accident** that occurs while the **Insured** is covered for this benefit. Acupuncture therapy must begin within 90 days after the date of the **Accident**. The Acupuncture Therapy Benefit is not payable for the same days that a Home Health Care, Follow-Up Doctor's Visit Benefit, Follow Up TeleMedicine Benefit, Vocational therapy, Speech Therapy, Behavioral Health Therapy, or a Rehabilitation/Skilled Nursing Benefit is paid. Benefit maximum is 10 day(s) per person, per **Accident**.

Lacerations
Puncture Wound
This benefit applies only if it is shown in the **Enhanced Scheduled Accident Benefits**.

We will pay the **Puncture Wound** Benefit, as shown in the **Enhanced Scheduled Accident Benefits**, if the **Insured** sustains a **Puncture Wound** as the result of an **Accident**. Only one Puncture Wound Benefit is payable per **Accident**, per **Insured**. The **Puncture Wound** must be treated by a **Doctor** within 24 hours after the **Accident**. This benefit will not be paid for any day for which an Animal Bite Benefit is payable.

Specific Injuries
Sprain
This benefit applies only if it is shown in the **Enhanced Scheduled Accident Benefits**.

We will pay the Sprain Benefit, as shown in the **Enhanced Scheduled Accident Benefits**, if an **Insured** sustains a sprain to one of the following body parts: ankle, knee, wrist, thumb, or shoulder as the result of an **Accident**. Benefit amounts are based on the type of sprain sustained by the **Insured** as indicated in the **Enhanced Scheduled Accident Benefits**. The sprain must be treated by a **Doctor** within 30 days after the **Accident**. Sprains to other body parts not named here will not be covered. **We** will pay no more than 2 sprain benefits per **Accident** per **Insured**.

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If an **Insured** sustains a sprain to a named body part and a fracture or dislocation due to the same **Accident**, **We** will pay benefits as noted for each condition.

Post-Traumatic Stress Disorder (PTSD) due to Covered Accident
This benefit applies only if it is shown in the **Enhanced Scheduled Accident Benefits**.

We will pay the PTSD benefit due to a Covered Accident Benefit, as shown in the **Enhanced Scheduled Accident Benefits**, if the **Insured** sustains, a new diagnosis of PTSD as the result of a covered **Accident**. The **Insured** must be diagnosed with PTSD within 90 days after the covered **Accident**.

Electric Shock/ Electrocution
This benefit applies only if it is shown in the **Enhanced Scheduled Accident Benefits**.

We will pay the Electrocution Benefit, as shown in the **Enhanced Schedule Accident Benefits**, if the **Insured** is electrocuted or receives an electrical shock as the result of an **Accident**. The **Injury** must require surgery or medical treatment within 24 hours after the **Accident**. This benefit will not be paid if the **Insured** dies as a result of their injuries.

Brain Injuries

Moderate Traumatic Brain injury (TBI)
This benefit applies only if it is shown in the **Enhanced Scheduled Accident Benefits**.

We will pay the Moderate TBI Benefit, as shown in the **Enhanced Scheduled Accident Benefits**, if the **Insured** suffers an **Injury** that results in a period of unconsciousness lasting between 30 minutes – 24 hours as the result of an **Accident**. The **Injury** must require surgery or medical treatment within **2** days after the **Accident**. Only one specific injury benefit is payable per **Accident** per **Insured**. If the **Insured** sustains multiple **Traumatic Brain Injuries**, only the highest benefit will be paid.

Severe Traumatic Brain injury (TBI)
This benefit applies only if it is shown in the **Enhanced Scheduled Accident Benefits**.

We will pay the Severe TBI Benefit, as shown in the **Enhanced Scheduled Accident Benefits**, if the **Insured** suffers an **Injury** that results in a period of unconsciousness lasting greater than 24 hours as the result of an **Accident**. The **Injury** must require surgery or medical treatment within **3** days after the **Accident**. Only one specific injury benefit is payable per **Accident** per **Insured**. If the **Insured** sustains multiple **Traumatic Brain Injuries**, only the highest benefit will be paid.

Intracranial Hemorrhage
This benefit applies only if it is shown in the **Enhanced Scheduled Accident Benefits**.

We will pay the Intracranial Hemorrhage Benefit, as shown in the **Enhanced Scheduled Accident Benefits**, if the **Insured** suffers an **Injury** that results in an Intracranial Hemorrhage as the result of an **Accident**. The **Injury** must require surgery or medical treatment within **3** days after the **Accident**. Only one specific injury benefit is payable per **Accident** per **Insured**. However, if the **Insured** sustains an intracranial hemorrhage as well as a **Traumatic Brain Injury**, both benefits will be paid.

Accidental Poisonings

Carbon Monoxide
This benefit applies only if it is shown in the **Enhanced Scheduled Accident Benefits**.

We will pay the Carbon Monoxide Poisoning Benefit, as shown in the **Enhanced Scheduled Accident Benefits**, if the **Insured** sustains carbon monoxide poisoning as the result of an **Accident**. The **Injury** must require medical treatment within 1 day after the **Accident**. Only one accidental poisoning benefit is payable per **Accident** per **Insured**. If the **Insured** sustains multiple accidental poisonings, only the highest benefit will be paid.

Lead/ Hazardous Chemical
This benefit applies only if it is shown in the **Enhanced Scheduled Accident Benefits**.

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We will pay the Lead/**Hazardous Chemical** Poisoning Benefit, as shown in the **Enhanced Scheduled Accident Benefits**, if the **Insured** sustains a lead or other **Hazardous Chemical** poisoning as the result of an **Accident**. The **Injury** must be substantiated by medical documentation from a **Physician, Doctor,** or other health care provider showing a moderate or severe poisoning resulting from a named **Hazardous Chemical** for which medical attention was sought within 3 day(s) after the **Accidental** ingestion or exposure. Only one Lead/ **Hazardous Chemical** Poisoning Benefit is payable per **Accident** per **Insured**. If the **Insured** sustains multiple **accidental** poisonings, only the highest benefit will be paid.

Exclusions
Alcohol poisoning resulting from ingestion of alcoholic beverages, and Carbon Monoxide poisoning are specifically excluded from this benefit.

Crime Victim

Carjacking
This benefit applies only if it is shown in the **Enhanced Scheduled Accident Benefits**.

We will pay the Carjacking Benefit, as shown in the **Enhanced Scheduled Accident Benefits**, if the **Insured** is the victim of carjacking and sustains a covered **injury** as a result. The carjacking must be documented via a police report within 24 hours of the incident. The **Injury** must require medical treatment within 2 days after the **Accident**.

Robbery/Aggravated Assault Benefit
This benefit applies only if it is shown in the **Enhanced Scheduled Accident Benefits**.

We will pay the Robbery/Aggravated Assault Benefit, as shown in the **Enhanced Scheduled Accident Benefits**, if an **Insured** sustains a robbery/aggravated assault resulting in covered **injuries**. The robbery/aggravated assault must be reported to local police, sheriff, or federal authorities, as appropriate for the crime, within 24 hours of the assault. The Robbery/Aggravated Assault Benefit is payable 1 time per **Accident** per **Insured**.

Gunshot Wound Benefit
This benefit applies only if it is shown in the **Enhanced Scheduled Accident Benefits**.

We will pay the **Gunshot** Wound Benefit, as shown in the **Enhanced Scheduled Accident Benefits**, if while on or off duty from any occupation, an **Insured** sustains a **Gunshot** wound resulting in covered **Injuries**. The **Gunshot** Wound Benefit is payable 1 time per **Accident** per **Insured**, regardless of the number of **Gunshot** wounds sustained. This benefit is not paid if the **Insured** doesn't survive the **Gunshot** wound injuries.

Animal Bites

Animal Bite Wound Benefit
This benefit applies only if it is shown in the **Enhanced Scheduled Accident Benefits**.

We will pay the Animal Bite Wound Benefit, as shown in the **Enhanced Scheduled Accident Benefits**, if an **Insured** sustains an animal bite wound resulting in covered **Injuries**. The animal bite wound benefit is payable 1 time per **Accident** per **Insured**, regardless of the number of animal bite wounds sustained.

Animal Bite Treatment Benefit (Tetanus, Rabies, or Anti-Venom)
This benefit applies only if it is shown in the **Enhanced Scheduled Accident Benefits**.

