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HEALTH BASICS
FIXED-PAYMENT INDEMNITY POLICY

Employer Name:	Cracker Barrel Old Country Store, Inc.
Policy Number:	11755000
Effective Date of Coverage:	January 1, 2022

CERTIFICATE OF COVERAGE

INTRODUCTION

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

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

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

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

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

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

This Certificate of Coverage replaces all others previously issued.

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

CERTIFICATE TABLE OF CONTENTS

SCHEDULE OF BENEFITS

Eligible Class(es) for Coverage

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

Class	Description
1	All RS and PAR 1-4 **Employees**, who have worked and been paid for an average of at least 30 hours each week; at your **Employer**'s normal place of business during the measurement period defined by your **Employer**.
2	Full-time **Employees**, who have worked and been paid for an average of at least 30 hours each week; at your **Employer**'s normal place of business during the measurement period defined by your **Employer.**

Service Waiting Period

The **Service Waiting Period** is the initial measurement period which will begin the first day of the month coinciding with or following the date of hire and continues for 11 months.

Employees who work an average of at least 30 hours per week during the initial measurement period will have a four week administrative period to enroll for coverage.

Annual Enrollment Period

The Annual Enrollment Period and standard measurement period are as communicated by your **Employer** on a yearly basis for a January 1st effective date.

Employee and Dependent Benefits

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

➢ **Ambulance Transportation Benefit**	
Ground Transport	$500 per day for ground ambulance service.
Air Transport	2 times the ground transport benefit amount. Ground and air ambulance transport services have a combined maximum of 5 days per **Calendar Year**.
➢ **Emergency Room Benefit**	$200 per day up to a maximum of $600 per **Calendar Year**
➢ **Inpatient Hospital Benefit**	
Hospital:	$800 per day, up to a maximum of 10 days per **Calendar Year** and 500 days per lifetime
Intensive Care Unit:	$1,600 per day, up to a maximum of 10 days per **Calendar Year** and 500 days per lifetime
Substance Abuse Facility:	$800 per day, up to a maximum of 10 days per **Calendar Year** and 500 days per lifetime
Mental Health Facility:	$800 per day, up to a maximum of 10 days per **Calendar Year** and 180 days per lifetime

SCHEDULE OF BENEFITS (CONTINUED)

Nursing Facility:	$400 per day, only if following a covered **Hospital** stay of at least 3 consecutive days and the **Insured** is less than age 65 up to a maximum of 60 consecutive days per stay and 500 days per lifetime

- **Outpatient Care Benefits**

Diagnostic X-Ray & Laboratory Benefit	$125 per day up to a maximum of $625 per **Calendar Year**
Doctor Visit Benefit	$80 per day up to a maximum of $640 per **Calendar Year**
Major Diagnostic Testing Benefit	$375 per day up to a maximum of 2 days per **Calendar Year**.

- **Surgical Benefits**

• ***Surgical Procedure Benefit***	Only one Surgical Procedure Benefit is payable per day up to a combined **Calendar Year** maximum of $5,000 for all surgical procedures
• ***Inpatient Hospital***	$2,000
• ***Outpatient Surgical Facility***	$600
• ***Outpatient Doctor's Office***	$90
Surgical Anesthesia Benefit	Only one Surgical Anesthesia Benefit is payable per day up to a combined **Calendar Year** maximum of $1,250 for all surgical procedures where anesthesia is administered
• ***Inpatient Hospital***	$500
• ***Outpatient Surgical Facility***	$150
• ***Outpatient Doctor's Office***	$22.50
Outpatient Surgical Facility Benefit	$500 per day up to a maximum of 2 days per Calendar Year for the use of an Outpatient Surgical Facility

- **Outpatient Prescription Drug Benefit**

Brand Name Drug	$35 per day up to a maximum 24 days per **Calendar Year**
Generic Drug	$5 per day up to a maximum 24 days per **Calendar Year**

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Brand Name Drug: a drug, approved by the U.S. Food and Drug Administration, that is marketed by a pharmaceutical company under a proprietary, trademark-protected name.

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

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

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

DEFINITIONS (CONTINUED)

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

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

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

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

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

Dependent: the following persons:

a. Your spouse, as defined by state law.
b. Your child who is under 26 years of age (Limiting Age).
c. Your unmarried child, who is incapable of self-sustaining employment by reason of intellectual or physical disability, provided the disabling condition occurs prior to age 26. The child must be chiefly dependent upon you for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer by the employee or member within thirty-one (31) days of the child's attainment of the limiting age and subsequently as may be required by the insurer, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

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

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

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

Is not a person who:

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

Durable Medical Equipment: equipment that is made to:

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

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

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

DEFINITIONS (CONTINUED)

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

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

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

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

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

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

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

Generic Drug: a drug that is determined by the U.S. Food and Drug Administration to be the same as an original brand name drug in terms of: active ingredients, dosage, safety, strength, how it is taken, quality, performance, and intended use.

Health Care Facility:

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

Hospital: a licensed healthcare facility that:

a. Provides acute care;
b. Provides 24-hour nursing services;
c. Provides inpatient therapeutic and diagnostic services for **Illness or Injury**;
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.

DEFINITIONS (CONTINUED)

Hospital does not include:

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

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

Illness:

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

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

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

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

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

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

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

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

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

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

Nursing Facility does not include:

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

DEFINITIONS (CONTINUED)

d. A place primarily for the treatment of **Mental Disorders**.

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

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

a. Routine preparation and recovery for diagnostic or surgical procedures.
b. Blood administration.
c. Care routinely provided in an **Emergency Room**.
d. Routine recovery and post-operative care after outpatient surgery.
e. The use of a bed for the convenience of the **Doctor**, **Insured**, and/or **Insured's** family.

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

Outpatient Surgical Facility: a facility which as its primary function provides, through an organized medical staff, surgical procedures not ordinarily performed in a private physician's office and not requiring inpatient hospitalization, including licensed standalone Surgery Facilities and licensed **Hospital** Facilities that perform outpatient surgery and that charge a Facility Fee, not to include the private offices of health care **Providers** who are engaged in the lawful practice of surgery.

Pharmacy: a retail establishment where prescription drugs are legally dispensed.

Pharmacy includes the following:

a. Retail pharmacy.
b. Mail order pharmacy.

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

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

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

Prescription: a **Doctor's** written order for drugs and medicines and any valid refill of that order.

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

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

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

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

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

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

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

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

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

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

ELIGIBILITY FOR COVERAGE

Eligible Employees

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

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

The Date You Are Eligible for Coverage

You first become eligible for coverage on the later of:

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

Enrollment

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

a. Within 30 days of your eligibility date.
b. During an Annual Enrollment Period designated by the **Employer**.
c. Within 30 days of the date you have a qualifying life event change.

Life Event Changes:

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

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

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 30 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.

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 30 days of the **Dependent's** eligibility date.
b. During an Annual Enrollment Period designated by the **Employer**.
c. Within 30 days of the date you have a qualified life event change.

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

If you have not enrolled yourself, you may not enroll a **Dependent**.

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

a. The date the **Dependent** becomes eligible (if you enroll the **Dependent** before that date).
b. The date you enroll the **Dependent** for coverage (if you do so within 30 days from the **Dependent's** eligibility date or the date of a life event change).
c. The date the next **Benefit Year** begins (if you enroll the **Dependent** during an Annual Enrollment Period).
d. The date **Premium** is received.

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

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

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

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

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

Any change in the amount of benefits due to a change in your class or status, is effective on the 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.

ELIGIBILITY FOR COVERAGE (CONTINUED)

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

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

Change in Amounts of Coverage

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

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

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

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 last day of the month in which 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 last day of the month in which the first of the following occurs:

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

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

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

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

ELIGIBILITY FOR COVERAGE (CONTINUED)

Continuation of Coverage

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

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

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

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

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

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

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

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

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

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

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

Reinstatement

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

Reemployment

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

Survivor Benefit

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

ELIGIBILITY FOR COVERAGE (CONTINUED)

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

BENEFITS

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

The Ambulance Transportation Benefit will be paid, as shown in the **Schedule of Benefits**, for the calendar day when costs are incurred for licensed ground or air ambulance services used to transport you from the place where you are Injured or stricken by **Illness** to the nearest accredited **Hospital** where adequate facilities for treatment are available. No other expenses for travel will be covered.

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

The Emergency Room Benefit will be paid, as shown in the **Schedule of Benefits**, for the calendar day when costs are incurred for **Eligible Services or Supplies** received in an **Emergency Room** as a result of an **Illness or Injury** that occurs while you are covered for this benefit.

