Plan Summary for:

12469000 - Nebraska Methodist Health System, Inc.

SYMETRA
RETIREMENT | BENEFITS | LIFE

Summary of Benefits

Critical Illness

Coverage Details	
Symetra's voluntary Critical Illness insurance provides a lump sum payment if a covered condition is diagnosed after coverage takes effect for the individual. Covered conditions include critical illnesses and/or conditions, as specified below.	
Core Benefits	Invasive Cancer: 100%, Minor Cancer: 50%, Skin Cancer: $500, Heart Attack: 100%, Stroke: 100%, Coronary Artery Disease Needing Surgery or Angioplasty: 50%, Sudden Cardiac Arrest: 100%, Transient Ischemic Attack: 50%, Major Organ Failure: 100%, Occupational HIV: 100%, End-Stage Renal Failure: 100%, Loss of Sight: 100%, Loss of Speech: 100%, Loss of Hearing: 100%, Paralysis: 100% (Covers Sickness and Accident), Severe Burns: 100%, Stem Cell Transplant: 100%
Neurological Conditions	ALS/Other Motor Neuron Disease: 100%, Advanced Alzheimer's: 100%, Parkinson's Disease: 100%, Advanced Multiple Sclerosis: 100%, Coma: 100% (Covers Accident and Sickness)
Childhood Conditions	Major Congenital Structural Anomaly: 50%, Congenital Metabolic Disorder: 50%, Congenital Chromosomal Abnormality: 50%, Chronic Medical Condition Commonly Diagnosed in Childhood: 50%, Autism Severity Level 3: 50%, Autism Severity Level 2: 25%, Autism Severity Level 1: 10%
Other Benefits	Significant Mental Illness: 25%, Severe Mental Illness: 50%, Occupational Tuberculosis: 25%, Occupational Hepatitis: 25%, Infectious Disease: 25% (Minimum Hospital Stay: 3 Days), Severe Complications of Birth Level I: 25%, Severe Complications of Birth Level II: 100%, Severe Complications of Pregnancy: 50%
Additional Occurrences	If you are diagnosed with a Covered Critical Illness, and you are then, at least one day later, diagnosed with a different Covered Critical Illness, we will also pay the additional Critical Illness benefit for the second covered condition.
Options	
Health Screening Benefit	Pays an annual benefit amount of $50 for x-ray and laboratory tests only incurred by the employee, spouse, or child. Annual physical is included. Childhood vaccinations are included.
Recurrence Benefit	Pays an additional benefit of 100% of the critical illness benefit when a specific critical illness recurs more than 6 month(s) after the first diagnosis. Each condition is payable an unlimited number of times unless otherwise specified in the certificate.

Waiver of Premium	If You are Disabled, We will waive the Premium that is owed by You for the coverage provided under this Certificate. The Waiver of Premium Benefit begins on the Premium due date after You have been disabled for 6 months. We will continue to waive the Premium that is owed by You until the earliest of: 1. 6 months after You become eligible for Waiver of Premium under this provision. 2. The date the Policy terminates. 3. The date You attain age 65. 4. The date You are no longer Disabled. When the Waiver of Premium ends, coverage will continue under the Policy provided that Premiums continue to be paid and Your coverage has not ended in accordance with the Termination of Your Coverage provision.
Employee Benefit Amount(s)	
Critical Illness Employee Benefit: $10,000, $20,000, or $30,000	
Guaranteed Issue Benefit: Up To $10,000, $20,000, or $30,000	
Dependent Benefit Amount(s)	
Spouse Benefit: 100% of the benefit amount, Child Benefit: 100% of the benefit amount	
Definitions	
Guaranteed Issue	Guaranteed issue is the benefit amount available without the need for evidence of insurability at the time an individual is first eligible for coverage.
Evidence of Insurability	The guaranteed issue benefit amounts in our offering are available with no medical underwriting. EOI will not be required at initial open or annual enrollment. Outside of selecting coverage during an enrollment period, EOI will not be required during the plan year when an employee pursues coverage as a new employee or as an existing employee following an approved change in life status when said elections are made within 30 days of eligibility under the plan or the change in status.
Age-Based Benefit Amount Reductions	None
Lifetime Maximum Benefit Payout	No lifetime maximum
Benefit Waiting Period	None
Pre-Existing Condition	None
Portability	Included

State variations may apply.

If/when Critical Illness coverage is currently offered through a different carrier: The current participants of an existing plan will receive credit for time served under that policy as part of the Continuity with Prior Coverage feature found in Critical Illness policy offered by the Symetra Life Insurance Company. Symetra will rely on the Policyholder to confirm existing coverage status.

Description of Benefits for:

12469000 - Nebraska Methodist Health System, Inc.

Critical Illness

Critical Illness Benefit

Critical Illness insurance provides a lump sum payment upon the first diagnosis of a covered condition once coverage is in effect.

Invasive Cancer

Invasive Cancer is defined as a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and invasion of neighboring tissue that is supported by histological evidence of malignancy. Invasive Cancer includes Leukemia, Lymphoma, Sarcoma, Malignant melanoma greater than 1mm in thickness, any type of breast cancer, or Multiple myeloma. Invasive Cancer must be diagnosed by a Specialist according to a Pathological or Clinical Diagnosis.