We will pay the Animal Bite Treatment Benefit, as shown in the **Enhanced Scheduled Accident Benefits**, if an **Insured** sustains an animal bite wound resulting in the need for **Tetanus, Rabies, or Anti-Venom** treatments. The need for the Tetanus, Rabies, or Anti-Venom treatment must be determined by a doctor. This animal bite treatment benefit is payable up to 3 time(s) per **Accident** per **Insured**, regardless of the number of animal bite treatments required.

Assistive Modifications

Assistive Modifications Benefit
This benefit applies only if it is shown in the **Enhanced Scheduled Benefits.**

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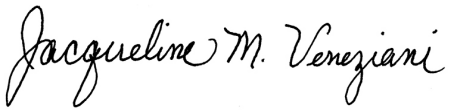
Assistive Modifications (Vehicle/ Home)
We will pay the Vehicle/ Home Modifications Benefit, as shown in the **Enhanced Scheduled Accident Benefits**, if the **Insured** sustains accidental **Injuries** while the **Insured** is covered for this benefit which results in the need for permanent modifications to their home or vehicle. The Vehicle/ Residence Modifications Benefit is payable up to 1 time(s) per **Accident** per **Insured**, but only once for each location that requires modification. The need for such assistive modifications must be identified within 365 days of the **Accident**.

Signed for by Symetra Life Insurance Company at Bellevue, Washington.

Margaret Meister,
President



Jacquie Veneziani
Secretary

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

ENHANCED CATASTROPHIC ACCIDENT BENEFIT(S) RIDER

Policyholder:
Name: Vanguard Academy Charter School
Master Policy Number: 13404000 - Plan 3
Master Policy Effective Date: 05/01/26

Eligible Group:
Name: Employees of Vanguard Academy Charter School
Policy Number: 13404000 - Plan 3
Effective Date of Coverage: 05/01/26
Rider Effective Date: May 1, 2026

This Rider is attached to and made a part of your Certificate as of the Rider Effective Date. It is subject to all of the terms, conditions, provisions, limitations and exclusions of the Certificate except as they are expressly modified by this Rider.

This Certificate is hereby amended to include additional benefits as provided by this Rider:

Schedule of Benefits

Catastrophic Accident Benefits

	Employee	Dependent Spouse	Dependent Child
➢ **Catastrophic Accident Benefits**			
Terminal Injury Advance Payment Benefit	10%	10%	10%
Workplace Death	10%	10%	10%
Natural Disaster Death	10%	10%	10%
Mass Shooting Death	10%	10%	10%
Survivor Income	5%	N/A	N/A

Definitions

Capitalized and bolded words and terms have the meanings set forth below.

Mass Shooting: *an incident where four or more individuals (excluding any perpetrators) were shot in conjunction with a single event or incident, regardless of number of fatalities or the motive.*

Natural Disaster: *catastrophic events that result from any of the Earth's natural phenomena. Covered events include floods, tornados, hurricanes, earthquakes, lightning strikes, volcanoes, landslides and tsunamis.*

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Benefit Descriptions

Terminal Injury Advance Payment Benefit 10%

This benefit applies only if it is shown in the list of **Catastrophic Accident Benefits.**

We will pre-pay the portion of additional benefit multiplier as shown in the **Schedule of Benefits** if the **Injury** sustained by the **Insured** results in a prognosis that the **Insured's** loss of life is predicted within 180 days. **We** must receive proof that the **Insured** sustained an **injury** that is projected to result in the loss of their life as the result of an **Accident** that occurred while covered under this benefit, and the **Injury**:

a. Was the direct result of an **Accident**;
b. Was independent of all other causes; and
c. The death is predicted to occur within 180 days of the **Accident**.

The balance of the **Accidental** Death Benefit will be paid following the death. Terminal **Injury** Advance Pre-Payment Benefits will be paid in accordance with the **beneficiary** designation provisions of this Certificate. If, after a pre-payment is paid, the **Insured** does not die, any pre-paid death benefit will not be re-paid to the **Company**. If the **Insured** should die between the time of diagnosis and 364 days from the date of the terminal diagnosis, only the remaining portion of the Accidental Death Benefit will be paid.

At 365 days from the date of the terminal diagnosis, if the **Insured** is still living, the Accidental Death Benefit will reset to the original full benefit amount, as shown in the **Schedule of Benefits**.

For example, if an **Insured's** Accidental Death Benefit is $50,000, and the plan includes a Terminal **Injury** Advance Payment Benefit of 15%, and that **Insured's** is diagnosed with a terminal **injury** as described above, this benefit would allow the **Insured** to receive 15% of that death benefit ($7,500) upon such diagnosis. The remaining $42,500 of **Accidental** Death Benefit will be paid if/ when the **Insured** dies from his terminal injuries, as noted above.

Workplace Death Benefit 10%

This benefit applies only if it is shown in the list of **Catastrophic Accident Benefits.**

We will pay the additional benefit multiplier as shown in the **Schedule of Benefits** if an **Injury** sustained by the **Insured** occurred in the **Insured's** workplace and results in the **Insured's** loss of life. **We** must receive proof that the **Insured** sustained the **Injury** that resulted in the loss of their life as the result of an **Accident** that occurred while covered under this benefit, and the death:

a. Was the direct result of an **Accident**
b. The **Accident** occurred at the **Insured's** place of work;
c. Was independent of all other causes; and
d. Occurred within 180 days of the **Accident**.

For example, if an **Insured's Accidental** Death Benefit is $50,000, and the plan contains a Workplace Death Benefit of 15% and that **Insured** sustains a workplace **injury** that results in the **Insured's** death, this benefit will pay an additional 15% of that death benefit ($7,500). The **Accidental** Death Benefit would pay $50,000, and this rider would pay an additional $7,500, for a total of $57,500.

Natural Disaster Death Benefit 10%

This benefit applies only if it is shown in the list of **Catastrophic Accident Benefits.**

We will pay the additional benefit multiplier as shown in the list of **Catastrophic Accident Benefits** if an **Injury** sustained by the **Insured** occurred as a direct result of a **Natural Disaster** and results in the **Insured's** loss of life. **We** must receive proof that the **Insured** sustained the injury that resulted in the loss of their life as the result of an **Accident** that occurred while covered under this benefit, and the death:

a. Was the direct result of an **Accident**
b. The **Accident** occurred as a direct result of a **Natural Disaster**;
c. Was independent of all other causes; and
d. Occurred within 180 days of the **Accident**.

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For example, if an **Insured's Accidental** Death Benefit is $50,000, and the plan includes a **Natural Disaster** Death Benefit of 15%, and that **Insured** dies as a result of a **Natural Disaster** as described above, this benefit would pay an additional 15% of that benefit ($7,500). The Accidental Death Benefit would pay $50,000, and this rider would pay another $7,500, for a total of $57,500.

Mass Shooting Death Benefit 10%

This benefit applies only if it is shown in the list of **Catastrophic Accident Benefits.**

We will pay the additional benefit multiplier as shown in the **Schedule of Benefits** if an **Injury** sustained by the **Insured** occurred as a direct result of a **Mass Shooting** and results in the **Insured's** loss of life. **We** must receive proof that the **Insured** sustained the **Injury** that resulted in the loss of their life as a result of an **Accident** that occurred while covered under this benefit, and the death:

a. Was the direct result of an **Accidental Injury**
b. The **Accident** occurred as a direct result of a **Mass Shooting**;
c. Was independent of all other causes; and
d. Occurred within 180 days of the **Accident**.

For example, if an **Insured's Accidental** Death benefit is $50,000, and the plan includes a **Mass Shooting** Death Benefit of 15%, and that **Insured** dies as a result of a **Mass Shooting** Death as described above, this benefit would pay an additional 15% of that benefit ($7,500). The **Accidental** Death Benefit would pay $50,000, and this rider would pay an additional $7,500, for a total of $57,500.

Survivor Income Benefit 5%

This benefit applies only if it is shown in the list of **Catastrophic Accident Benefits.**

a. We will pay the Survivor Income Benefit Amount shown in the Benefit Schedule if: 1) **You** die as the result of an **Accident** for which a death benefit is payable under the **Policy**; 2) at the time of **Your** death, one or more of **Your Dependent(s)** are living and covered under the **Policy** and 3) the death: Was the direct result of an **Injury**
b. Was independent of all other causes; and
c. Occurred within 180 days of the **Accident**.

This benefit is only payable for each month following the date of **Your** death until the earlier of: 1) a total of 6 monthly payments have been made; or 2) all of **Your Dependent(s)** become deceased. This benefit is only payable once per month regardless of **Your** number of living **Dependent(s)**. This benefit is payable in addition to any other benefits payable under the **Policy**.