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

a. Drugs, supplies or additional **Ancillary Services** that may be required for a particular emergency treatment.
b. **Doctor** visits (including **Emergency Room Doctors**, who bill separately for their services).
c. Diagnostic X-ray and laboratory tests.

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

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

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

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

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

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

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

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

d. The date you become covered under another group policy.

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

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

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

Outpatient Major Diagnostic Testing Benefit
This benefit applies only if it is shown in the **Schedule of Benefits**.

The Outpatient Major Diagnostic Testing Benefit will be paid, as shown in the **Schedule of Benefits**, for the calendar day when costs are incurred for the following major diagnostic tests ordered or performed by a **Doctor**. One benefit is payable for all X-ray and laboratory tests administered on the same calendar day.

a. Magnetic Resonance Imaging (MRI)
b. Computed Tomography (CT, Cat Scan)
c. Mammography
d. Stress Tests
e. Electrocardiogram (ECG, EKG)
f. Ultrasound
g. Bone Density
h. Amniocentesis
i. Chromosome analysis

Outpatient Diagnostic X-Ray and Laboratory Benefit
This benefit applies only if it is shown in the **Schedule of Benefits**.

The Outpatient Diagnostic X-ray and Laboratory Benefit will be paid, as shown in the **Schedule of Benefits**, for the calendar day when costs are incurred for **Eligible Services or Supplies** received for outpatient diagnostic X-ray and laboratory tests when ordered or performed by a **Doctor**. One benefit is payable for all X-ray and laboratory tests administered on the same calendar day.

Exclusions and Limitations
No Outpatient Diagnostic X-ray and Laboratory Benefit will be paid if you are **Confined** in:

a. A **Hospital**.
b. A licensed **Nursing Facility**.
c. A licensed **Substance Abuse Disorder** facility.
d. A licensed **Mental Disorder** facility.

No Outpatient Diagnostic X-ray and Laboratory Benefit will be provided for the following Major Diagnostic Tests:

a. Magnetic Resonance Imaging (MRI)
b. Computed Tomography (CT, Cat Scan)
c. Mammography

d. Stress Tests
e. Electrocardiogram (ECG, EKG)
f. Ultrasound
g. Bone Density
h. Amniocentesis
i. Chromosome analysis

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

The Doctor Visit Benefit will be paid, as shown in the **Schedule of Benefits**, for the calendar day when costs are incurred for **Eligible Services or Supplies** received while you are covered for this benefit. Services may be provided at the **Doctor's** office, an outpatient **Hospital** clinic or **Urgent Care** facility.

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

a. Services or supplies to help prevent **Illness** and diagnose a problem early including, but not limited to, routine physicals, general health exams, cancer screening, routine immunizations and vaccinations.
b. Care received in an **Emergency Room**.
c. Inpatient or outpatient surgical procedures.
d. Diagnostic X-ray and laboratory tests.
e. Drugs, supplies or additional **Ancillary Services** that may be provided during the visit.

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

The Surgical Procedure Benefit will be paid, as shown in the **Schedule of Benefits** based on the place where a surgical procedure is performed. It will be paid for the calendar day when costs are incurred for a surgical procedure performed in connection with an **Illness** or **Injury** while you are covered under this benefit. Surgical benefits will not exceed the maximum amount shown in the **Schedule of Benefits**.

If a surgical procedure is performed in more than one place on the same calendar day, the benefit paid will be based on the location (**Hospital**, **Outpatient Surgical Facility**, or **Doctor's** office) that provides the largest benefit amount.

Exclusions and Limitations
No Surgical Procedure Benefit will be paid for the following:

a. The cost of surgical **Anesthesia**.
b. **Ancillary Services** received in conjunction with a surgical procedure or other **Illness**, except as stated in the **Schedule of Benefits**.
c. Oral surgery except for:

    i. Surgical excision of impacted third molars.
    ii. Closed or open reduction of fracture or dislocation of the jaw.

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

The Surgical Anesthesia Benefit will be paid, as shown in the **Schedule of Benefits**, for the calendar day when separate costs are incurred for **Anesthesia** administered by an **Anesthesiologist** or **Anesthetist** in connection with a covered surgical procedure.

If **Anesthesia** for a covered surgical procedure is administered in more than one place on the same calendar day, the benefit paid will be based on the location (**Hospital**, **Outpatient Surgical Facility**, or **Doctor's** office) that provides the largest benefit amount.

Exclusions and Limitations
No Surgical Anesthesia Benefit will be paid:

a. For **Anesthesia** administered in connection with surgical procedures for preventive care or routine cancer screening.
b. For Anesthesia administered by someone other than an **Anesthesiologist** or **Anesthetist.**
c. When the costs incurred for **Anesthesia** are billed together with the costs incurred for the associated surgical procedure.
d. When no benefit is payable for the associated surgical procedure.

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

The Outpatient Surgical Facility Benefit will be paid, as shown in the **Schedule of Benefits**, for the calendar day when costs are incurred for the use of an **Outpatient Surgical Facility**. The surgical procedure must be in connection with an **Illness** or **Injury** and performed at the facility while you are covered under this benefit. Outpatient Surgical Facility benefits will not exceed the maximum amount shown in the **Schedule of Benefits**.

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

The Outpatient Prescription Drug Benefit will be paid, as shown in the **Schedule of Benefits**, for the calendar day when a **Prescription** for a **Brand Name Drug** or **Generic Drug** is filled or refilled while you are covered for this benefit.

To qualify for payment of a benefit, a covered **Prescription** must be:

a. Ordered by a **Doctor**;
a. Filled or refilled by a licensed pharmacist or **Doctor**; and
b. Dispensed by a **Pharmacy**.

Covered Prescriptions
The following drugs and medicines are covered **Prescriptions**:

a. Legend drugs – those drugs required to have "Caution: Federal law prohibits dispensing without a Prescription" written on the label.
b. Drugs dispensed in disposable pre-filled needles/syringes.
c. Compound drugs - at least one ingredient must contain a legend drug.
d. Any other drug, which under federal or applicable state law, may only be dispensed by a licensed pharmacist or **Doctor.**
e. Oral contraceptives and the following contraceptive devices

    i. Patches
    ii. Diaphragms
    iii. Cervical caps
    iv. Contraceptive rings

f. Tretinoin or other drugs (e.g., Retin-A) used as acne treatment for individuals under age 26.
g. Disposable blood/urine glucose/acetone testing agents (e.g., Chemstrips®, Acetest® tablets, and Clinitest® tablets).

h. Growth hormones.
i. Pre-natal prescription vitamins.

Exclusions and Limitations
No Outpatient Prescription Drug Benefit will be paid for the following:

a. Drugs or medicine available without a **Prescription**.
b. **Prescriptions** for the following drugs and medicines:

   i. Anorectics (any drugs used for the purpose of weight loss).
   ii. Dietary supplements.
   iii. Fluoride supplements.
   iv. Hematinics.
   v. Immunosuppressants.
   vi. Infertility drugs.
   vii. Minerals.
   viii. Minoxidil (Rogaine®) for the treatment of alopecia.
   ix. Smoking deterrent medications or any other smoking cessation aids, all dosage forms (e.g., Nicorette®, Nicoderm®, etc.).
   x. Vitamins, singly or in combination.

c. Medicines and devices for the following birth control methods:

   i. Over-the counter condoms, sponges, and spermicides
   ii. Implanted devices (IUDs, implantable rods)
   iii. Hormonal injections
   iv. Emergency oral contraceptives (Plan B, Ella)
   v. Sterilization.

d. Medical cannabis (marijuana).
e. Drugs or medicine taken while in or administered by a hospital or any other **Health Care Facility**.
f. Any prescribed drug or medicine dispensed by a hospital, **Health Care Facility**, **Doctor's** office, an outpatient hospital clinic or other outpatient facility capable of dispensing drugs.
g. Any prescribed drug or medicine dispensed by a specialty pharmacy.
h. Any prescribed drug or medicine dispensed by an internet pharmacy.
i. Any prescribed drug or medicine obtained from a **Pharmacy** or other source located outside of the United States.
j. Any prescribed drug or medicine which the U.S. Federal Food and Drug Administration has determined to be contraindicated.
k. Any prescribed drug or medicine not approved by the U.S. Federal Food and Drug Administration for a particular indication, unless such drug is recognized as effective for treatment of such indication:

   i. In one of the standard reference compendia.
   ii. In the majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia.
   iii. By the Federal Secretary of Health and Human Services.

l. Refills of any **Prescription** in excess of the number specified by the **Doctor.**
m. Drugs, dispensed at one time, which exceeds the following limits:

   i. a 34-day supply or 100 unit or doses, whichever is greater when filled by a retail pharmacy.
   ii. a 90-day supply when filled by mail order pharmacy.

n. Drugs dispensed more than one year after the date of the **Prescription**.
o. Drugs consumed or administered at the place where they are dispensed.