Minor Cancer (In Situ)

Minor Cancer (In Situ) is defined as a cancer wherein the tumor cells lie within the tissue of origin and have not spread to neighboring tissue. Non-Invasive Cancer includes: chronic lymphocytic leukemia that has not progressed beyond RAI Stage 0; Stage 1A (T1a) malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion); or early prostate cancer classified as T1a or T1b (or equivalent staging) without lymph node or distant metastasis. The diagnosis must be confirmed with a report from a Specialist that includes the pathology report.

Non-Melanoma Skin Cancer

Non-Melanoma Skin Cancer is defined as a malignant growth that arises on the surface of the skin that is any of the following: Basal cell carcinoma; Squamous cell carcinoma, or Merkel cell carcinoma. The diagnosis must be made by a Specialist and based on a pathological examination of tissue from skin lesions.

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

Stroke

Stroke is defined as an acute cerebrovascular incident resulting in irreversible death of brain tissue due to intra-cranial hemorrhage or cerebral infarction due to embolism or thrombosis in an intra-cranial vessel.
This event must result in neurological functional impairment with objective neurological abnormal signs on physical examination by a Specialist and the diagnosis must also be supported by findings on brain imaging and must be consistent with the diagnosis of a new Stroke.

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

Sudden Cardiac Arrest

Sudden Cardiac Arrest is defined as the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction. The diagnosis must be confirmed by a Specialist and the Sudden Cardiac Arrest must be the result of Coronary artery disease, Cardiomyopathy, hypertension, Valvular heart disease, Primary heart rhythm abnormality such as Brugada's syndrome or long QT syndrome, or Congenital heart disease.

Transient Ischemic Attack (TIA)

Transient Ischemic Attack (TIA) is defined as an acute ischemic event in which there are temporary, functional neurological impairments, without evidence of acute cerebral infarction. The diagnosis must be made by a Specialist according to clinical diagnostic criteria for the condition, including the following: There is no evidence of cerebral tissue damage on diagnostic imaging; The new onset of reversible functional neurological impairments; The temporary neurological impairments are not the result of seizures, migraines, metabolic disturbances, syncope, or other similar conditions.

Major Organ Failure

Major Organ Failure is defined as the permanent failure or loss of one or more of the following organs: heart, liver, lung, or pancreas, that requires a surgical transplant of a human organ. A Specialist must determine that a transplant of one or a combination of the above mentioned organs is necessary to treat organ failure in the Insured and the Insured must be actively engaged in a course of treatment with the goal of eventual transplant. The transplant goal requirement is waived if the Insured is too ill to undergo transplant surgery, but surgery would otherwise be recommended due to the organ failure.

Occupational Human Immunodeficiency Virus (HIV)

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 or its territories and while covered under the Policy. In addition, the Insured must report the Accident to the employer within 24 hours of the Accident.

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.

End Stage Renal Failure (Kidney Failure)
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. A Specialist must confirm that either of the following is necessary: the Insured must undergo regular renal dialysis at least weekly; or the Insured needs a kidney transplant.

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

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

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

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

Severe Burns
Severe Burns is defined as having sustained third degree burns. The third degree burns must cover at least 20% of the surface area of an insured's body.

Stem Cell (Bone Marrow) Transplant
Stem Cell Transplant is defined as the need for an autologous or allogeneic stem cell transplant, necessitated by compromise of the bone marrow's ability to produce sufficient blood cells. Diagnosis must be made by a Specialist who is a hematologist or oncologist and the Insured must be actively engaged in a course of treatment with the goal of eventual transplant.
The transplant goal requirement is waived if the Insured is too ill to undergo stem cell transplant, but stem cell transplant would otherwise be recommended due to compromised bone marrow ability to produce sufficient blood cells.

Amyotrophic Lateral Sclerosis (ALS) and other Motor Neuron Diseases

Amyotrophic Lateral Sclerosis (ALS) and other Motor Neuron Diseases is defined as a definite diagnosis by a Specialist of spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease) or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be permanent functional neurological impairment with objective evidence of motor dysfunction with muscle weakness that has persisted for a continuous period of at least 90 days.

Advanced Alzheimer's Disease

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

The diagnosis of Alzheimer's disease must be confirmed by a Specialist and the diagnosis must be supported by clinically accepted standardized cognitive testing and neurological examination. There must be Advanced Alzheimer's Disease where there is significant reduction in mental and social functioning where the Insured is unable to perform independently, at least 2 of the following 6 "Activities of Daily Living" for a continuous period of at least 180 days:

Activities of Daily Living are defined as:

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

Parkinson's Disease

Parkinson's Disease is defined as an unequivocal diagnosis of idiopathic Parkinson's disease. There must be resting tremor, rigidity, bradykinesia and gait disturbance compatible with the diagnosis of Parkinson's Disease as assessed by a Specialist.

Multiple Sclerosis

Multiple Sclerosis is defined as a diagnosis made by a Specialist of definite Multiple Sclerosis.