For example, if an **Insured's** Accidental Death Benefit is $50,000, and the plan includes a Survivor Income Benefit of 15%, and that **Insured** dies as a result of an **Accident** as described above, and has a living **dependent** as described above who is covered under the **Policy**, we will pay the **Accidental** Death Benefit of $50,000, and we will also pay a Survivor income benefit of 15% ($7,500) per month as described above.

Exclusions:

Any/all **Dependent Insureds** are ineligible for this benefit.

Signed for Symetra Life Insurance Company at Bellevue, Washington.

Margaret Meister,
President

Jacquie Veneziani
Secretary

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(Domiciled in Iowa)

CONTINUATION OF COVERAGE RIDER

Policyholder:	
Name:	Vanguard Academy Charter School
Master Policy Number:	13404000 - Plan 3
Master Policy Effective Date:	05/01/26
Eligible Group:	
Name:	Employees of Vanguard Academy Charter School
Policy Number:	13404000 - Plan 3
Effective Date of Coverage:	05/01/26
Rider Effective Date:	May 1, 2026

This Rider is attached to and made a part of **Your** Certificate as of the Rider Effective Date. It is subject to all of the terms, conditions, provisions, limitations and exclusions of the Certificate except as they are expressly modified by this Rider.

The Certificate is hereby amended to include additional benefits as provided by this rider:

This Rider provides for continuation of an **Insured's** coverage when temporarily absent from work.

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**.

Personal 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.

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 3 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. 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**.

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Military Leave of Absence:
If **You** are on a military leave of absence take 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 12 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.

Sabbatical:
If **You** are on an employer-approved sabbatical, all of **Your** coverage may be continued for up to 2 months 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 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 2 months 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** not at work due to a labor strike or dispute, all of **Your** coverage may be continued for up to 1 months 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.

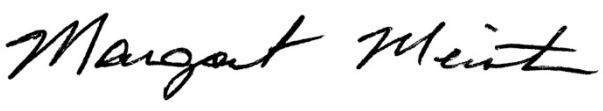
Your coverage will not be continued for any Absence occurring within thirty (30) days after any Absence for which coverage was continued.

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

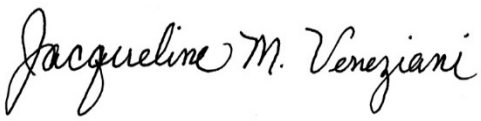
Upon written request from **Your Employer**, we may agree to continue **Your** coverage for reasons other than those listed above, provided **Your Employer** provides a plan of continuation which applies to all **Employees** the same way.

5/1/26

Signed for by Symetra Life Insurance Company at Bellevue, Washington.



Margaret Meister
President



Jacqueline M. Veneziani
Secretary

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WELLNESS SCREENING BENEFIT(S) RIDER

Policyholder:	
Name:	Vanguard Academy Charter School
Master Policy Number:	13404000 - Plan 3
Master Policy Effective Date:	05/01/26
Eligible Group:	
Name:	Employees of Vanguard Academy Charter School
Policy Number:	13404000 - Plan 3
Effective Date of Coverage:	05/01/26
Rider Effective Date:	May 1, 2026

This Rider is attached to and made part of **Your** Certificate as of the Rider **Effective Date**. It is subject to all of the terms, conditions, provisions, limitations and exclusions of the **Certificate** except as they are expressly modified by this **Rider**.

The **Certificate** is hereby amended to include additional benefits as provided by this rider:

Benefit(s)

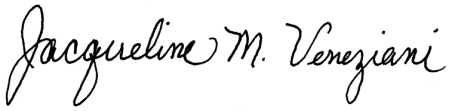
We will pay the benefit amount indicated in the table below for each day **You** or **Your Dependent(s)** undergo any of the screening tests or exams listed in this **Rider** during a calendar year. The benefit(s) listed in this **Rider** will be limited to 1 screening test or exam per calendar year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

Screening Tests	Benefit Amount
Abdominal aortic aneurysm ultrasonography	$75
Baseline testing for Concussion	$75
Blood test for lipids, including total cholesterol, LDL, HDL and triglycerides	$75
Bone Density screening	$75
Bone Marrow testing	$75
Breast MRI	$75
Breast Ultrasound	$75
CA 15-3 blood test for breast cancer	$75
CA 125 blood test for ovarian cancer	$75
Carotid Doppler	$75
CEA blood test for colon cancer	$75
Chest X-ray	$75
Colonoscopy or virtual colonoscopy	$75
CT angiography	$75
Electrocardiogram	$75
Fasting blood glucose test	$75
Flexible sigmoidoscopies	$75
Mammograms	$75
Pap smears	$75
Prostate-specific antigen (PSA) test	$75
Serum cholesterol test to determine level of HDL and LDL	$75
Stress test on a bicycle or treadmill	$75
Testicular ultrasound	$75
Thermography	$75
ThinPrep Pap Test	$75

Exams	Benefit Amount
Annual Physical Exams	$75
Biometric Screening	$75
Child sports physicals	$75
Dental Exam/Cleaning	$75
Eye exam	$75
Immunizations	$75
Well Child visit	$75

Signed for Symetra Life Insurance Company at Bellevue, Washington.

Margaret Meister,
President



Jacquie Veneziani,
Secretary

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

ORGANIZED SPORT ACTIVITY BENEFIT(S) RIDER

Policyholder:	
Name:	Vanguard Academy Charter School
Master Policy Number	13404000 - Plan 3
Master Policy Effective Date:	05/01/26
Eligible Group:	
Name:	Employees of Vanguard Academy Charter School
Policy Number:	13404000 - Plan 3
Effective Date of Coverage:	05/01/26
Rider Effective Date:	May 1, 2026

This Rider is attached to an made a part of your Certificate as of the Rider Effective Date. It is subject to all of the terms, conditions, provisions, limitations and exclusions of the Certificate except as they are expressly modified by this Rider.

The Certificate is hereby amended to include additional benefits as provided by this Rider:

Schedule of Benefits

This Rider provides an additional 25%, up to $5,000 for benefits payable under the **Policy** if the **Accident** occurred while an **Insured** is participating in an **Organized Sport**. To be paid, the **injured** person must be **insured** under the **Policy** on the date the **Accident** occurred.

Definition(s)

Capitalized and bolded words and terms have the meanings set forth below.

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

Signed for Symetra Life Insurance Company at Bellevue, Washington.

Margaret Meister,
President

Jacqueline M. Veneziani,
Secretary

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

Policyholder:	
Name:	Vanguard Academy Charter School
Master Policy Number:	13404000 - Plan 3
Master Policy Effective Date:	05/01/26
Eligible Group:	
Name:	Employees of Vanguard Academy Charter School
Policy Number:	13404000 - Plan 3
Effective Date of Coverage:	05/01/26
Rider Effective Date:	May 1, 2026

This Rider is attached to and made part of your Certificate as of the Rider Effective Date. It is subject to all of the terms, conditions, provisions, limitations and exclusions of the Certificate except as they are expressly modified by this rider.

The Certificate is hereby amended to include additional benefits as provided by this rider:

Rider Benefit Face Amount: $5,000

Childcare Benefit $1,600

We will pay the Childcare Benefit, as the noted portion of the face amount as shown above, if the **Insured** or their covered **Dependent** spouse, domestic partner or civil union partner who is responsible for the care of covered Dependent child(ren) aged 12 or younger that reside in their home, sustains a covered accidental **Injury**(ies) while the **Insured** is covered for this benefit. The Childcare Benefit is payable weekly up to 4 times per **Accident** per **Insured**, regardless of the number of children the **Insured** has. Documentation of the childcare expenses must be submitted. The benefit will not be paid for childcare that was already in place before the covered accident.

Pet Care/ Boarding Benefit $800

We will pay the Pet Care/ Boarding Benefit, as the noted portion of the face amount as shown above, if the **Insured** or their covered **Dependent** spouse, domestic partner or civil union partner who is responsible for the care of canine, feline or equine pets that reside at their residence sustains **accidental Injuries** while the **Insured** is covered for this benefit. The Pet Care/ Boarding Benefit is payable weekly, up to 4 times per **Accident** per **Insured**, regardless of the number of pets the **Insured** has. Documentation of the pet care/ boarding expenses must be submitted. The benefit will not be paid for pet care/ boarding that was already in place before the covered accident.

Signed for Symetra Life Insurance Company at Bellevue, Washington.