BENEFITS (CONTINUED)

p. Drugs that can be obtained without charge under local, state or federal programs, including Workers' Compensation, but excluding Medicaid.
q. Therapeutic devices or appliances including support garments, or other non-medical substances, regardless of their intended use.
r. Immunization agents, biological sera, blood or blood plasma products and their administration.

EXCLUSIONS AND LIMITATIONS

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

However, we will not except, limit, or reduce benefits or otherwise fail to pay for services rendered by a non-governmental charitable research hospital because it bills patients for services rendered, but does not enforce by judicial proceedings collection from individual patients in the absence of insurance coverage.

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

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

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

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

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

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

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

w. For treatment of **Temporomandibular Joint Dysfunction (TMJ)** pain syndrome, orofacial, or myofascial syndrome whether medical or dental in scope.
x. For an **Illness** or **Injury** caused wholly or partly, directly or indirectly by:

i. Declared or undeclared war or act of war.
ii. Committing or attempting to commit a felony.
iii. Inciting or taking part in any form of public violence.
iv. Intentionally self-inflicted **Injury**, while sane or insane.

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

GENERAL PROVISIONS

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

a. 20 days after the date an **Eligible Service or Supply** is received.
b. 90 days after the date of death.
c. 20 days after a **Prescription** is filled or refilled.

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, supplies received and/or the **Prescription's** drug name and the date filled or refilled and the costs you incurred.
c. The names and addresses of all **Providers** and/or the **Pharmacy**.
d. A certified copy of the death certificate (if applicable).
e. Your **Beneficiary** designation (if applicable).
f. If applicable, documentation of:

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

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

All proof submitted must be satisfactory to us.

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

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

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

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

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

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

In the event you die and, on the date you die, there is no living named **Beneficiary**, we may, at our option, pay any benefits due under the **Policy** to the following surviving relatives of yours:

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

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

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

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

Symetra Select Benefits
118 Third Street East
P.O. Box 440
Ashland, WI 54806
1-800-497-3699

Your written request should include:

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

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

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

a. Until 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**.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Your **Employer** no longer provides group coverage for medical and prescription drug benefits to any **Employees**.
b. You do not pay the **Premium** for your extension of coverage on time.

c. You become covered under another group policy for medical and prescription drug benefits that does not include a preexisting condition exclusion or limitations on preexisting conditions you may have after the date of your extension of coverage election.
d. You become entitled to **Medicare** after the date of your extension of coverage election.
e. The person whose Social Security disability enabled the extended coverage is determined to have recovered.

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

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004-5135
1-800-796-3872
TTY/TDD 1-800-833-6388

TENNESSEE AMENDATORY RIDER

Policy/Certificate LGC-10011P/LGC-10011C 1011:

The Policy and Certificate to which this rider is attached is amended as follows:

POLICYHOLDER PROVISIONS section**, Renewal** provision, is hereby deleted and replaced with the following:

Renewal

We may renew **Your** coverage under this **Policy** on each **Policy Anniversary** by giving **You** 31 days prior written notice, indicating in that notice the amount of **Premium** due.

DEFINITIONS section, definition of **Dependent** is hereby deleted in its entirety and replaced with the following:

Dependent the following persons:

a. **Your** spouse, as defined by state law
b. **Your** child who is under 26 years of age (limiting age; or
c. A child, who is incapable of self-support due to **Developmental Disability** or physical disability, provided the condition occurs prior to the age 26.

A child can include stepchildren, adopted children, or foster children, a judicially appointed minor ward of **Yours**, or a child legally placed for adoption and primarily dependent upon **You** for support.

A child can include any child you are legally responsible to provide for by virtue of a court order specifically naming you as the permanent responsible party.

DEPENDENT ELIGIBILITY section is hereby amended by the addition of the following:

Court Ordered Health Coverage for Dependent Children

This section applies to the Accident **Benefits** shown in the **Summary of Benefits** of this **Policy**,

If **You** are eligible for **Dependent** coverage under this **Policy**, and **You** are required under an **Order** to provide health insurance coverage for a child, **You** may enroll such child for **Dependent** coverage under this **Policy** regardless of enrollment period restrictions.

If **You** are enrolled under this **Policy** for coverage, but **You** did not enroll the child for **Dependent** coverage under this **Policy**, regardless of enrollment period restrictions, enrollment on behalf of such child, may be made by:

a. The non-insuring parent;
b. A child support enforcement agency; or
c. The state agency administering the Medicaid program.

You may not terminate coverage for the child unless written evidence is provided to **Us** that:

a. The order is no longer in effect;
b. The child has been or will be enrolled under other reasonable health insurance coverage that will take effect on or before the effective date of the termination;
c. **Your Policyholder** has eliminated **Dependent** coverage for all of its **Certificateholders**; or
d. **Your** employment with **Your Policyholder** ceases, except if **You** elect to exercise the Extension of Coverage Benefit, coverage shall then be provided for the child consistent with the provisions of the Extension of Coverage Benefit for post-employment coverage for **Dependents**.

Enrollment for coverage of a child of **Yours** will not be denied because the child:

a. Was born out of wedlock;
b. Is not claimed as a **Dependent** on **Your** federal income tax return; or
c. Does not reside with **You**.

If the child has coverage through **You**, **We** shall:

a. Provide to the non-insuring parent membership cards, claims forms, and any other information necessary for the child to obtain **Benefits** through the coverage; and
b. Process the claims forms and make appropriate payment to the non-insuring parent, health care provider, or state Medicaid agency if the non-insuring parent incurs covered expenses for health care provided to the child.

""**Order**" means a ruling that:

1. Is issued by a court of this State or another state or an administrative agency of another state; and
2. Creates or recognizes the right of a child to receive **Benefits** under a parent's health insurance coverage.

CLAIMS PROVISIONS section, **Proof of Loss** is hereby deleted in its entirety and replaced with the following:

Proof of Loss

Written proof of claim must be given to **Us** within 90 days after the following, the date of loss or treatment.

However, the **Claim** will not be denied or reduced if:

a. It is not reasonably possible to give proof in that time; and
b. Proof is submitted within one year and 90 days from the date of loss or treatment.

This one-year and 90 day period will not apply when **You** are legally incapable of submitting proof. All **Proof of Loss** or loss must be satisfactory to **Us**.

RIGHT TO APPEAL A DENIED CLAIM section is hereby deleted in its entirety and replaced with the following:

If **You** disagree with a decision on a **Claim**, **You** or **Your** representative may, within 426 days of receiving an initial denial notice (or within the selected time period above if **You** receive no response regarding **Your Claim**) submit a written request to:

Select Benefit Administrators
118 Third Street East
P.O. Box 440
Ashland, WI 54806
1-800-497-3699

a. Include comments and questions in writing.
b. Review documents that apply to **Your Claim**.

If **Your** written request for review is not received within 426 days of receiving a denial notice, **You** will forfeit **Your** right to an appeal.

Important Appeal Deadline

Failure to comply within the 426 day deadline may cause **You** to forfeit any right to any further review of an adverse decision under these procedures or in a court of law**.**

Your written appeal should state the reasons that **You** feel **Your Claim** should not have been denied. It should include any additional facts and/or documents that **You** feel support **Your Claim**. **You** may also ask additional questions or make comments and **You** may review pertinent documents.

Notification of Adverse Benefit Decision

We will review and make a decision regarding **Your** claim within a reasonable period but no later than 30 days after it is submitted and **We** will notify **You** in writing of **Our** decision. If the decision remains the same, a denial, **We** will specify the reason for the denial and upon request, specify the **Policy** provisions, protocol or guideline relied upon which the decision is based.

If **Your** coverage is governed by the Employee Retirement Income Security Act, known as "ERISA" (most employment related health coverage, other than that which is provided by governmental entities or churches), **You** have a right to file a lawsuit under Section 502(a) of ERISA to recover benefits due **You** at any point after completion of an appeal. **You** may have other legal rights and remedies available under state or federal law.

Claims Fiduciary

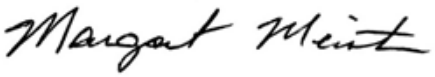
We are designated as the **Claims** fiduciary for **Benefits** provided under the **Policy**. **We** have full discretion and authority to determine eligibility for **Benefits** and to construe and interpret all terms and provisions of the **Policy**.

Preemption of State Law

If applicable state law requires **Us** to take action on a **Claim** or appeal in a shorter timeframe, the shorter period will apply.