Both of the following two (2) criteria must be present:

1. There must be permanent functional neurological impairment with objective evidence of motor or sensory dysfunction, which must have persisted for a continuous period of at least 180 days.
2. The diagnosis must also be confirmed with objective neurological investigations, such as lumbar puncture, evoked visual responses, evoked auditory responses and MRI evidence of lesions of the central nervous system.

Coma

Coma is defined as a state of profound unconsciousness from which an Insured cannot be aroused to consciousness by external or internal stimulation, as determined by a Doctor as the result of an [Accident] [or] Illness.

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.

Major Congenital Structural Anomaly

Major Congenital Structural Anomaly is defined as a structural malformation that arises in utero and results in significant medical, social or cosmetic consequences for the affected individual, and requires medical treatment. Examples of Major Congenital Structural Anomalies include, but are not limited to, complex congenital heart disease, spina bifida (excluding occulta), cleft lip/palate, anencephaly, omphalocele, and club foot.

A Major Congenital Structural Anomaly must be diagnosed and named by a Specialist according to clinically accepted diagnostic criteria. The Specialist must establish a treatment plan specific to the condition.

Congenital Metabolic Disorder

Congenital Metabolic Disorder is defined as a genetic or inherited disorder resulting from an enzyme defect in biochemical and metabolic pathways affecting proteins, fats, carbohydrates metabolism or impaired organelle function presenting as complicated medical conditions involving several human organ systems. Examples of Congenital Metabolic Disorders include, but are not limited to, phenylalanine hydroxylase deficiency, Niemann-Pick, Tay Sachs, Gaucher's Disease, phenylketonuria, and cystic fibrosis.

A Congenital Metabolic Disorder must be diagnosed and named by a Specialist according to clinically accepted diagnostic criteria. The Specialist must establish a treatment plan specific to the condition.

Congenital Chromosomal Abnormality

Congenital Chromosomal Abnormality is defined as a congenital abnormality present at birth in the number or structure of chromosomes, other than those causing Congenital Metabolic Disorders, which leads to conditions requiring medical treatment. Examples of Other Chromosomal Abnormalities include, but are not limited to, Down syndrome, DiGeorge syndrome, Turner syndrome, sickle cell disease, achondroplasia, fragile X, hemophilia, neurofibromatosis, muscular dystrophy, Prader Willi, and glucose-6-posophate dehydrogenase deficiency (G6PD). The diagnosis of a Congenital Chromosomal Abnormality must be diagnosed and named by a Specialist according to clinically accepted diagnostic criteria. The Specialist must establish a treatment plan specific to the condition.

Chronic Medical Condition Commonly Diagnosed in Childhood

Chronic Medical Condition Commonly Diagnosed in Childhood is defined as a named condition requiring ongoing medical treatment that is expected to persist for at least five years following diagnosis. Examples of Chronic Medical Conditions Commonly Diagnosed in Childhood include, but are not limited to, epilepsy, human growth hormone deficiency, bronchopulmonary dysplasia, cerebral palsy, scoliosis, asthma, and Type 1 Diabetes.

The Chronic Medical Condition Commonly Diagnosed in Childhood must be diagnosed by a Specialist based on the appropriate clinically accepted criteria for the named condition. The condition must be severe, which means the condition meets at least one of the following criteria:

a. A condition requiring medical treatment for a minimum of 12 consecutive months, where treatment includes prescribed oral, inhaled, injected, or infused medication taken on a regular schedule and excluding antibiotic prophylaxis.
b. A condition that requires physical, speech, or occupational therapy for a minimum of 12 consecutive months.
c. A condition that requires bracing or other ongoing prescribed non-surgical treatment for a minimum of 12 consecutive months.
d. Asthma that requires daily use of inhaled corticosteroids and at least one other long-acting inhaled drug for a minimum of 12 consecutive months.

The Specialist must establish a treatment plan specific to the condition.

Autism Spectrum Disorder - DSM-V Severity Level [1-3]

Autism Spectrum Disorder is defined as a neurodevelopmental disorder that is characterized by:
a. Persistent deficits in social communication and interaction across multiple contexts;
b. Repetitive patterns of behavior, interests, or activities;
c. Symptom presence in the early developmental period (prior to 24 months of age);
d. Symptoms that cause clinically significant impairment in social, occupational, or other important areas of current functioning.

The diagnosis of Autism Spectrum Disorder must be confirmed by a Specialist and made according to the criteria established for Autism Spectrum Disorder in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The diagnosis must include a severity level rating of [1][,] [2] [or] 3 according to the DSM severity level criteria for Autism Spectrum Disorder.

Significant Mental Illness

Significant Mental Illness is defined as a Mental Illness that causes You to lose Actively at Work status for at least 30 consecutive days. The diagnosis of a Significant Mental Illness must be confirmed by a Specialist according to the appropriate diagnostic criteria for the named condition as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), and result in Your loss of Actively at Work status that lasts for at least 30 consecutive days. If the DSM diagnostic criteria for the named Mental Illness includes severity levels, the diagnosis must be designated by a Specialist as moderate or severe.