Margaret Meister,
President

Jacqueline M. Veneziani,
Secretary

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PARENTAL CAREGIVER BENEFIT(S) RIDER

Policyholder:	
Name:	Vanguard Academy Charter School
Master Policy Number:	13404000 - Plan 3
Master Policy Effective Date:	05/01/26
Eligible Group Name:	Employees of Vanguard Academy Charter School
Policy Number:	13404000 - Plan 3
Effective Date of Coverage:	05/01/26
Rider Effective Date:	May 1, 2026

This Rider is attached to and made a part of your Certificate as of the Rider Effective Date. It is subject to all of the terms, conditions, provisions, limitations and exclusions of the Certificate except as they are expressly modified by this Rider.

The Certificate is hereby amended to include additional benefits as provided by this rider:

DEFINITIONS

Capitalized and bolded words and terms have the meanings set forth below.

Accident: a sudden, unforeseen, unexpected and involuntary event definite as to time and place. In order for benefits under the **Policy** to be payable, the **Accident** must occur while the **Insured**'s coverage is in force.

Dependent:

By attaching this rider to a **Certificate**, the definition of a **Dependent**, as shown in the certificate, is hereby amended to also include the following additional dependents:

a. **Your** parent(s) and/or grandparent(s) that reside with **You** full time.
b. The parent(s) and/or grandparent(s) of **Your** spouse, as defined by state law, or the parent(s) and/or grandparent(s) of **Your** same or opposite sex civil union or domestic partner, that reside with **You** full time. All references to spouse, or any other term that denotes a spousal relationship, used in this Certificate will apply to a civil union partner or domestic partner.

Benefit Amounts
By attaching this rider to a certificate, the individuals defined in items a. and b. above will become (a) covered insured(s) under the certificate. The benefit amounts payable for parent(s) or grandparent(s) of the employee or their covered spouse or same or opposite sex civil union or domestic partner will be same as shown on the **Schedule of Benefits** and any attached riders for the employee, except as noted below.

Exclusions

Parental Caregiver Benefits do not include any of the following benefits which may be included on the plan's Schedule of Benefits:

- Wellness Screening Benefits Rider
- Organized Sport Activity Benefits Rider
- Catastrophic/Enhanced Catastrophic Accident Benefits / Dismemberment Benefits
- Family Care Benefit Rider

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Signed for Symetra Life Insurance Company at Bellevue, Washington.

Margaret Meister,
President

Jacqueline M. Veneziani,
Secretary

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RESIDENCE STATE AMENDMENT

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

If **You** do not reside in the Governing Jurisdiction state shown above, **Your Certificate** is hereby amended as stated below to comply with the laws of **Your** state of residence.

Only those references in this amendment to benefits, provisions or terms actually included in **Your Certificate** will apply to **You**. In addition, any reference made herein to **Dependent** coverage will only apply if **Dependent** coverage is provided in **Your Certificate**.

This amendment is attached to and made part of the **Certificate** that forms part of the **Policy**. All other provisions of **Your Certificate** remain unchanged.

For Alaska Residents

1. Item e. in the definition of "**Hospital**" appearing in the **DEFINITIONS** section shall read:

e. Operates pursuant to **Law**.

2. Item n. in the **EXCLUSIONS AND LIMITATIONS** section shall read:

n. Any **Loss** treated outside the United States, Canada or Mexico;

For Arkansas Residents

1. The third paragraph of the "**Termination of Dependent Coverage**" provision in the **ELIGIBILITY FOR COVERAGE** section shall read:

Proof of the disabling impairment must be given to as soon as reasonably possible after the date **Your** child attains the **Limiting Age**. Subsequently, **We** have the right to require proof of **Your** child's impairment, at **Our** expense, but not more often than once per year after two years from the date the **Limiting Age** is attained.

For California Residents

1. The **DEFINITIONS** section is amended by deleting the definition of "**Custodial Care**."

2. The definition of "**Injury**" in the **DEFINITIONS** section is revised to read:

Injury: bodily harm that is caused by an **Accident** and is the proximate/predomination cause of the loss.

3. The "**Proof of Loss**" provision in the **GENERAL PROVISIONS** section is amended by deleting the sentence "All proof submitted must be satisfactory to **Us**."

4. The "**Time Limit on Certain Defenses**" provision in the **GENERAL PROVISIONS** section shall read:

After this **Policy** has been in force for three years, no statements of the **Employer** contained in the application, and no statement relating to insurability made by any **Insured** eligible for coverage under this **Policy** shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of three years during the lifetime of the person with respect to whom any such statement was made.

5. Items m., p., and q. in the **EXCLUSIONS AND LIMITATIONS** section shall read:

m. Disease or bodily/mental illness, infirmity or degenerative process that is not the result of an **Accident**, or any related medical/surgical treatment or diagnostic procedures for such disease, illness or degenerative process.

p. Dental treatment except as a result of **Accident**; or

q. Services (including room and board) or supplies that:
   i. Are provided to an **Insured** primarily to help the **Insured** walk, groom, bathe, dress, get in or out of bed, toilet, eat or prepare foods;
   ii. Can safely be provided by persons without special occupational skills and experience; and
   iii. Are not essential for the diagnosis or treatment of the condition regardless of where these services or supplies are provided or who recommends them.

For Connecticut Residents

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

THIS IS A LIMITED BENEFIT POLICY. PLEASE READ IT CAREFULLY.

Notice: This is a group accident only insurance Policy. It does not pay benefit for losses caused by sickness.

2. The "**BENEFITS**" section of the **Table of Contents** is amended to also include:

Home Health Care Benefit

3. The "**Emergency Room**" item in the "**Emergency Care & Diagnostics**" part of the **SCHEDULE OF BENEFITS**, the following provision is added:

Emergency Room*
* If the Emergency Room benefit is payable as a result of the accidental ingestion of a controlled drug, the maximum amount payable per **Accident**, per Insured is $500.

4. The "**Accident Hospitalization & Surgical Benefits**" part of the **SCHEDULE OF BENEFITS** is amended by adding:

Home Health Care	Employee **$100**	Dependent Spouse **$100**	Dependent Child **$100**

5. The **DEFINITIONS** section is amended by adding:

Home Health Agency: an agency or organization that:
a) Is primarily engaged in the activities of, and is federally certified as, a Home Health Agency:
b) Is duly licensed by the appropriate licensing authority, if such licensing is required, to provide nursing and other therapeutic services;
c) Provides for full-time supervision of such services by a physician or by a registered nurse;
d) Maintains a complete medical record on each patient;
e) Has an administrator; and
f) Whose policies are established by a professional group associated with such agency or organization, including at least one physician and at least one registered nurse, to govern the services provided.

Participation or Participating: voluntarily taking part in, engaging in, or actively planning an activity or event.

Riot: a disturbance of the peace for personal or political reason which causes: (1) the disruption of normal public or business activities; or (2) damage or destruction of property; or (3) injury or death to persons.

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

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

7. The "**Hospital Confinement Benefit**" (if included) is amended by adding:

In addition, if the **Hospital Confinement Benefit** is payable as a result of the accidental ingestion of a controlled drug, the benefit will only be paid for a maximum of 30 days per **Accident**, per **Insured**.

8. The **BENEFITS** section shall include the following "**Home Health Care**" benefit:

Home Health Care Benefit
We will pay the **Home Health Care** benefit for each **Day You** or **Your Insured Dependent** receive(s) **Home Health Care** as a result of **Injuries** sustained in a **Covered Accident**. **We** will pay the **Home Health Care** benefit only if **You** or **Your Insured Dependent** were confined in a **Hospital** as a result of Injuries sustained in a **Covered Accident**, and continued **Hospital** confinement would otherwise be required if **Home Health Care** is not provided. **You** or **Your Insured Dependent's Home Health Care** plan, for the same **Injury** for which the hospitalization occurred, must be approved in writing by a **Physician** or advanced practice registered nurse, and must be provided by a **Home Health Agency**. The **Home Health Care** plan must be approved and begin within 7 **Days** of the **Date** of discharge. The **Home Health Care** must being within 90 **Days** of a **Covered Accident**. This benefit is payable for up to 80 days per person per **Covered Accident**.

This **Home Health Care Benefit** will not be paid for the same day as a **Hospital Confinement Benefit**, a **Physical Therapy Benefit** or the **Rehabilitation Unit Benefit** (if included).

9. The **EXCLUSIONS AND LIMITATIONS** section is amended as follows: Item d. is deleted and items c. and e. shall read:

c. Voluntary intoxication or used of a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now and hereafter amended, unless administered by or taken according to the instruction of a **Physician** or medical professional;

e. Participation in an assault or felony or voluntary participation in a riot or insurrection;

10. The "**Payment of Benefits**" provision in the **GENERAL PROVISIONS** section is amended by adding:

Payment for covered **Ambulance** services will be made directly to the ambulance provider, if such provider has completed the applicable assignment requirements when the provider submits a bill for such service.