All other terms and conditions of the Policy remain unchanged.

Symetra Life Insurance Company



Margaret Meister,
President

HEALTH BASICS GROUP ACCIDENT CERTIFICATE OF COVERAGE

Certificate Specifications

This Policy is issued to: **Cracker Barrel Old Country Store, Inc.**

Policy Number: **11755000**

Policy Effective Date: **January 1, 2017**

Policy Anniversary: **January**

Governing Jurisdiction: This **Policy** is delivered in and governed by the laws of **Tennessee**.

This **Policy** has been issued in consideration of the signed Application and payment of **Premium**. 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 Executive Vice President, executed this **Policy** as of this **Policy Effective Date** and caused it to be duly countersigned at Bellevue, Washington.

Margaret Meister,
President

Michael Fry,
Executive Vice President

NOTICE TO THE BUYER

This Policy is issued as an Accident Only Policy. It does not pay benefits for loss caused by illness.

THIS POLICY PROVIDES LIMITED COVERAGE,
PLEASE READ YOUR POLICY CAREFULLY.

SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004-5135
1-800-796-3872
TTY/TDD 1-800-833-6388

Table of Certificate Contents

Introduction

This is **Your** Certificate of Coverage. It describes the **Benefits** provided through the **Policyholder** under the **Policy** issued by Symetra Life Insurance Company to the **Policyholder.**

The complete terms of the coverage provided are set forth in this Certificate.

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** section replaces all others previously issued to **You** or your assignee.

Summary of Benefits and Benefit Amounts

This **Policy** is issued to: **Cracker Barrel Old Country Store, Inc.**
Policy Number: **11755000**
Policy Effective Date: **January 1, 2017**
Policy Anniversary: **January**

Eligible Classes of Certificateholders

All eligible **Certificateholder**s of the **Policyholder** who are defined as follows:

Class	Description
1	All RS and PAR 1-4 **Employees**, who have worked and been paid for an average of at least 30 hours each week; at your **Employer's** normal place of business during the measurement period defined by your **Employer**.
2	**Employees**, who have worked and been paid for an average of at least 30 hours each week; at your **Employer**'s normal place of business during the measurement period defined by your **Employer**.

Certificateholder and Dependent Accident Benefit

Accident Benefit Amount:

100% of **Eligible Expenses** up to $500 for each **Accident** occurrence up to a maximum of 3 occurrences per person per **Calendar Year.**

Service Waiting Period

The **Service Waiting Period** is the initial measurement period which will begin the first day of the month coinciding with or following the date of hire and continues for 11 months.

Employees who work an average of at least 30 hours per week during the initial measurement period will have a four week administrative period to enroll for coverage.

The Annual enrollment period and standard measurement period are as communicated by your **Employer** on a yearly basis for a January 1st effective date.

Definitions

Accident
an **Injury** sustained by **You,** which is a sudden, unforeseen, unexpected and involuntary event definite as to time and place and which is independent of disease or bodily infirmity.

Amendment
a document that modifies this **Policy**, and becomes part of this **Policy**, also known as an **Endorsement** or **Rider**.

Benefit
the dollar amount payable by **Us** to a claimant or assignee under this **Policy**.

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

Certificateholder
a. a person who is employed by, and paid by, the **Policyholder**; or
b. a person who is employed by, and paid by an association acting in the capacity of the master **Policyholder** or the **Insured** of a member company of an association; or
c. a person who is eligible for coverage under this **Policy** as a worker including one who is under exclusive contract with an employer or as a **Dependent**, and is enrolled, and for whom **Premium** is paid.

Claim
a request for payment of **Benefits**.

Confined/Confinement
an **Inpatient** in a **Hospital** or other health care facility.

Contract Year
a period of one year commencing on the **Policyholder's Effective Date of Coverage** and ending at 12:00 midnight on the last day of the one-year period.

Dependent
the following persons:
a. **Your** spouse, as defined by state law;
b. **Your** child who is under 26 years of age (limiting age); or
c. **Your** child, who is incapable of self-support due to **Developmental Disability** or physical disability, provided the condition occurs prior to age 26.

Your child can include stepchildren, adopted children, or foster children, a judicially appointed minor ward of **Yours**, or a child legally placed for adoption and primarily dependent upon **You** for support.

Developmental Disability
a. a disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or another neurological condition closely related to mental retardation; or from
b. a condition that requires treatment similar to that required for mentally retarded individuals, which disability originates before such individual attains the "limiting age", which has continued or can be expected to continue indefinitely, and which constitutes a substantial handicap to such individual.

Effective Date
the date on which coverage under this Certificate begins.

Effective Date of Coverage
the date coverage under this Certificate goes into effect any eligible **Certificateholders** and **Dependents**.

Eligible Expenses
services or supplies received by or on behalf of an **Insured** for treatment of a covered **Accident** that are not excluded under this **Policy**.

Emergency Room
a staffed and equipped **Hospital** room or **Hospital** area for the reception and evaluation of persons with conditions, such as **Illness** or **Injury**, requiring immediate medical attention. Treatment in an Emergency Room does not constitute admittance to the hospital.

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

Experimental/Investigational
a method of care (e.g. any treatment, procedure, facility, equipment, drug device or supply) which meets one or more of the following criteria as determined by Symetra:

a. the chosen method of care cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time such care is provided; or
b. the method of care is currently undergoing review by the treating facility's Institutional Review Board or other body serving a similar function or if such review or approval is required by law or if the method of care is considered experimental or investigational by the Food and Drug Administration; or
c. if Reliable Evidence shows that the method of care is the subject of ongoing phase I or phase II clinical trials or is the research, experimental, study or investigational arm of ongoing phase III clinical trials or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
d. if *Reliable Evidence* shows that the prevailing opinion among experts regarding the method of care is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or its efficacy as compared with a standard means of treatment or diagnosis. In its determination of Experimental/Investigational, Symetra will rely on evidence produced by experts selected by Symetra. Conflicting evidence will defer to the exercise of independent judgment by Symetra.

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

Hospital
a licensed health care facility which:

a. provides acute care; and
b. provides 24-hour nursing services; and
c. provides **Inpatient** therapeutic and diagnostic services for **Injury** or **Illness**; and
d. provides facilities for major surgery or has a formal arrangement with another health care facility for surgical facilities; and
e. is approved by the Joint Commission on the Accreditation of Health Care Facilities as a **Hospital**.

Hospital does ***not*** include:

a. a rest home or nursing home, home for the aged, or convalescent home;
b. a **Nursing Facility**;
c. a **Hospice** or a place for **Custodial Care** or a **Birthing Center**;
d. a place primarily for the treatment of **Substance Abuse Disorders**; or
e. a place primarily for the treatment of **Mental Disorders**.

Hours of Work Credit
the hours worked by **You** for whom contributions have been made on **Your** behalf by the **Policyholder**.

Illness

a. physical sickness or disease; or
b. a **Mental Disorder** as defined under this Certificate; or
c. complications of pregnancy; or
d. congenital abnormalities.

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

Inpatient
a person who has been admitted to a **Hospital** or other health facility and for whom a room and board charge has been made to receive diagnosis,

treatment or other health services; and does not include a person who has received services in an Emergency Room, except when the **Hospital** admission is within 24 hours of an Emergency Room visit.

Insured
a person who is eligible for coverage under this Certificate as a **Certificateholder** or as a **Dependent**, is enrolled, and for whom **Premium** is paid.

Lifetime Maximum
the dollar limitation on **Benefits** that will be paid for **You** during **Your** lifetime while covered under this Certificate.

Medically Necessary
any services or supplies provided for the diagnosis and treatment of a specific **Injury**, which are:
a. ordered or recommended by a **Physician**;
b. required for the treatment or management of a medical condition or symptom;
c. the most appropriate supply or level of service which can safely be provided to **You**;
d. provided in accordance with approved and generally accepted medical or surgical practice;
e. not for the convenience of **You**, **Your Physician**, or another **Provider**;
f. Not for services or supplies which are **Experimental or Investigational**;
g. necessary for detoxification as an emergency medical condition provided **You** are not yet enrolled in other chemical treatment; and
h. furnished in the least intensive type of medical care setting required by **Your** condition.

Services and supplies will ***not*** automatically be considered **Medically Necessary** because a **Physician** ordered them.

Nurse
any one of the following who is not a member of the **Insured's** immediate family or employed by the **Hospital** where the **Insured** is **Confined**:
a. Licensed Practical Nurse (L.P.N.); or
b. Licensed Vocational Nurse (L.V.N.); or
c. graduated Registered Nurse (R.N).

Outpatient
an individual who receives health care services where he is not admitted to a **Hospital**.