Severe Mental Illness

Severe Mental Illness is defined as a Mental Illness that results in any of the following:

a. The Insured has an acute Hospitalization specifically for treatment of the Mental Illness.

b. The Insured has an acute Hospitalization for a suicide attempt.

c. The Mental Illness diagnosis includes psychotic features or catatonia.

The diagnosis of a Severe Mental Illness must be confirmed by a Specialist according to the appropriate diagnostic criteria for the named condition as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Occupational Tuberculosis

Occupational Tuberculosis is defined as infection with Tuberculosis resulting from the Insured's inhalation exposure to aerosolized Mycobacterium tuberculosis during the course of the duties of the Insured's normal occupation.The Accident causing the infection of Tuberculosis must have occurred in the United States or its territories and while covered under the Policy. In addition, the Insured must report the Accident to the employer within 24 hours of the Accident.

All of the following conditions must be satisfied: A blood or skin test showing Tuberculosis infection following a blood or skin test within the prior 24 months that showed no latent or active Tuberculosis infection; Occupational Tuberculosis is assumed when all of the following criteria are met: The Insured is not a close contact of a person with active Tuberculosis disease; the Insured has not immigrated from or traveled within the past 12 months to areas of the world where Tuberculosis infection is endemic.

The Insured is not a member of a group with high rates of Tuberculosis transmission, specifically homeless persons, injection drug users, and persons with HIV infection; the Insured is not a close contact of a member of a group with high rates of Tuberculosis transmission as specified above.

OR all of the following conditions are met: a. The Insured has occupational exposure to an individual with active Tuberculosis infection; b. a blood or test for Tuberculosis within 14 days of exposure shows no Tuberculosis infection; c. a blood or skin test within 180 days of exposure shows Tuberculosis infection.

Occupational Hepatitis

Occupational Hepatitis is defined as infection with Hepatitis B or C resulting from accidental Injury which exposed the Insured to Hepatitis-contaminated blood or bodily fluids during the course of the duties of the Insured's normal occupation. The Accident causing the infection of Hepatitis must have occurred in the United States or its territories and while covered under the Policy. In addition, the Insured must report the Accident to the employer within 24 hours of the Accident.

All of the following conditions must be satisfied to establish a Hepatitis B infection:

a. A blood test showing Hepatitis B susceptibility (Hepatitis B surface antigen (HBsAg) negative, total Hepatitis B core antibody (anti-HBc) negative, and Hepatitis B surface antibody (anti-HBs) negative) must be carried out within 7 days of the Accident.

b. A blood test showing acute Hepatitis B infection by positive IgM antibody to Hepatitis B core antigen (IgM anti-HBc) within 180 days of the Accident.

All of the following conditions must be satisfied to establish a Hepatitis C infection:

a. A blood test showing no Hepatitis C infection by nonreactivity for Hepatitis C antibody must be carried out within 7 days of the Accident.

b. A blood test showing acute Hepatitis C infection by reactivity for Hepatitis C antibody and Hepatitis C RNA detect within 180 days of the Accident.

Infectious Disease

Infectious Disease is defined as any of the following: a community acquired infection; A nosocomial infection (healthcare-associated or Hospital-acquired), including surgical site infections following Hospital discharge or following the date of a surgical procedure, or Infections in individuals who are immunocompromised.

Infectious Disease includes an infection of any organ or tissue, including but not limited to, subcutaneous tissue, eyes, lungs, central nervous system, bone, muscle, blood (sepsis/bacteremia), liver, urinary tract, gastrointestinal tract.

While the agent(s) responsible for the Infectious Disease cannot always be identified and an Insured may be treated empirically based on the Specialist's clinical assessment of an infection, an Infectious Disease may be caused by bacteria, viruses, fungi, or protozoa. Examples of infectious agents include (COVID-19), staphylococcus aureus (methicillin resistant and methicillin susceptible), streptococcus, enterococcus, anaerobic bacteria, clostridium difficile, Escherichia coli, hepatitis, influenza, candida, aspergillus, and plasmodium, among others. The diagnosis of an Infectious Disease must be confirmed by a Specialist and supported by objective findings in a laboratory test. The Infectious Disease must result in a Hospitalization for the treatment of the Infectious Disease that lasts at least [3-15] consecutive days.

Severe Complication of Birth

Severe Complication of Birth is defined as a named condition of a newborn child that requires a minimum of 2 days of newborn care during the birth Hospitalization at a higher acuity level than the normal newborn nursery.

Severe Complications of Birth must be diagnosed by a Specialist and include clinically accepted diagnostic testing. The diagnosis must be accompanied by a Level I or Level II Hospitalization that falls within one of the following categories.

A **Level I Severe Complication of Birth** Hospitalization requires a minimum of 2 days of level 2 nursery care (special care nursery), where level 2 nursery care is generally applicable to newborns requiring close monitoring. This includes the following types of infants:

a. An infant born at greater than 32 weeks gestation and weighing greater than 1500 grams who has physiologic immaturity.
b. An infant born moderately ill with problems that are expected to resolve rapidly and is not anticipated to need subspecialty services on an urgent basis.
c. An infant requiring mechanical ventilation for a brief duration (less than 24 hours) or continuous positive airway pressure.