11. The second sentence of the "**Statements**" provision in the **GENERAL PROVISIONS** section shall read:

No statement will be used in any contest unless it was made within two years of the effective date of coverage, it was made 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.

For Idaho Residents

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

Notice To Buyer: The **Policy** is a supplemental accident only insurance policy

2. The "**Congenital Anomaly**" provision (if included) in the **SCHEDULE OF BENEFITS** section shall read:

Congenital Anomaly $1,000 (all plan levels)

3. The "**Miscellaneous Goods and Services**" provision (if included) in the **RIDERS** part of the **SCHEDULE OF BENEFITS** section is amended by adding:

The benefits described in this paragraph are not insurance benefits

4. The **DEFINITIONS** section is amended as follows:

A. The definition of "**Accident**" shall read:

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

B. If included, the following text from e. of the definition of "**Dependent**" shall not apply to **You**:

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

C. The 2nd paragraph of the definition of "**Dependent**" shall read

A child can include: stepchildren; legally-adopted children; foster children, including any children legally placed with **You** for adoption or for whom a legal adoption agreement has been signed; any children **You** support under court order; any other children, related to **You** by blood or marriage or a civil union or domestic partnership, 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.

D. The definition of "**Injury**" shall read:

Injury: bodily harm that is caused by an **Accident** and results directly from the **Accident** and independently of disease, bodily infirmity, or any other cause.

E. The following definitions are added:

Congenital Anomaly means, for the purpose of this Certificate, a condition existing at or from birth that is a significant deviation from the common form or function of the body and which impairs the function of the body. Anomalies includes but may not be limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, or sixth toes or fingers.

Placement for Adoption: the physical placement of a child in the care of the **Insured** or other member, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when the **Insured** or other member signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child.

Professional or semi-professional capacity: a capacity which includes payment on a full-time or routine part0time basis, respectively, which payment is relied upon in whole or in part as a regular source of income, but which excludes casual paid participation.

5. The following text from item h. in "**The Date a Dependent is Eligible for Coverage**" provision in the **ELIGIBILITY FOR COVERAGE** section is deleted:

"The first day of the month following the"…

6. The 2nd paragraph of the "**Effective Date of Dependent Coverage**" provision in the **ELIGIBILITY FOR COVERAGE** section shall read:

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

a. **You** notify **Your Employer**, in writing, within 60 days of the birth, or the earlier of the date of adoption or placement for adoption of such child; and
b. Within 31 days following the date on which **You** are notified by **Your Employer** of a premium change due to the birth, adoption or placement for adoption of a **Dependent** child, **You** pay the required **Premium** or authorize **Your Employer** to deduct **Your** required contribution toward the cost of **Your Dependent** coverage from **Your** pay.

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

If **You** are deemed totally disabled or are confined to a **Hospital** as the result of a covered **Accident** at the time the **Policy** terminates, **Your** coverage will be continued for 12 months following the date of **Termination**.

8. The following "**Congenital Anomaly Benefit**" provision is added to the **BENEFITS** section:

Congenital Anomaly Benefit
We will pay the **Congenital Anomaly Benefit** as shown in the **Schedule of Benefits** if a dependent child born, adopted, or placed for adoption after the effective date of coverage is affected with **Congenital Anomaly** that requires reconstructive surgery. The reconstructive surgery must be prescribed by a **Doctor** within 90 days after the birth or adoption of the child. This benefit is payable once per **Accident** per **Insured**, regardless of the number of surgeries the **Insured** requires.

Exclusions and Limitations
- No **Congenital Anomaly Benefit** will be paid for cosmetic surgery that is not required to repair a functional defect.
- The **Congenital Anomaly Benefit** will not apply if coverage for **Dependent** children is not elected.

9. The "**EXCLUSIONS AND LIMITATIONS**" section is modified as follows:

A. Item e. shall read: "Participating in an assault or felony or voluntary participation in a riot or insurrection."

B. Item f. is deleted.

C. Item h. is amended by adding "in a Professional or semi-professional capacity."

D. In items i. and j., the work "Paid" is added to the beginning of the first sentence and the words "in a Professional or semi-professional capacity" are added to the end of each item.

E. Item k. is amended by adding "or due to **Congenital Anomaly** of a **Dependent** child."

For Indiana Residents

1. If **You**:

(a) Need the assistance of the governmental agency that regulates insurance; or
(b) Have a complaint you have been unable to resolve with your insurer,

You may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395
Complaints can be filed electronically at www.in.gov/idol

2. In the definition of "**Dependent**" in the **DEFINITIONS** section, "a child" may also include a child subject to legal guardianship.

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

a. The date **You** become eligible.
b. The date **You** acquire a **Dependent** such as through marriage, birth, or in the case of adoption, the earlier of:
    i. The date of placement for the purpose of adoption; or
    ii. The date the entry of an order granting the adoptive parent custody of the child for purposes of adoption.

4. The time period state in the "**Termination of Dependent Coverage**" provision in the **ELIGIBILITY FOR COVERAGE** section shall read "120 days."

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

Time Payment of Claims
For claims that are submitted electronically, **We** will pay benefits within 30 days after **We** receive all essential information needed to make a determination on the claim. For claims that are submitted in paper format, **We** will pay benefits within 45 days after **We** receive all essential information **We** need to make a determination on the claim.

6. The time period in b. of the "**Legal Actions**" provision in the **GENERAL PROVISIONS** section shall read "3 years."

For Kansas Residents

1. The following "**Spinal Manipulative Services Benefit**" provision (if included) in the **BENEFITS** section shall read:

Spinal Manipulative Services Benefit
This benefit applies only if it is shown in the **Schedule of Benefits**. **We** will pay the **Spinal Manipulative Services Benefit** as shown in the **Schedule of Benefits**, for any calendar day the **Insured** receives Spinal Manipulative Services as the result of an **Injury** that occurs while the **Insured** is covered for this benefit.

Spinal Manipulative Services care must begin within 90 days after the date of the **Accident** and must be ordered by a **Doctor**. Chiropractic care may be performed by any type practitioner provided that the services rendered are within the lawful scope of the practitioner's current state licensure. The **Spinal Manipulative Services Benefit** is not payable for the same days that a **Follow-Up Doctor's Visit Benefit** (if included) or a **Rehabilitation/Skilled Nursing Benefit** (if included) is paid.

2. In the **EXCLUSIONS AND LIMITATIONS** section, the exclusion "For any **Injury** covered by any Worker's Compensation Act or similar law" shall read:

For any **Injury** paid by any Worker's Compensation Act or similar law, to the extent **You** are covered or required to be covered by the workers' compensation law. If **You** enter into a settlement giving up **Your** right to recover future medical benefits under a workers' compensation law, the **Policy** will not pay those medical benefits that would have been payable in absence of that settlement.

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

We will pay benefits as soon as **We** receive all essential information needed to make a determination on the claim.

4. The time period in b. of "**Legal Actions**" provision in the **GENERAL PROVISIONS** section shall read "5 years."

For Louisiana Residents

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

2. The "**Reinstatement**" provision (if included) in the **ELIGIBILITY FOR COVERAGE** section is amended by adding:

If **You** ceased to be eligible for coverage due to active service in the uniformed services, **Your** coverage will be reinstated once **You** return to employment with **Your** Employer as an eligible **Employee** and reapply for coverage.

For Maine Residents

1. The definitions of "**Accident**" and "**Injury**" in the **DEFINITIONS** section shall read:

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

Injury: bodily harm that is caused by an **Accident** and results directly from the **Accident** for which a benefit is payable under this **Policy**.

2. In the **BENEFITS** section, in the **Accidental Death Benefit, Common Carrier Accidental Death Benefit**, and **Accidental Dismemberment Benefit** (if included):

- Item a. shall read:
  a. Was the direct result of an **Accident** for which benefits are payable under this **Policy**.
- Item b. is deleted.

3. The time period stated in the "**Notice of Claim**" provision in the **GENERAL PROVISIONS** section shall read "30 days."

4. The 2nd sentence of the last paragraph of the "**Proof of Loss**" provision in the **GENERAL PROVISIONS** section is deleted.