Physician
a duly licensed member of a medical profession who:
a. has an M.D. or D.O. degree;
b. is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
c. provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:
a. is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
b. provides medical services which are within the scope of his or her license or certificate;
c. under applicable insurance law is considered a "physician" for purposes of this coverage;
d. has the medical training and clinical expertise suitable to treat your condition;
e. specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
f. a physician is not you or related to you.

Policy
the Group Accident Policy of which this Certificate forms a part that is issued to the **Policyholder**.

Policy Anniversary
the date twelve months after the date of the **Policyholder's Effective Date of Coverage** under the **Policy**, or as indicated on Summary of Benefits listed in this Certificate.

Policyholder
the entity named on the Application and the **Summary of Benefits,** who has applied for coverage under the **Policy**.

Premium
the dollar amount shown on the Schedule of **Premium Rates** page and amount paid by the **Policyholder** and/or **You** to keep the **Policy** in force.

Provider
any **Physician**, health professional, **Hospital**, **Nursing Facility**, home health agency or other person or recognized entity licensed to provide service for **Hospital** or medical services to **Insureds** covered under this **Policy.**

Rate
the pricing factor upon which the **Policyholder's** and/or **Your Premium** is based.

Reinstatement
the resumption of coverage that has lapsed under the **Policy**.

Renewal
continuance of coverage under the **Policy** beyond its original term by **Our** acceptance of the **Premium** for a new **Policy** term.

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

Service Waiting Period
the length of time as specified in the **Summary of Benefits You** must wait from **Your** date of employment or application for coverage, until **Your** coverage is effective.

Summary of Benefits
the pages of this Certificate**,** which list the **Benefits** selected by the **Policyholder** and **You**.

Totally Disabled/ Total Disability
Your inability to perform the substantial and material duties of **Your** occupation.

We/Us/Our/Company
Symetra Life Insurance Company.

Workers' Compensation
benefit payments to any eligible individual as required by state law for accidents or occupational disease arising out of or in connection with the individual's employment.

Certificateholder Eligibility

Eligible Certificateholders - Hours of Work Credit

Each **Certificateholder** of a **Policyholder** who meets all of the following conditions is eligible for coverage under this **Policy**:

a. performing all the normal duties of his job at the normal place of business of the **Policyholder**;
b. working in an eligible class; and
c. has worked and been paid for at least theminimum required hours at the normal place of business of the **Policyholder**.

The Date You are Eligible for Coverage

You become eligible for coverage upon completion of the **Service Waiting Period**.

Effective Date of Your Coverage

In order to become covered under this **Policy**, **You** must first enroll in writing on a form approved by **Us** giving the information **We** require.

If **You** are not required to contribute to the cost of **Your** coverage, coverage will become effective on the first day following the administrative period, following the latest of the following dates:

a. the date **Premium** is received; or
b. the date following completion of the **Service Waiting Period,** if any.

If **You** are required to contribute to the cost of **Your** coverage, the date coverage begins will depend on the date **You** enroll for coverage. However, it will be the first day following the administrative period, following the latest of the following dates:

a. the date **Premium** is received; or
b. the date following completion of the **Service Waiting Period**, if any; or
c. the date **You** enroll for coverage.

Late Enrollment

If **You** fail to enroll **Yourself** or **Your** eligible **Dependents** within 30 days of **Your** or **Your** eligible **Dependent's** original eligibility date, then **You** or **Your** eligible **Dependent** will not be eligible to enroll for coverage under this **Policy** until the **Policyholder's** next open enrollment**,** if any. In the case of no open enrollment, late enrollment will be at the discretion of the **Policyholder**.

Dependent Eligibility

Please Note: This may not apply to **You** or **Your** coverage. **Dependent** coverage only applies if it is listed on **Your** Summary of Benefits and Benefit Amounts.

Eligible Dependents

A **Dependent** of **Yours** is eligible for coverage under this **Policy** if:

a. **You** are an **Insured** under this **Policy**;
b. **You** are in a class that qualifies for **Dependent Benefits**;
c. the **Dependent** is not covered as a **Certificateholder** under this **Policy;** and
d. if both **You** and **Your** spouse or is covered under this **Policy** as **Certificateholders**, either, but not both, may elect to cover children who are eligible **Dependents**.

Date a Dependent is Eligible for Coverage

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

a. the date **You** become eligible for **Certificateholder** coverage; or
b. the date **You** acquire **Your** first **Dependent** to include a newborn or newly placed adopted child; or
c. the first day of the month following the date **You** acquire a spouse.

Effective Date of Dependent Coverage

In order for a **Dependent** to become an **Insured**, **You** must first enroll the **Dependent** by submitting an enrollment form with the "Dependent box" checked within 30 days of acquiring a new eligible **Dependent** for **Dependent** coverage giving the information **We** require.

If **You** are not required to contribute to the cost of **Dependent** coverage, **Dependent** coverage will become effective on the first day following the administrative period, following the latest of the following dates if the **Dependent** is not **Confined** on that date:

a. the date **Premium** is received; or
b. the date **You** become eligible for **Dependent** coverage; or
c. the date the person becomes a **Dependent.**

If **You** are required to contribute to the cost of **Dependent** coverage, **Dependent** coverage will become effective on the first day following the administrative period, following the latest of the following dates if the **Dependent** is not **Confined** on that date:

a. the date **Premium** is received; or
b. the date **You** become eligible for **Dependent** coverage; or
c. the date **You** enroll for **Dependent** coverage.

If **You** had elected **Dependent** coverage before the birth or adoption of a child, **Dependent** coverage will be provided from the moment of birth or adoption of such child.

If **You** did not elect **Dependent** coverage before the birth or adoption of a child, **Dependent** coverage will be provided for the first 60 days following the birth or adoption of such child. Coverage will continue beyond the 60 day period for that child, if:

a. **You** notify **Us** in writing of the birth or adoption of such child; and

b. **You** authorize the **Policyholder** to make the required payroll deductions toward the cost of **Your Dependent** coverage within 60 days of the date of birth or adoption.

We require **You** to notify **Us** of additional **Dependents** to assure accurate **Claims** handling.

If a **Dependent** child is **Confined** to a **Hospital** or other health care 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.

Benefit Changes

Change in Amounts of Benefits

Any change in the amount of **Benefits** due to a change in **Your** class or status, will be effective on the first business day of the month following the month in which **You** work and are paid for the minimum required hours, if any, provided:

a. **You** are performing all the normal duties of **Your** job at the **Policyholder's** normal place of business; and
b. **You** make any required payment for the change to be effective.

Changes in amounts of **Benefits,** due to an **Amendment, Endorsement** or **Rider** to this **Policy** or the **Policyholder's** coverage under this **Policy,** will take effect for **You** on the **Effective Date** of the **Amendment, Endorsement** or **Rider**.

Benefits payable under this **Policy** will be based on the coverage in effect at the time the eligible expenses were incurred.

Change in Amounts of Coverage

Once **You** have made **Your Benefit** elections for a given year, **You** cannot change those elections until the **Policyholder's** next open enrollment. Increases in the amount of **Certificateholder** coverage are effective on the first of the month following the date of change provided. **You** are performing all the normal duties of **Your** job at your normal place of business.

Decreases in the amount of **Certificateholder** coverage are effective on the first of the month following the date of change, provided **You** are performing all the normal duties of **Your** job at the **Policyholder's** normal place of business.

Termination Provisions

Termination of Your Coverage

Your coverage will cease on the earlier of:

a. the date this **Policy** is canceled;
b. the date the **Policyholder's** coverage ceases under this **Policy**; or
c. the last day of the month in which the first of the following occurs:
   i. **Your** membership in an eligible class ceases;
   ii. **Your** employment with the **Policyholder** ceases;
   iii. **You** or the **Policyholder** cease **Premium** payments for **Your** coverage;
   iv. **You** are pensioned or retired, as defined by the **Policyholder**;
   v. the date **You** begin active duty in the armed forces.

In addition, if **You** are classified as an **"**Hourly **Certificateholder" Your** coverage will cease on the first day of the month following any month in which **Your Hours of Work Credit** fall below the required number of hours, as established by the **Policyholder.**

Termination of Dependent Coverage

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

a. the date this **Policy** is canceled;
b. the date **Your** coverage ceases;
c. the date **We** cancel all **Dependent** coverage under this **Policy**; or
d. last day of the month in which the first of the following occurs:
   i. **You** are no longer in a class eligible for **Dependent** coverage; or
   ii. the **Dependent** ceases to be an eligible **Dependent**.

In addition, coverage under this **Policy** will cease for a **Dependent** on the first day of the month following any month in which **Your** number of hours worked, falls below the minimum required hours.