A **Level II Severe Complication of Birth Hospitalization** requires a minimum of 2 days of level 3 or 4 neonatal intensive care unit (NICU) care generally applicable to newborns requiring intensive care. This includes the following types of infants:

a. An infant requiring sustained life support.
b. An infant born at less than 32 weeks gestation and weighing less than 1500 grams.
c. An infant requiring urgent access to pediatric subspecialists.
d. An infant dependent on intensive respiratory support.

Severe Complication of Pregnancy

Severe Complication of Pregnancy is defined as a health problem related to pregnancy that requires a distinct maternal Hospitalization at any point from the antepartum period extending through 6 weeks postpartum for the primary purpose of treating the complication. The Severe Complication of Pregnancy must be a named complication of pregnancy or delivery, or a maternal condition exacerbated by pregnancy such that Hospitalization is required.

Severe Complication of Pregnancy also includes a named pregnancy or delivery complication that results in an extended-stay delivery Hospitalization lasting a minimum of 4 days for vaginal delivery or 6 days for Cesarean section that is determined by a Doctor to be necessary for treatment of the mother. The Severe Complication of Pregnancy must be diagnosed by a Specialist and include clinically accepted diagnostic testing.

Health Screening Benefit

The Health Screening Benefit will be paid once per year, per covered Insured, when one or more of the following exams, X-rays, laboratory tests are administered to during a Calendar Year. A Health Screening Benefit is payable once per covered Insured during a Calendar Year, regardless of the number of exams, X-rays, laboratory tests administered during that year.

1. Tests to Screen for Cancer:
(a) Biopsy
(b) Bone marrow testing
(c) Breast ultrasound
(d) CA 125 (blood test for ovarian cancer)
(e) CA 15-3 (blood test for breast cancer)
(f) CEA (blood test for colon cancer)
(g) Colonoscopy
(h) Flexible sigmoidoscopy
(i) Hemoccult stool specimen
(j) Mammogram
(k) Pap test
(l) PSA (prostate-specific antigen tests)
(m) Serum protein electrophoresis (blood test for myeloma)
(n) Thermography
2. Tests to screen for Heart-related Disease
(a) Blood test for triglycerides
(b) Chest x-ray
(c) Serum cholesterol test to determine HDL/LDL level
(d) Stress test on a bicycle or treadmill
3. Test to screen for Organ-related Disease
(a) Fasting blood glucose test

Portability/ Post-Termination Continuation of Coverage:

Allows coverage to continue for an unlimited period of time following termination of employment or loss of eligibility. Review the certificate of coverage to understand full details of this provision.

If there is any conflict between this information and the policy issued, the terms of the policy will prevail.

Rates for:

12469000 - Nebraska Methodist Health System, Inc.

Critical Illness

Employee Benefit Amount(s)
Critical Illness Employee Benefit: $10,000, $20,000, or $30,000
Guaranteed Issue Benefit: Up To $10,000, $20,000, or $30,000
Dependent Benefit Amount(s)
Spouse Benefit: 100% of the benefit amount, Child Benefit: 100% of the benefit amount

Cost is dependent upon how much coverage is selected and the age of the insured as of the effective date. Because attained age rating applies, premiums may increase due to age changes upon the start of the next policy year.

Monthly 4-Tier Premium Rates--Non-Tobacco

	Employee Attained Age	$10,000	$20,000	$30,000
Employee Only	29 and Under	$6.22	$10.15	$14.09
	30-39	$10.15	$18.02	$25.90
	40-49	$17.08	$32.24	$47.42
	50-59	$28.02	$54.14	$80.24
	60-69	$51.96	$102.02	$152.06
	70 and Over	$146.40	$290.88	$435.36
	Employee Attained Age	$10,000	$20,000	$30,000
Employee + Spouse	29 and Under	$12.46	$20.30	$28.18
	30-39	$20.33	$36.05	$51.79
	40-49	$34.16	$64.50	$94.82
	50-59	$56.04	$108.26	$160.48
	60-69	$103.92	$204.02	$304.12
	70 and Over	$292.78	$581.74	$870.70
	Employee Attained Age	$10,000	$20,000	$30,000
Employee + Child(ren)	29 and Under	$11.14	$19.32	$27.48
	30-39	$15.07	$27.19	$39.29
	40-49	$21.18	$39.88	$58.58
	50-59	$32.12	$61.76	$91.40
	60-69	$56.06	$109.64	$163.24
	70 and Over	$150.50	$298.50	$446.52
	Employee Attained Age	$10,000	$20,000	$30,000
Family	29 and Under	$18.55	$31.70	$44.83
	30-39	$26.42	$47.45	$68.45
	40-49	$39.26	$73.98	$108.72
	50-59	$61.14	$117.76	$174.36
	60-69	$109.02	$213.52	$318.02
	70 and Over	$297.88	$591.24	$884.60

Rates include Health Screening benefit for Employee, Spouse, and Child.