For Maryland Residents

1. The "**BENEFITS**" part of the "**Table of Contents**" is amended by adding the following after "**ICU Confinement Benefit**:"

Second Opinion Benefit

2. If the **Hospital Confinement Benefit** or **ICU Confinement Benefit** is shown in the "**Accident Hospitalization & Surgical Benefits**" part of the **SCHEDULE OF BENEFITS**, the following shall be added to your **Certificate**:

Second Opinion	Employee **$100**	Dependent Spouse **$100**	Dependent Child **$100**

3. Item c. in the definition of "**Dependent**" in the **DEFINITIONS** section shall read:

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

4. In the "**Termination of Dependent Coverage**" provision in the **ELIGIBILITY FOR COVERAGE** section, the word "disabling" is changed to "incapacitating."

5. Items b. and e. in the "**Life Event Changes**" provision in the **ELIGIBILITY FOR COVERAGE** section shall read:

b. A change in the number of **Your Dependents**, including birth, death, adoption, placement for adoption, award of legal guardianship, or court-ordered coverage.

e. A change in employment status or involuntary termination of employment which causes **Your** spouse or a domestic or civil union partner to become ineligible for group coverage.

6. Item h. in the "**Enrollment**" provision in the **ELIGIBILITY FOR COVERAGE** section shall be amended by adding "or within 6 months from the date **Dependent** coverage terminates if the termination is due to **Your** spouse's involuntary termination of employment."

7. Item d. in the "**Termination of Your Coverage**" provision in the **ELIGIBILITY FOR COVERAGE** section shall read:

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

8. Item i. in the "**Termination of Dependent Coverage**" provision in the **ELIGIBILITY FOR COVERAGE** section shall read:

i. The date a court order is no longer in effect.

9. The first 2 paragraphs of the "**Hospital Confinement Benefit**" provision (if included) in the **BENEFITS** section are replace by the following:

Hospital Confinement Benefit
This benefit applies only if it is shown in the Schedule of Benefits.

We will pay the **Hospital Confinement Benefit**, as shown in the **Schedule of Benefits**, if the **Insured** is **Confined** in a **Hospital** for treatment of an **Injury**. An objective second opinion will be provided to the insured when required by a utilization review program pursuant to state law.

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

If **You** are confined in a **Hospital** due to a covered **Accident** on the date coverage terminates, the **Hospital Confinement** benefit shall continue to be paid for the confinement until the earlier of:
a. The date **You** are discharged from the **Hospital**; or
b. 12 months after the date coverage terminates

12. The "**Intensive Care Unit (ICU) Confinement Benefit**" provision (if included) in the **BENEFITS** section shall read:

Intensive Care Unit (ICU) Confinement Benefit
This benefit applies only if it is shown in the SCHEDULE OF BENEFITS

We will pay the ICU Confinement Benefit, as shown in the **SCHEDULE OF BENEFITS**, if the **Insured** is **Confined** in an ICU for treatment of an **Injury**. An objective second opinion will be provided to the **Insured** when required by a utilization review program pursuant to state law.

ICU Confinement Benefits will be paid only is all of the following are met:
a. The **Insured** is **Confined** in an ICU for a minimum of 24 consecutive hours;
b. The ICU is operating within the scope of its license;
c. A charge is made for room and board;
d. ICU **Confinement** begins within 365 days from the date of the **Accident**;

e. The entire duration of **Confinement** is recommended and approved by a **Doctor**;
f. The **Confinement** is the result of an **Injury**.

If **You** are confined in a **Hospital** ICU due to a covered **accident** on the date coverage terminates, the ICU Confinement benefit shall continue to be paid for the confinement until the earlier of: (i) the date **You** are discharged from the ICU; or (ii) 12 months after the date coverage terminates.

13. The following provision is added to the "**Hospital Confinement Benefit**" and "**Intensive Care Unit (ICU) Confinement Benefit**" provisions (if included) in the **BENEFITS** section:

Second Opinion Benefit

We will pay the applicable **Second Opinion Benefit** shown in the **Certificate** for **Hospital Confinement** or **ICU Confinement** if:
a. An **Insured** is admitted to a **Hospital** due to **Injuries** sustained in a **Covered Accident**;
b. The Hospital's utilization review program requires a second opinion from a Physician; and
c. The second opinion is provided within 30 days after the **Covered Accident**.

14. The first item c. in the "**Rehabilitation/Skilled Nursing Benefit**" in the **BENEFITS** section is deleted.

15. The 2nd paragraph of the "**Accidental Death Benefit**" provision in the **BENEFITS** section shall read:

Benefits for loss of life will be paid after coverage has terminated if the **Loss** occurred prior to the date of Termination and will be paid in accordance with the beneficiary designation provisions of this **Certificate**.

16. The "**Common Carrier Accidental Death Benefit**" provision in the **BENEFITS** section is amended by adding:

Benefits for loss of life will be paid after coverage has terminated if the **Loss** occurred prior to the date of **Termination**.

17. The "**Common Carrier Accidental Dismemberment Benefit**" provision in the **BENEFITS** section is amended by adding:

Accidental Dismemberment Benefits will be paid after coverage has terminated if the **Loss** occurred prior to the date of **Termination**.

18. In the 2nd paragraph of the **EXCLUSIONS AND LIMITATIONS** section:

a. Items d. and e. are deleted.
b. At the end of item j., the phrase "or other similar extreme sports or high risk activities" is deleted.

19. The **EXCLUSIONS AND LIMITATIONS** section is amended by adding:

No **Accidental Death, Common Carrier Accidental Death,** or **Accidental Dismemberment (Catastrophic Accident)** benefits are payable under the **Policy** for any loss sustained or contracted in consequences of the **Insured's**:

a. Being intoxicated (as defined by the law of the jurisdiction in which the **Injury** occurred) or while under the influence of any narcotic; or
b. For which a contributing cause was **Your Commission** of or attempt to commit a felony.

20. The "**Claim Forms**" provision in the **GENERAL PROVISIONS** section shall read:

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 of receiving a notice of claim, **You** shall be deemed to have complied with the requirements of the **Policy** if **You** submit, within the time period noticed in the **Proof of Loss** provision, written proof of the occurrence, character, and extent of the **Loss** for which the claim is made.

21. The time period in item b. of the "**Legal Actions**" provision in the **GENERAL PROVISIONS** section shall read "3 years."

22. The "**Entire Contract**" provision in the **GENERAL PROVISIONS** section shall read:

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

23. The "**Statements**" provision in the **GENERAL PROVISIONS** section is amended by adding the following phrase to the beginning of the provision:

"Absent fraud," …

24. The "**Time Limit on Certain Defenses**" provision in the **GENERAL PROVISIONS** section shall read:

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 or to reduce benefits after this **Policy** has been in force for two years during the person's lifetime. In order to be used, the statement must be in writing and, signed by the person making the statement, group policyholder or **Insured**, and a copy of the written statement has been given to the group policyholder, **Insured**, or beneficiary of the **Insured**. 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**.

For Mississippi Residents

1. The time period in the "**Notice of Claim**" provision in the **GENERAL PROVISIONS** section shall read "30 days."

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

Time Payment of Claims
All benefits payable under this policy for any loss will be paid within twenty-five (25) days after receipt of due written proof of such loss in the form of a clean claim where claims are submitted electronically, and will be paid within thirty-five (35) days after receipt of due written proof of such loss in the form of clean claim where claims are submitted in paper format. Benefits due under the policies and claims are overdue if not paid within twenty-five (25) days or thirty-five (35) days, whichever is applicable, after **We** receive a clean claim containing necessary medical information and other information essential for **Us** to administer preexisting condition, coordination of benefits and subrogation provisions. A "clean claim" means a claim received by **Us** for adjudication and which requires no further information, adjustment or alteration by the provider of the services or the **Insured** in order to be processed and paid by **Us**. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected. Errors, such as system errors, attributable to **Us**, do not change the clean claim status.

A clean claim does not include any of the following:

a. A duplicate claim, which means an original claim and its duplicated when the duplicate is filed within thirty (30) days of the original claim;

b. Claims which are submitted fraudulently or that are based upon material misrepresentations;

c. Claims that require information essential for **Us** to administer preexisting condition, coordination of benefits or subrogation provisions; or

d. Claims submitted by a provider more than thirty (30) days after the date of service; if the provider does not submit the claim on behalf of the **Insured**, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the provider to the **Insured**.

Not later than twenty-five (25) days after the date **We** actually receive an electronic claim, **We** shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the **Insured** (where the claim is owed to the **Insured**) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than thirty-five (35) days after the date **We** actually receive a paper claim, **We** shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the **Insured** (where the claim is owed to the **Insured**) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by **Us** shall be paid within twenty (20) days after receipt.