With respect to the **Benefits** of this **Policy**, coverage will be continued for a **Dependent** child beyond the "limiting age," as defined in the definition of **Dependent**, as long as the child continues to be both:

a. incapable of self-sustaining employment by reason of **Developmental Disability** and/or physical incapacity; and
b. primarily dependent on **You** for support and maintenance.

Proof of such incapacity must be given to **Us** not more than 31 days after the date such **Dependent** attains the "limiting age" , as defined in the definition of **Dependent**, and subsequently as required by **Us**, but not more often than once per year after the initial two year period from the date such **Dependent** attains the "limiting age."

Reinstatement

If **You** have ceased to be eligible for coverage **You** may qualify for **Reinstatement** within 30 days from the date **You** were last eligible. **You** will be reinstated and eligible for coverage on the first day of the calendar month following the month in which **You** work and are paid for the minimum required hours. If **You** do not qualify for **Reinstatement** within 30 days from the date **You** were last eligible, **You** will be treated as a new worker.

Continuation of Coverage

Under the conditions that follow, **Benefits** for **You** and **Your** covered **Dependents** may continue beyond the day coverage would otherwise cease under the "Benefit Changes" and "Termination Provisions" sections if the required **Premium** is paid and this **Policy** is in force for the **Policyholder** during the continuation period shown below.

Coverage under this **Policy** will end on the first day **You** begin work for pay or profit with another employer.

Your Coverage

In the following circumstances, employment will be deemed to continue as shown, or until the **Policyholder**, acting under rules that preclude individual selection, terminates **Your** employment:

Continuation Period

Cause of Absence	Period in which Employment is deemed to continue	Coverage
Illness or Injury	6 months	All coverages
Temporary Lay-Off	2 months	All coverages
Leave of Absence	2 months	All coverages

Upon written request from the **Policyholder**, **We** may agree in writing to continue **Your** coverage for situations other than those listed above.

Dependent Coverage

If any of the situations above apply to **You**, **Dependent** coverage may continue until **Your** coverage ends.

Accident Benefit

Benefits will be paid as shown in the **Summary of Benefits** for **Eligible Expenses** that are incurred as a result of an **Accident** that occurs while the **You** are covered under this **Policy.**

The expenses must be incurred:

a. Within 52 weeks from the date of the **Accident;** and
b. The first expense must be incurred within 60 days after the date of the **Accident**.

The combined expenses paid for Medical, Dental, Surgical, Inpatient Hospital, X-ray and Lab and Inpatient Prescription Drug Benefits will not exceed the maximum Benefit amount shown in the **Summary of Benefits**.

Services and supplies paid under this Benefit include:

Medical Benefits

Medical **Benefits** will be provided for **Eligible Expenses** incurred in connection with an **Accident** while **You** are covered under this **Policy** for services and supplies rendered or prescribed by a licensed **Physician** or other licensed healthcare provider practicing within the scope of their license for the following:

a. **Nursing** services;
b. **Physician's** office visits;
c. **Hospital Emergency Room** visits;
d. **Outpatient Hospital** visits;
e. Urgent care visits;
f. Chiropractic visits;
g. Rehabilitation services.

Medical Benefits will not be provided for services or supplies for preventive care, including but not limited to routine physicals, general health exams, routine immunizations and vaccinations.

Dental Benefits

Dental **Benefits** will be provided for **Eligible Expenses** incurred when rendered by a licensed **Physician** or licensed Dentist in connection with an **Accident** while **You** are covered under this **Policy.** Procedures include:

a. A closed or open reduction of a fracture;
b. Dislocation of the jaw; or
c. **Injury** to **Your** natural teeth.

Exclusions and Limitations

Dental **Benefits** will not be provided:

a. For tooth re-implantology not resulting from an **Accident**;
b. For procedures, services, or supplies, which do not meet accepted standards of dental practice;
c. For treatment initiated while not covered under this **Policy.**

Surgical Benefits

Surgical **Benefits** will be provided for **Eligible Expenses** incurred when rendered by a licensed **Physician** for surgical procedures performed in connection with an **Accident** while **You** are covered under this **Policy**.

Inpatient Hospital Benefits

Inpatient Hospital Benefits will be provided for **Eligible Expenses** incurred in connection with an **Accident** while **You** are covered under this **Policy**.

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

a. the **Insured** is **Confined** in a **Hospital**; and
b. a charge is made for room and board; and
c. the entire duration of such **Hospital Confinement** is recommended and approved by a **Physician**; and
d. **Confinement** is the result of a non-occupational **Accident**; and
e. the services and supplies are not excluded under the Exclusions and Limitations provision of this **Policy**.

X-ray and Laboratory Benefits

Diagnostic X-ray and Laboratory **Benefits** will be provided for:

a. **Eligible Expenses** incurred in connection with an **Accident** while **You** are covered under this **Policy**; and
b. when they are ordered or performed by a **Physician**.

Inpatient Prescription Drugs

Inpatient Prescription Drugs **Benefits** will be provided for **Eligible Expenses** incurred if:

a. **You** are **Confined** in a **Hospital;** and
b. the drugs are prescribed by a **Physician;** and
c. the drugs are administered in the **Hospital** by a licensed healthcare provider, in connection with an **Accident** while **You** are covered under this **Policy**.

Claim Provisions

Notice of Claim

Written notice of **Claim** must be given to **Us** within 20 days after the date any **Injury** or loss occurs or begins. If such notice is not furnished within that 20 day period, a **Claim** will still be considered for payment and will not be denied or reduced due to the delay if it is shown that notice was given as soon as was reasonably possible.

Claim Forms

We will furnish forms for filing **Proof of Loss** after **We** receive the Notice of **Claim**. If such forms are not furnished within 15 days of receipt of the notice, the claimant will be deemed to have met with the terms of this provision of this **Policy** if he submits written **Proof of Loss** within the time set forth in the **Proof of Loss** provision.

Proof of Loss

Written proof of **Claim** must be given to **Us** within 90 days after the date of loss or treatment.

However, the **Claim** will not be denied or reduced if:

a. It is not reasonably possible to give proof in that time; and
b. Proof is submitted within 12 months from the date of loss or treatment.

This 12 month period will not apply when **You** are legally incapable of submitting proof.

Proof of Loss means a **Claim** form or an itemized bill with ICD-9 Codes (or successor codes) from the healthcare provider sent to **Our Policy** administrator, before any **Benefits** may be paid under this **Policy**.

Time Payment of Claims

Benefits payable under this **Policy** for any loss other than loss for which this **Policy** provides any periodic payment will be paid immediately upon receipt of due written proof of such loss.

Payment of Benefits

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

a. **You**;
b. **Your** legally appointed guardian if **You** are not legally able to accept such **Benefits**; or
c. a **Provider** upon **Your** assignment.

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

Physical Examination and Autopsy

We, at **Our** own expense, will 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.

Claim Procedures

Filing of Claims

We are responsible for evaluating all benefit **Claims** under this **Policy**. In order to receive **Benefits You** or **Your Authorized Representative** must complete, sign and submit a written **Claim** on a form approved by **Us**. An "**Authorized Representative**" means a person **You** authorize in writing to act on **Your** behalf. A person given the **Claim** authority to act by court order will be recognized and may submit **Claims** on **Your** behalf. The **Claim** form must be received within 90 days following the receipt of treatment to which the **Claim** relates unless

(a) it was not reasonably possible to file the **Claim** within such time; and
(b) the **Claim** is filed as soon as possible and in no event (except in the legal incapacity of the claimant) later than 12 months after the date of the receipt of the treatment to which the **Claim** relates.

We will make a decision on **Your Claim** within a reasonable time after it is received but no later than 30 days after the receipt of the **Claim**. If more information is required due to circumstances beyond the **Our** control, the time period may be extended up to an additional 15 days. **You** will be notified of the extension before the expiration of the initial 30-day period. **We** have the right to secure independent medical advice and to require such other evidence as **We** deem necessary in order to decide **Your Claim**. If **We** deny **Your Claim** in whole or in part, **You** will receive a written notification setting forth the reasons for the denial within a reasonable time period, but no later than 30 days after receipt of the **Claim** unless a determination that an extension of time for processing is needed as described above.

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 (or within the selected time period above if **You** receive no response regarding **Your Claim**) submit a written request to:

Select Benefit Administrators
118 Third Street East
P.O. Box 440
Ashland, WI 54806
1-800-497-3699

a. Include comments and questions in writing.
b. Review documents that apply to **Your 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.