Monthly 4-Tier Premium Rates--Tobacco

	Employee Attained Age	$10,000	$20,000	$30,000
Employee Only--Tobacco	29 and Under	$6.60	$10.90	$15.19
	30-39	$11.78	$21.26	$30.74
	40-49	$23.12	$44.32	$65.52
	50-59	$56.62	$111.34	$166.06
	60-69	$122.20	$242.50	$362.78
	70 and Over	$259.44	$516.98	$774.52
	Employee Attained Age	$10,000	$20,000	$30,000
Employee + Spouse -Tobacco	29 and Under	$13.20	$21.79	$30.38
	30-39	$23.57	$42.53	$61.49
	40-49	$46.22	$88.62	$131.02
	50-59	$113.26	$222.68	$332.10
	60-69	$244.40	$484.98	$725.56
	70 and Over	$518.90	$1,033.96	$1,549.02
	Employee Attained Age	$10,000	$20,000	$30,000
Employee + Child(ren)--Tobacco	29 and Under	$11.52	$20.06	$28.58
	30-39	$16.70	$30.43	$44.16
	40-49	$27.22	$51.94	$76.68
	50-59	$60.72	$118.98	$177.22
	60-69	$126.30	$250.12	$373.96
	70 and Over	$263.54	$524.62	$785.68
	Employee Attained Age	$10,000	$20,000	$30,000
Family--Tobacco	29 and Under	$19.30	$33.17	$47.06
	30-39	$29.66	$53.93	$78.17
	40-49	$51.32	$98.12	$144.92
	50-59	$118.34	$232.18	$346.00
	60-69	$249.50	$494.48	$739.46
	70 and Over	$523.98	$1,043.44	$1,562.92

Rates include Health Screening benefit for Employee, Spouse, and Child.

To Calculate: Weekly=Monthly cost x 12 ÷52; Bi-Weekly =Monthly cost x 12÷26; Semi-Monthly=Monthly cost x 12 ÷24

Policyholder: **Nebraska Methodist Health System, Inc.**
Policy Issue State: **NE**
Critical Illness Plan
Insured by Symetra Life Insurance Company

Exclusions

We will not pay benefits for any Illness, (Injury), or disease that is not specifically named or described in the Benefits section of the Policy. (Parenthesized text is N/A for policies issued in IL or NH and also for residents of NH[1].)(The entire 1st sentence is N/A for policies issued in SD or for residents of SD[1].) Further, no benefit will be paid for a critical illness that is:

a. Diagnosed after the Insured's coverage terminates, except as provided under the Policy;

b. Diagnosed more than once while covered under the Policy, except as provided under any included Recurrence Benefit;

c. Not diagnosed by a Doctor, Specialist, or qualified medical professional as specified in the certificate;
   1. Alternate text for policies issued in TX only: Diagnosed by a Doctor or Specialist who:
      i. Ordinarily resides in Your household.
      ii. Is a member of Your immediate family.
      iii. Is employed by or affiliated with Your Employer Group.

d. Diagnosed before the Insured is covered under the Policy (N/A for policies issued in MD or for residents of MD[1]);
   1. (For policies issued in TX only, add: ", subject to the pre-existing condition limitation")

e. Diagnosed during any Benefit Waiting Period (N/A for policies issued in MD, MN, NJ, and for residents of MD[1] or MN[1]);

f. Diagnosed by a physician outside the United States or its territories:
   1. (For policies issued in TX only, add: "unless the diagnosis can be confirmed by physician licensed and practicing in the United States");

g. (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)";
   1. (1st parenthesized section N/A for policies issued in IL or NH, and for residents of NH[1])
   2. (2nd parenthesized section N/A for policies issued in CA and for CA residents covered under any policy where the majority of the group resides in CA*[1])

h. Caused (wholly or partly, directly or indirectly) by (Parenthesized section N/A for policies issued in CA and for CA residents covered under any policy where the majority of the group resides in CA*[1]) (Alternate text used for policies issued in IL: "Caused directly by"):
   1. Full-time active duty as a member of the armed forces (land, water, air) of any country or international authority;
   2. Declared or undeclared war or act of war;
      i. (For policies issued in OK and residents of OK[1], add: "when serving in the military or an auxiliary unit thereto")
      ii. (For policies issued in NC and NC[1] residents, add: "NOTE: undeclared war does not include acts of terrorism.")
   3. Committing or attempting to commit (an assault or) felony. (N/A for policies issued in ID, MD, MI, MN, NV, NH and for residents of ID[1], MD[1], MN1, and NH[1]);
      i. ("an assault or" is N/A for policies issued in SD and for residents of SD[1],
      ii. Alternate text for policies issued in:

1 Regardless of where the policy is issued.
2 These benefits can be selected by the group to either cover the condition only if it's due to an illness, or it may be included to also cover the condition when due to an accident or injury (where allowed by law). see your plan's enrollment materials for plan details.
*Check with your employer if you want more information about the number of employees in certain states.

This document is intended as a summary of information on exclusions and state-required plan variations. For complete details, please see the certificate of coverage that will be provided for those who enroll. If there is a discrepancy between this summary and the terms of the policy, the policy will govern.