For purposes of this provision, the term "pay" means that **We** shall either send cash or a cash equivalent by United States mail, or send cash or a cash equivalent by other means such as electronic transfer, in full satisfaction of the appropriate benefit due the provider (where the claim is owed to the provider) or the **Insured** (where the claim is owed to the **Insured**). To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to the last known address of the provider (where the claim is owed to the provider) or the **Insured** (where the claim is owed to the **Insured**) in a properly addressed, postpaid envelope, or, if not so posted, or not sent by United States mail, on the date of delivery of payment to the provider or **Insured**.

If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed in this provision, **We** must pay the provider (where the claim is owed to the provider) or the **Insured** (where the claim is owed to the **Insured**) interest on accrued benefits at a rate of three percent (3%) per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due pursuant to this provision is less than One Dollar ($1.00), such amount shall be credited to the account of the person or entity to whom such amount is owed. The provisions of this subparagraph 3 shall not apply to any claims or benefits owed under the Medicare Advantage plans or Medicare Advantage Prescription Drug plans.

In the event **We** fail to pay benefits when due, the person entitled to such benefits may bring action to recover such benefits, any interest which may accrue as provided in subparagraph 3 of this paragraph (h) and any other damages as may be allowable by law. If it is determined in such action that **We** acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, the person entitled to such benefits (health care provider or **Insured**) shall be entitled to recover damages in the amount up to three (3) times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

3. The "**Physical Examination and Autopsy**" provision in the **GENERAL PROVISIONS** section shall read:

Physical Examination
We, at **Our** own expense, have the right to have **You** examined as often as **We** may reasonably require while a claim is pending.

4. In the "**Legal Actions**" provision in the **GENERAL PROVISIONS** section, the time period in b. shall read "3 years."

For New Hampshire Residents

1. The following notices are added to the first page of the **Certificate**:

Notice to Buyer: This is an accident-only **Certificate** and it does not pay benefits for loss from sickness. Review your **Certificate** carefully.

This **Certificate** provides limited benefits. Benefits are not intended to cover medical expenses.

RIGHT TO EXAMINE: This **Policy** may, at any time within 30 days after its receipt by the **Policyholder**, be returned by delivering it or mailing it to the company or the agent through whom it was purchased. Immediately upon such delivery or mailing, the **Policy** will be deemed void from the beginning, and any **Premium** paid on it will be refunded.

2. In the "**Eligible Class(es) for Coverage**" provision in the **SCHEDULE OF BENEFITS**, the minimum number of hours an employee needs to have worked and been paid for shall not exceed 15 hours per week.

3. The "Surgery" item under "**Accident Hospitalization & Surgical Benefits**" in the **SCHEDULE OF BENEFITS** shall read:

Surgery	Employee	Dependent Spouse	Dependent Child
- Major	$2,000	$2,000	$2,000
- Minor and Outpatient	$300	$300	$300

4. The "**Burns**" and "**Lacerations**" parts of the **SCHEDULE OF BENEFITS** shall read:

➢ **Burns – Second Degree**	Employee	Dependent Spouse	Dependent Child
Less Than 10% of the body	$400	$400	$400
More than 10% of the body	$1,500	$1,500	$1,500

➢ **Burns – Third Degree**	Employee	Dependent Spouse	Dependent Child
Less Than 10% of the body	$4,000	$4,000	$4,000
More than 10% of the body	$16,000	$16,000	$16,000

➢ **Lacerations**	Employee	Dependent Spouse	Dependent Child
Under 3 inches	$150	$150	$150
3 to 6 inches	$400	$400	$400
Over 6 inches	$800	$800	$800

5. The "**Emergency Dental Work**" and "**Eye Injuries**" parts of the **SCHEDULE OF BENEFITS** shall read:

➢ **Emergency Dental Work**	Employee	Dependent Spouse	Dependent Child
Repair or extraction of broken tooth, or Repair of Missing Tooth	$300	$300	$300

➢ **Eye Injuries**	Employee	Dependent Spouse	Dependent Child
	$400	$400	$400

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

7. Item e. of the definition of "**Hospital**" in the **DEFINITIONS** section shall read:

e. Is licensed to operate as a **Hospital** pursuant to law.

8. The title of the "Blood/Plasma/Platelets" Benefit (if included) in the **BENEFITS** section shall read "Blood/Plasma/Platelets/Non-Blood Substitutes" Benefit and the following "**Exclusions and Limitations**" are added:

Exclusions and Limitations
Blood/Plasma/Platelet/Non-Blood Substitutes Benefits will not be paid for:
a. Intravenous solutions used for hydration;

b. Intravenous solutions used to replace vitamins, minerals, or other nutrients depleted due to **Illness**; or
c. Intravenous solutions used to deliver medication for the treatment of **Illness**.

9. The 2nd paragraph of the "**Notice of Claim**" provision in the **GENERAL PROVISIONS** section shall read:

If **You** are not able to notify **Us** within the applicable time period, then **You** must notify **Us** as soon as reasonably possible. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. **Your** notice must include the claimant's name, address and the **Policy Number**.

For Ohio Residents

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

2. The time period in item b. of the "**Legal Actions**" provision in the **GENERAL PROVISIONS** section shall read "3 years"

For Oklahoma Residents

1. Item k. in the **EXCLUSIONS AND LIMITATIONS** section shall read:

k. Declared or undeclared war or act of war when serving in the military or an auxiliary unit thereto;

For South Dakota Residents

1. Item b. in the 2nd paragraph of the definition of "**Doctor**" in the **DEFINITIONS** section shall read:

b. Is a member of **Your** immediate family unless it is the only doctor in the area, provided that the doctor is acting within the scope of practice.

2. Item e. in the 1st paragraph of the definition of "**Hospital**" in the **DEFINITIONS** section is deleted.

3. In the 1st sentence of the "**Ambulance Transportation Benefit**" (if included) in the **BENEFITS** section, the word "accredited" is deleted.

4. If included, the "**Hospital Admission Benefit**," the "**Intensive Care Unit (ICU) Admission Benefit**," the "**Hospital Confinement Benefit**," and the "**Intensive Care Unit (ICU) Confinement Benefit**" are amended by deleting the requirement that **You** have to be confined for a minimum number of hours.

5. In items a. and b. of the "Exclusions" for the "**Emergency Dental Work Benefit**" (if included) in the **BENEFITS** section, the works "sound, natural" are deleted.

6. The **EXCLUSIONS AND LIMITATIONS** section shall be amended as follows:

- Items c. and d., regarding "voluntary intoxication," are deleted.
- Items o. shall read:
  o. For any **Injury** paid by any Worker's Compensation Act or similar law;

7. The time period stated in the 1st paragraph of the "**Notice of Claim**" provision in the **GENERAL PROVISIONS** section shall read "30 days."

8. The time period in item b. of the "**Legal Actions**" provisions in the **GENERAL PROVISIONS** section shall read "3 years."

For Vermont Residents

1. The 1st page is amended by adding:

This **CERTIFICATE** is delivered in and is governed by the laws of the state of VERMONT

2. The “Notice” in the box in the **INTRODUCTION** section is amended by adding:

“and should not be purchased if **You** are not already covered by comprehensive major medical insurance”

3. The “Class Description” provision in the **SCHEDULE OF BENEFITS** is amended by adding:

“A part time Employee must work and be paid for a minimum of 17.5 hours per week.”

4. The definitions of “**Accident**,” “**Dependent**,” and “**Hospital**” in the **DEFINITIONS** section are amended as follows:

In the definition of “**Accident**,” the works “sudden, unforeseen” are deleted.

In item c. of the definition of “**Dependent,**” the work “unmarried” is deleted.

Items d. and e. of the definition of “**Hospital**” are deleted.

5. The “**Portability**” provision (if included) in the **ELIGIBILITY FOR COVERAGE** section is deleted.

6. In the **Benefit** provisions listed below, if included in the **BENEFITS** section, the requirement that a certain action be performed, treatment sought, or an even occur within a certain number of days is deleted.