Important Appeal Deadline

Failure to comply within the 180 day deadline may cause **You** to forfeit any right to any further review of an adverse decision under these procedures or in a court of law**.**

Your written appeal should state the reasons that **You** feel **Your Claim** should not have been denied. It should include any additional facts and/or documents that **You** feel support **Your Claim**. **You** may also ask additional questions or make comments and **You** may review pertinent documents.

Notification of Adverse Benefit Decision

We will review and make a decision regarding **Your** claim within a reasonable period but no later than 30 days after it is submitted and **We** will notify **You** in writing of **Our** decision. If the decision remains the same, a denial, **We** will specify the reason for the denial and upon request, specify the **Policy** provisions, protocol or guideline relied upon which the decision is based.

If **Your** coverage is governed by the Employee Retirement Income Security Act, known as "ERISA" (most employment related health coverage, other than that which is provided by governmental entities or churches), **You** have a right to file a lawsuit under Section 502(a) of ERISA to recover benefits due **You** at any point after completion of an appeal. **You** may have other legal rights and remedies available under state or federal law.

Claims Fiduciary

We are designated as the **Claims** fiduciary for **Benefits** provided under the **Policy**. **We** have full discretion and authority to determine eligibility for **Benefits** and to construe and interpret all terms and provisions of the **Policy**.

Preemption of State Law

If applicable state law requires Us to take action on a Claim or appeal in a shorter timeframe, the shorter period will apply.

Extension of Coverage Benefit

Extension of Coverage applies to all **Benefits** shown in the **Summary of Benefits** of this **Policy**. **This Extension of Coverage Benefit** applies only to loss of accident coverage under this Select Benefits **Accident** Insurance **Policy.**

You and **Your Dependents** may qualify to temporarily extend the accident **Benefits** of this **Policy** at group rates (Extension of Coverage) in certain situations where coverage would otherwise end. **You** may only extend the **Benefits** of said **Policy** which **You** and/or **Your Dependents** had immediately prior to the date coverage ended.

You may choose Extension of Coverage for **Yourself** and any covered **Dependent** if **You** lose **Your** group accident coverage because of a reduction in hours or termination of employment (for reasons other than gross misconduct). If **You** are a covered spouse, or **Dependent** child of a **Certificateholder**, **You** may choose Extension of Coverage for **Yourself** if **You** lose group accident coverage for any of the following reasons (qualifying event):

a. **Your** spouse dies;
b. **Your** spouse's, or if a dependent, **Your** parent's employment ends (for reasons other than gross misconduct), or his hours are reduced;

c. **You** or, or if a **Dependent**, **Your** parents' divorce or legally separate;
d. **Your** spouse or parent becomes entitled to Medicare; or

Covered **Dependent** children of a **Certificateholder** may continue coverage if they cease to qualify as **Dependents** under the group policy. **You** or **Your Dependent** are responsible for notifying the **Policyholder** when certain qualifying events occur. These events include divorce or legal separation and ceasing to qualify as a **Dependent** under the group plan.

The **Policyholder** must be notified within 60 days of the later of:
a. the event; or
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; or
b. the date the **Policyholder** informed **You** that **You** may choose Extension of Coverage.

If **You** do not choose Extension of Coverage, **Your** coverage under this policy with the **Policyholder** will end. If **You** choose Extension of Coverage, it will be identical to coverage **You** and/or **Your Dependents** had immediately prior to the date coverage ended.

If **You** elect Extension of Coverage, **You** must pay the full cost of coverage each month. **You** have the option to continue coverage for **Yourself** and/or **Your** covered **Dependents** for 18 months if **You** lose group accident coverage due to termination of employment or a reduction in hours. A longer coverage period may be available in case of disability. If the Social Security Administration determines that **You** or a covered **Dependent** are disabled by the end of the first 60 days of Extension of Coverage following termination of employment, coverage for the disabled person and all covered **Dependents** may be extended for an additional 11 months up to a total of 29 months. This same 11-month extension is provided to a disabled child if the child is born or placed for adoption during the Extension of Coverage period and the child is determined to be disabled within the first 60 days of Extension of Coverage. In order to qualify for coverage extension, **You** must notify the **Policyholder** before the end of the 18-month Extension of Coverage period and provide a copy of the Social Security disability determination letter within 60 days of the determination date. If, during the 18-month Extension of Coverage period, another qualifying event takes place, coverage may be extended for up to 36 months for covered **Dependents**. In no case will the total Extension of Coverage period exceed 36 months.

Extension of Coverage may be terminated for any of the following reasons:
a. the **Policyholder** no longer provides group accident coverage to any **Certificateholders**;
b. **You** do not pay the **Premium** for **Your** Extension of Coverage on time;
c. **You** become covered under another group accident plan 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; or
e. the person whose Social Security disability enabled the extended coverage is determined to have recovered.

If **You** have any questions about Extension of Coverage, contact the **Policyholder.**

Non-Duplication of Benefits

To avoid duplication of benefit payments to an **Insured**, **Benefits** under this **Policy** will be coordinated with benefits payable under the Select Benefits Group Indemnity Policy and Select Benefits Group Outpatient Prescription Drug Policy**,** if applicable.

Exclusions and Limitations

Whether or not these may be considered accidents, benefits will not be paid for any expense for services or supplies:

a. for which there is no charges made which an insurer is required to pay;
b. received after Termination of Coverage, except as provided under this **Policy**;
c. received as a result of participation in any sport for pay or profit;
d. received as a result of participation in parachuting, bungee jumping, rappelling, mountain climbing or hang gliding;
e. received as a result of participation in any form of aeronautics, except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports;
f. received as a result of participation or driving in any organized scheduled race or speed test or while testing an automobile or any vehicle on any racetrack or speedway;
g. for hernia repair, including complications;
h. related to cosmetic surgery, except for reconstructive surgery on an injured part of the body;
i. related to dental care, except as required on account of **Injury** resulting from an **Accident** while covered under this **Policy**;
j. which are not **Medically Necessary**;
k. for durable medical equipment;
l. that are not approved or accepted as essential to the treatment of the **Injury** by any of the following:
    i. the American Medical Association;
    ii. the U.S. Surgeon General;
    iii. Department of Public Health; or
    iv. the National Institute of Health.
m. for disease, **Illness**, or bacterial infection, except infection resulting directly from an **Accidental Injury**;
n. for an **Injury** or **Illness** caused wholly or partly, directly or indirectly by:
    i. declared or undeclared war or act of war;
    ii. intentionally committing or attempting to commit an assault or felony;
    iii. intentionally self-inflicted **Injury**, while sane or insane.
o. any **Illness** or **Injury** covered by any **Worker's Compensation** Act or similar law.

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004-5135
1-800-796-3872
TTY/TDD 1-800-833-6388

SYMETRA®
RETIREMENT | BENEFITS | LIFE

HEALTH BASICS
CRITICAL ILLNESS POLICY

Employer Name:	Cracker Barrel Old Country Store, Inc.
Policy Number:	11755000
Effective Date of Coverage:	January 1, 2017
Policy Anniversary:	January 1, 2018

CERTIFICATE OF COVERAGE

INTRODUCTION

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

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

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

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

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

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

This Certificate of Coverage replaces all others previously issued.

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

CERTIFICATE TABLE OF CONTENTS

CERTIFICATE TABLE OF CONTENTS (CONTINUED)

SCHEDULE OF BENEFITS

Eligible Class(es) for Coverage

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

Class	Description
1	All RS and PAR 1-4 **Employees**, who have worked and been paid for an average of at least 30 hours each week; at your **Employer's** normal place of business during the measurement period defined by your **Employer**.
2	**Employees**, who have worked and been paid for an average of at least 30 hours each week; at your **Employer**'s normal place of business during the measurement period defined by your **Employer**.

Service Waiting Period

The **Service Waiting Period** is the initial measurement period which will begin the first day of the month coinciding with or following the date of hire and continues for 11 months.

Employees who work an average of at least 30 hours per week during the initial measurement period will have a four week administrative period to enroll for coverage.

Annual Enrollment Period

The Annual Enrollment Period and standard measurement period are as communicated by your **Employer** on a yearly basis for a January 1st effective date.

Employee Critical Illness Benefit

- **Critical Illness Benefit** — $5,000 per critical illness

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

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

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

Spouse Critical Illness Benefit

- **Critical Illness Benefit** — $5,000 per critical illness

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

- **Guaranteed Issue Amount** $5,000
- **Recurrence Benefit** 100% of the Critical Illness Benefit paid for the first occurrence of the same condition

Child Critical Illness Benefit

- **Critical Illness Benefit** $1,250 per critical illness

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

- **Guaranteed Issue Amount** $1,250
- **Recurrence Benefit** 100% of the Critical Illness Benefit paid for the first occurrence of the same condition

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

DEFINITIONS

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

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

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

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

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

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

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

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

Dependent: the following persons:

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

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

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

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

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

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

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

DEFINITIONS (CONTINUED)

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

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

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

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

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

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

The cost of the Prior Coverage must have been paid through its date of termination. The termination date must have occurred within 30 days of your **Employer**'s **Effective Date of Coverage** under the **Policy**.