A. CA and for CA residents covered under any policy where the majority of the group resides in CA* [1].: "Committing or attempting to commit felony or illegal occupation."
B. MN and MN residents only: "Engaging in any activity for which the insured was convicted of a felony."
C. NV only: "Committing or attempting to commit an assault or felony for which the Insured has been found guilty in a court of law. (This exclusion does not apply if You are the victim of domestic violence)";

4. Inciting or taking part in any form of public violence (N/A for policies issued in MD or NH, or for residents of MD[1] or NH[1]);
   i. Alternate text for policies issued in:
      A. NV only: Inciting or taking part in any form of public violence for which the Insured has been found guilty in a court of law.
      B. MI only: "Inciting, committing, attempting to commit, or taking part in any form of willful criminal activity that rises to the level of misdemeanor or felony."
      C. ID or residents of ID[1] only: "Voluntary participation in a felony"
   ii. NH or residents of NH[1] only: "Voluntary participation in a felony, riot, or insurrection."
5. Intentionally self-inflicted Injury (N/A for policies issued in IL & MI);
   i. Alternate text for policies issued in CA or for CA residents covered under any policy where the majority of the group resides in CA* [1], add: "including a suicide while sane".

6. Being intoxicated or under the influence of alcohol, illegal drugs or any narcotic (including overdose) unless as prescribed by or administered by a physician (N/A for policies issued in CA, CO, ID, MD, MN, NH, NJ, OR, SD, VT, or for residents of ID[1], MD[1], MN[1], NH[1], SD1 or VT[1], and for policies issued in CA or for CA residents covered under any policy where the majority of the group resides in CA* [1]);
   i. For policies issued in NC and VA, the word "illegal" is omitted.
   ii. For policies issued in AR and IL, and for residents or AR[1], Intoxicated means that which is defined and determined by the laws of the state where the loss or cause of the loss was incurred.
   iii. Alternate text for policies issued in:
      A. NJ: "Being intoxicated or under the influence of any narcotic (including overdose) unless as prescribed by or administered by a physician"
      B. CO: "Being intoxicated or under the influence of alcohol, or use of a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now and hereafter amended, illegal drugs or any narcotic (including overdose) unless as prescribed by or administered by a physician."
      C. MI: "Being intoxicated or under the influence of alcohol, illegal drugs or any narcotic (including overdose) during the insured's commission or attempt to commit a felony or being involved in an illegal occupation."
      D. CA or for CA residents covered under any policy where the majority of the group resides in CA* [1]: "The Insured being intoxicated or under the influence of alcohol, illegal drugs or any narcotic (including overdose) controlled substance, unless as prescribed by or the controlled substance is administered on the advice of a Physician."
      E. MN or for residents of MN[1]: "When convicted of being intoxicated or under the influence of alcohol when operating a motor vehicle, illegal drugs or any narcotic (including overdose) unless as prescribed by or administered by a physician."
      F. NH and for residents of NH[1]: "Voluntary consumption of unprescribed drugs"
7. Alcoholism or drug addiction. (N/A for policies issued in CA, MD, NH, NJ, OR, SD, VT, or for residents of MD [1], NH[1], SD[1] or VT[1], and for CA residents covered under any policy where the majority of the group resides in CA* [1].)

State-Specific Plan Variations

If the benefits below are included in your plan, the following state requirements may apply, depending on the state where you live or the policy issue state (as shown above). Apart from any state requirements, please see your plan's enrollment material to determine if these benefits are available.

Invasive Cancer benefits will not be paid for pre-malignant tumors or polyps, Non-Melanoma Skin Cancer, or Minor Cancer (In Situ), except breast cancer, which we consider as an Invasive Cancer diagnosis. This benefit is always included for policies issued in IA, MO, MT, and WA, and for residents of MT[1] and WA[1]. For policies issued in NY and for NY residents covered under any policy where the majority of the group resides in NY*[1], if Invasive Cancer is included in the plan, then Minor Cancer (In Situ) and Non-Melanoma Skin Cancer are both also always included.

Minor Cancer (In Situ) benefits will not be paid for skin cancer other than invasive malignant melanoma of the dermis or deeper or skin malignancies that have become metastatic, pre-malignant lesions (such as intraepithelial neoplasia), Non- Melanoma Skin Cancer, Invasive Cancer, or benign tumors or polyps. For policies issued in NY and for NY residents covered under any policy where the majority of the group resides in NY*[1], if Minor Cancer (In Situ) is included in the plan, then Invasive Cancer and Non-Melanoma Skin Cancer are both also always included.

Non-Invasive Cancer (Available for policies issued in CA or for CA residents covered under any policy where the majority of the group resides in CA*[1]) benefits will not be paid for any Non-Melanoma Skin Cancer, any Invasive Cancer, pre-malignant lesions (such as intraepithelial neoplasia), any all tumors which are histologically described as benign, non- malignant, premalignant, borderline, low malignant potential, dysplasia (all grades) or intraepithelial neoplasia, benign tumors or polyps, or pre-malignant tumors or polyps.