Ambulance Transportation Benefit
Emergency Room Benefit
Major Diagnostic Testing Benefit
Pain Management / Epidural Benefit
Initial Doctor Visit Benefit
X-Ray Benefit
Hospital Admission Benefit
Intensive Care Unit (ICU) Admission Benefit
Hospital Confinement Benefit
Intensive Care Unit (ICU) Confinement Benefit
Rehabilitation / Skilled Nursing Benefit
Surgery Benefit
Outpatient/Miscellaneous Surgery Benefit
Transportation Benefit
Family Lodging Benefit
Coma Benefit
Follow Up Doctor’s Visit Benefit
Physical Therapy Benefit
Chiropractic Visit Benefit
Medical Equipment Benefit
Prosthetic Device Benefit
Paralysis Benefit
Emergency Dental Work Benefit
Eye Injury Benefit
Specific Injury Benefit
Dislocations Benefit
Fractures Benefit
Accidental Death Benefit
Common Carrier Accidental Death Benefit
Accidental Dismemberment Benefit

7. The **EXCLUSIONS AND LIMITATIONS** section is amended as follows:

- In item a., the words “whether sane or insane” are deleted.
- Item c. is deleted.
- Item f. is deleted.
- In item m., the words “bodily/mental” are deleted.

8. The “**Time Payment of Claims**” provision in the **GENERAL PROVISIONS** section shall read:

Time Payment of Claims
We will pay benefits immediately, and no later than 30 days, upon receipt of all essential information needed to make a determination on the claim.

For Washington Residents

1. The **SCHEDULE OF BENEFITS** shall read:

Emergency Room Benefit	Employee $150	Dependent Spouse $150	Dependent Child $150

2. The “**Portability**” provision (if included) in the **ELIGIBILITY FOR COVERAGE** section is deleted.

3. In the “**Ambulance Transportation Benefit**” (if included) in the **BENEFITS** section, the following sentences are deleted:

Air ambulance transportation must be within 96 hours of the **Accident**. Ground ambulance transportation must be within 90 days of the **Accident**.

4. The following benefit is included in **your Certificate** and replaces any other **Emergency Room Benefit** (if included);

We will pay the **Emergency Room Benefit**, as shown in the **Schedule of Benefits**, if the **Insured** is treated in an **Emergency Room** for an **Injury** that occurs while the **Insured** is covered for this benefit. The **Emergency Room Benefit** is payable 2 times per **Accident** per **Insured**.

5. In the **EXCLUSIONS AND LIMITATIONS** section, items c. and d. are deleted.

Signed for Symetra Life Insurance Company at Bellevue, Washington.

Margaret Meister
President

Jacqueline M. Veneziani
Secretary

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

RESIDENCE STATE AMENDMENT

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

If **You** do not reside in the Governing Jurisdiction state shown above, **Your Certificate** is hereby amended as stated below to comply with the laws of **Your** state of residence.

Only those references in this amendment to benefits, provisions or terms actually included in **Your Certificate** will apply to **You**. In addition, any refence made herein to **Dependent** coverage will only apply if **Dependent** coverage is provided in **Your Certificate**.

This amendment is attached to and made part of the **Certificate** that forms part of the **Policy**. All other provisions of **Your Certificate** remain unchanged.

For Minnesota Residents

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

2. The following provision is added to the **INTRODUCTION** section:

Incontestability of Certificate
We will not contest this **Certificate** after it has been in force for two years with respect to **You**, except for fraudulent misstatements made by **You**. No misstatements made by an **Insured** relating to his insurability will be used to contest his coverage:
a. After his coverage has been in force during his lifetime for two years; and
b. Unless such statement is in writing and signed by him.

3. The following provision is added to the **GENERAL PROVISIONS** section:

Change in Beneficiary
You may change the beneficiary by completing and signing a form provided by **Us** for changing a beneficiary and returning the form to **Our** administrative office for **Our** written acknowledgement. Naming a new beneficiary voids any prior designation unless stated otherwise in the new designation. When **We** furnish **You** written acknowledgement of the change of beneficiary, the change become effective on the date **You** signed **Our** form. **We** are not liable for payments made or action take prior to **Our** written acknowledgement of the beneficiary change.

Signed for Symetra Life Insurance Company at Bellevue, Washington.

Margaret Meister
President

Jacqueline M. Veneziani
Secretary

SYMETRA
RETIREMENT | BENEFITS | LIFE

Consumer Privacy Statement

We value our relationship with you. Symetra is serious about keeping your personal information private and secure.

This notice of our privacy policy explains where we get information about you, who we may share your information with and how that information is kept safe.

Symetra does not sell or rent information about you to others.

Types and sources of information

The information we get about you comes from different sources, depends on our relationship with you and may include:

- Information that you give us on applications, online, communications with us, and other forms, such as your name, address, telephone number, Social Security number and/or biometric information, such as your voice print for authentication.
- Information from your transactions with us, our affiliated companies, or our business partners. This includes products and services you have purchased from us or information about your payment history or claims.
- Information we receive from other sources, such as consumer reporting agencies, medical information bureaus, government agencies or other third-parties to confirm or add to facts given by you.
- Information we receive from your financial professional. This may include updated information about your policy or account.

Sharing information

In order to conduct our business and offer you the products and services that you may want, we may share your information as allowed or required by law.

We may share your information with our affiliates or third parties outside the Symetra family of companies to service, market or underwrite our products and services to you.

We may share your information with financial professionals who sell our products and services. We may also share your information with financial institutions that we have joint marketing agreements with to sell our products and services.

Working with these businesses allows us to provide you with a broader selection of insurance and investment products and services from our companies. These businesses are legally obligated to keep your information private and secure, and to use it only for the services we request.

We may share your information to respond to a subpoena or judicial process or inquiry from a government regulatory authority, prevent fraud and other crimes, and to comply with legal requirements.

If any sharing of your information would require us to give you the option to opt-out of or opt-in to the information sharing, we will provide you with this option.

We will continue to follow our privacy policy as described in this notice even when you are no longer our customer.

Medical information

We obtain or share medical information only in connection with specific products and services. This may include underwriting a life insurance policy, processing a claim, or any other use that we disclose to you before the information is collected.

About financial professionals

The independent financial professionals who sell our products and services are not our employees and are not subject to our privacy policy.

They may have received personal information about you that we do not have. They may use this information differently than we do. Contact your financial professional to learn more about their privacy practices.

Keeping your personal information safe

We protect your personal information in a variety of ways.

We are legally obligated to maintain physical, administrative, and technical safeguards to protect this information from unauthorized access or acquisition.

Employees receive training to protect personal information and are authorized to access this information only when they have a business need to do so. We expect the financial professionals who sell, and the third parties who service, our products and services to maintain a high regard for privacy and to safeguard customer information, as required by law.

We follow your state law when it protects your privacy more than federal law.

Accuracy of your information

We need accurate information to provide you with the best possible service.

If you need to update your information, or if the information we have about you is inaccurate or incomplete, please contact us. Please be sure to include your name, address, and policy or contract number and your relationship with us. All requests must provide sufficient information to allow us to reasonably verify your identity. To fulfill your request, we may ask for more information, dependent on your relationship with us.

You may choose to authorize an agent to make a request on your behalf. We may request that such authorized agent provide information sufficient to confirm they are authorized to act on your behalf, and capable of verifying your request and authenticating your identity.

- By telephone: You can call us at the telephone number shown on your account statement or on other information we have sent you. You can also call us at **1-800-796-3872**.
- In writing: You can write to us at the address shown on your account statement or on other information we have sent to you. You can also write to use at **P.O. Box 34690, Seattle, WA 98124-1690**.

You can also request a copy of the information that we have about you in our files to make sure it is correct. You must make your request in writing and send it to the address shown on your policy or contract or to the address shown above. We will send you the information within 30 business days of receiving your request. We will advise you of any person or group to whom we have given the information during the last two years.

If you believe the information about you in our files is wrong, you can notify us in writing. We will review your file and respond to you within 30 business days. If we agree with you, we will change our records. This change will become part of the file. It will be sent to those that received inaccurate information from us. It will also be included in any later disclosures to others.

If we disagree with you, we will explain why. You can provide us with a statement explaining why you believe the information is wrong. This statement will become part of the file. It will be sent to those that received the disputed information from us. It will also be included in any later disclosures to others.

Privacy and Symetra's websites

This notice also applies to our websites. If you would like more information about our website privacy and security practices, go to www.symetra.com and click on the Privacy and Security links.

California Resident?

If you are a California resident, you may have additional privacy rights. Please visit www.symetra.com/CCPA for more information. Alternatively, you can call our CCPA hotline at 1-800-SYMETRA (796-3872) and enter extension 22216.

The Symetra family of companies

This notice applies to the following companies:

- Symetra Life Insurance Company
- Symetra National Life Insurance Company
- First Symetra National Life Insurance Company of New York
- Symetra Assigned Benefits Service Company
- Symetra Securities, Inc.
- Clearscope Funding Corporation

SYMETRA®
RETIREMENT | BENEFITS | LIFE

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