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

Provider: any doctor, health professional, hospital, nursing facility, home health agency or other person or recognized entity licensed to provide hospital or medical services to **Insureds** covered under the **Policy**.

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

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

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

Specialist: a person who:

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

Examples of a Specialist are:

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

DEFINITIONS (CONTINUED)

A Specialist is not a person who:

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

ELIGIBILITY FOR COVERAGE

Eligible Employees

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

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

The Date You Are Eligible for Coverage
You first become eligible for coverage on the later of:

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

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

a. Within 30 days of your eligibility date.
b. During an Annual Enrollment Period designated by the **Employer**.
c. Within 30 days of the date you have a qualified life event change.

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

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

Effective Date of Your Coverage
Your coverage becomes effective on the 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 30 days from the date you first become eligible or have a life event change).
c. The date the next **Benefit Year** begins (if you enroll during an Annual Enrollment Period)
d. The date **Premium** is received

If, because of illness or **Injury**, you are not **Actively at Work** on the date your coverage would normally take effect, your **Effective Date of Coverage** will be delayed until the first day of the month following the date you have returned to active work for a period of 5 days. If you were absent from work for more than 30 days following the date your coverage would normally take effect, you will be required to provide new evidence of insurability.

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 a Spouse or Child Critical Illness Benefit.

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

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

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

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

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

Enrollment
In order for a **Dependent** to become an **Insured**, you must first enroll the **Dependent** in writing 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 30 days of the **Dependent's** eligibility date.
b. During an Annual Enrollment Period designated by the **Employer**.
c. Within 30 days of the date you have a qualified life event change.

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

If you have not enrolled yourself, you may not enroll a **Dependent**.

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

a. The date the **Dependent** becomes eligible (if you enroll the **Dependent** before that date).
b. The date you enroll the **Dependent** for coverage (if you do so within 30 days from the **Dependent's** eligibility date or the date of a life event change).
c. The date the next **Benefit Year** begins (if you enroll the **Dependent** during an Annual Enrollment Period)
d. The date **Premium** is received

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

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

If a **Dependent**, other than a newborn child, is confined to a hospital or other healthcare facility on the date he would otherwise become an **Insured**, he will become an **Insured** on the first day following his release from the hospital or health care facility. If the **Dependent** was confined for more than 30 days following the date he would otherwise become an **Insured**, you will be required to provide new evidence of the **Dependent's** insurability.

Termination of Your Coverage

Your coverage will cease on the earlier of:

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

Termination of Dependent Coverage

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

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

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

Proof of the disabling impairment must be given to us no later than 30 days after the date your child attains the limiting age. Subsequently, we have the right to require proof of your child's impairment, but not more often than once per year after two years from the date the limiting age is attained.

Continuation of Coverage During Temporary Absence

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

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

ELIGIBILITY FOR COVERAGE (CONTINUED)

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

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 3 consecutive months from the date you were last **Actively at Work**.

Personal Leave of Absence
If you are on an employer-approved leave of absence, all of your coverage may be continued for up to 1 month following the date you were last **Actively at Work**. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Family Medical Leave of Absence
If you are on a leave of absence approved in accordance with the federal Family and Medical Leave Act of 1993 and any amendments to it (FMLA) or a similar state law, all of your coverage may be continued for up to 1 month following the date you were last **Actively at Work**. If the leave terminates prior to the agreed upon date, this continuation will cease immediately. Continuation under this FMLA leave provision will not apply if coverage may be continued for a longer period of time under the provision for temporary absence due to illness or **Injury**.

Military Leave of Absence
If you are on a military leave of absence taken in accordance with the federal Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments to it (USERRA), all of your coverage may be continued for up to 1 week following the date you were last **Actively at Work**. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Sabbatical
If you are on an employer-approved sabbatical, all of your coverage may be continued for up to 1 month following the date you were last **Actively at Work**. If the sabbatical terminates prior to the agreed upon date, this continuation will cease immediately.

Temporary Layoff
If you are temporarily laid off by the **Employer** due to lack of work, all of your coverage may be continued for up to 1 month following the date you were last **Actively at Work**. If the layoff becomes permanent, this continuation will cease immediately.

Temporary Production Shutdown
If you are not at work due to a temporary production shutdown by the **Employer**, all of your coverage may be continued for up to 1 month following the date you were last **Actively at Work**. If the production shutdown becomes permanent, this continuation will cease immediately.

Labor Strike/Labor Dispute
If you are not at work due to a labor strike or dispute, all of your coverage may be continued for up to 1 month following the date you were last **Actively at Work**. If the labor strike or dispute ends earlier, this continuation will cease immediately.

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

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

ELIGIBILITY FOR COVERAGE (CONTINUED)

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

Post-Termination Continuation of Coverage

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

a. You were **Actively at Work** on the date your employment ceases.
b. You are under 70 years of age.
c. You are not pensioned or retired, as defined by your **Employer**.
d. You are not scheduled for immediate deployment as a full-time member of the armed services of any country.

Post-termination continuation of coverage is not available for **Dependents**.

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

Coverage may be continued up to the date last day of the month in which the first of the following events occurs:
a. You have been covered under this Continuation of Coverage provision for 1 month.
b. You begin work for pay or profit with another employer.
c. You attain 70 years of age.
d. You are pensioned or retired, as defined by your **Employer**.
e. You enter full-time active duty as a member of the armed forces (land, water, air) of any country or international authority.
f. You request, in writing, to cancel coverage.

Any continued coverage:

a. Is subject to payment of the required **Premium**.
b. Terminates if:
   i. The **Policy** terminates.
   ii. Your **Employer** ceases to be a **Employer** under the **Policy**.
   iii. After you have been covered under this Continuation of Coverage provision for 31 days, we terminate your coverage.

Reinstatement

If you ceased to be eligible for coverage, coverage that terminated may be reinstated if you become eligible again within 30 days from the date you were last eligible. Your reinstated coverage will be identical to the coverage you and your **Dependents** had immediately prior to termination. It will take effect on the first day of the calendar month following the date you become eligible again.

Reemployment

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

BENEFITS

Critical Illness Benefit

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

Covered Critical Illness

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

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

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

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

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

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

a. 12 months for a critical illness in the same category.
b. 1 month for a critical illness in another category.

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

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

Covered Critical Illness Descriptions

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

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

a. Pathological Diagnosis

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

b. Clinical Diagnosis

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

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

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

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

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

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

g. Thyroid cancer that is classified as T1 by the AJCC Staging System and is less than or equal to 2 cm in diameter, without lymph node or distant metastasis.

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

1. Carcinoma in-situ (cancer which has not spread to neighboring tissue) that is classified as (Tis) by the AJCC Staging System, of all organs except skin.
2. Malignant prostate cancer that is classified as T1 by the AJCC Staging System and has a Gleason Score that is less than or equal to 6, without lymph node or distant metastasis.
3. Malignant melanoma of that is less than or equal to 1.0 mm in maximum Breslow thickness, without lymph node or distant metastasis;
4. Malignant thyroid cancer that is classified as T1 by the AJCC Staging System and is less than or equal to 2 cm in diameter, without lymph node or distant metastasis.

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

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

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

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

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

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

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

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

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

a. Established or old heart attack (myocardial infarction) found on imaging or electrocardiogram.

b. Angina.
c. Cardiomyopathy.
d. Myocarditis.
e. All other forms of acute coronary syndromes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Diagnosis Requirements
All of the following conditions must be satisfied:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Recurrence Benefit

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EXCLUSIONS AND LIMITATIONS

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

Exclusions

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

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

GENERAL PROVISIONS

Notice of Claim

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

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

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

Claim Forms

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

Proof of Loss

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

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

All proof submitted must be satisfactory to us.

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

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

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

Time Payment of Claims

We will pay benefits immediately after we receive all essential information needed to make a determination on the claim.

Payment of Benefits

Benefits payable under the **Policy** will be paid directly to:
a. You.
b. Your legally appointed guardian if you are not legally able to accept such benefits.
c. Your estate, in the event any payment is owed at the time of your death.

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

Physical Examination and Autopsy

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

Examination of Specialist's Records

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

Right to Appeal a Denied Claim

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

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

Your written request should include:

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

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

Legal Actions

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

a. Until 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**.