Non-Melanoma Skin Cancer benefits will not be paid for tumors which are histologically described as benign, non- malignant, pre-malignant, borderline, low malignant potential, dysplasia (all grades) or intraepithelial neoplasia, or Melanoma skin cancer. This benefit is not available for policies issued in NJ. For policies issued in NY and for NY residents covered under any policy where the majority of the group resides in NY*[1], if Non-Melanoma Skin Cancer Minor Cancer (In Situ) is included in the plan, then Invasive Cancer and Minor Cancer (In Situ) are both also always included.

Heart Attack benefits will not be paid for established or old heart attack found on imaging or electrocardiogram, Sudden Cardiac Arrest, Angina, Cardiomyopathy, Myocarditis, or other forms of acute coronary syndromes. This benefit is always included for policies issued in NH and for residents of NH[1].

Sudden Cardiac Arrest benefits will not be paid for the same event for which a Heart Attack Critical Illness benefit is payable. This benefit is not available for policies issued in NY or NJ.

Coronary Artery Disease Needing Surgery or Angioplasty benefits will not be paid for coronary artery conditions that are treatable by non-surgical intervention procedures including, but not limited to, diagnostic coronary angiography. This benefit is not available for policies issued in ID or NJ or for residents of ID[1].

Severe Coronary Artery Disease (For policies issued in ID and NJ, and for residents of ID~~1~~ only,) benefits will not be paid for coronary artery disease with at least 75% cross-sectional occlusion of one or more major coronary arteries (left, main, left anterior descending, circumflex, or right coronary artery).

Stroke benefits will not be paid for Transient Ischemic Attacks (TIA), brain damage due to an Accident, Injury or hypoxia, vascular disease affecting the eye, optic nerve, or vestibular functions, or asymptomatic silent stroke found on imaging.

Transient Ischemic Attack (TIA) benefits are payable once per Insured per lifetime. This benefit is not available for policies issued in NY, NJ or WA.

Major Organ Failure benefits will not be paid for transplant of any other organs other than heart, liver, lung, or pancreas, unless specifically named in the certificate. Parts of organs, tissues or cells is not included in this definition. If an Insured is diagnosed with the need for multiple organ transplants, only one benefit will be paid. For policies issued in:

a. ID and NJ and residents of ID[1] and NJ[1], Major Organ Failure also covers stem cell/ bone marrow transplant.

b. NY and when the majority of the group resides in NY[1], Major Organ Failure also covers kidney/renal and bone marrow transplant.

End Stage Renal Disease benefits will not be paid for acute reversible kidney failure that only needs temporary renal dialysis. This benefit is not available for policies issued in NY or NJ.

Loss of Sight[2] benefits will not be paid if the blindness is correctable by aides or surgical procedures or for loss of sight caused by a Childhood Condition for which a benefit was paid in the last 12 months. This benefit is not available for policies issued in ID, NY, NJ, or WA. For policies issued in MI and NH, this condition is only covered if the loss of sight is due to an illness.

Loss of Speech[2] benefits will not be paid for Loss of Speech resulting from Stroke or Invasive Cancer, all psychiatric causes, or Loss of speech caused by a Childhood Condition for which a benefit was paid in the last 12 months. This benefit is not available for policies issued in ID, NY, NJ, or WA. For policies issued in MI and NH, this condition is only overed if the loss of speech is due to an illness.

Loss of Hearing[2] benefits will not be paid for hearing loss that is correctable with aids or surgery or for hearing loss caused by a Childhood Condition for which a benefit was paid in the last 12 months. This benefit is not available for policies issued in ID, NY, NJ or WA. For policies issued in MI and NH, this condition is only covered if the loss of hearing is due to an illness.

Paralysis[2] benefits will not be paid for paralysis resulting from an accident or injury for policies issued in NJ. The Paralysis benefit is not available for policies issued in ID, NY, NJ, or WA. For policies issued in MI and NH, this condition is only covered if the paralysis is due to an illness.

Severe Burns benefits will not be paid when the degree of burn damage is classified as first-degree or second-degree. This benefit is not available for policies issued in ID, NY, NJ, or WA.

Amyotrophic Lateral Sclerosis (ALS) and other Motor Neuron Diseases: For policies issued in NY only Amyotrophic Lateral Sclerosis (ALS) is covered. Benefits will not be paid for other motor neuron diseases for policies issued in NY.

Alzheimer's Disease and/or Dementia benefits will not be paid for other causes of dementia, such as Psychiatric illnesses, Alcohol or other drug related brain damage, Stroke and vascular dementia, Parkinson's disease, Huntington's disease, or Coma. Dementia benefits are not available for policies issued in NY. For policies issued in MD, the exclusion regarding Alzheimer's and/or Dementia caused by alcohol and drug-related brain damage does not apply. In MI, benefits will also not be paid if the Alzheimer's and/or Dementia is caused by an accident or injury.

Coma[2] benefits will not be paid for coma resulting from an Accident or Injury for policies issued in MI & NH. The Coma benefit is not available for policies issued in ID, NY, NJ or WA. For policies issued in MI and NH this condition is only covered if the coma is due to an illness.

Parkinson's Disease benefits will not be paid for drug-induced or toxic causes of Parkinsonism. This benefit is not available for policies issued in NY or NJ.

Multiple Sclerosis benefits will not be paid for policies issued in NJ or NY, as this benefit is not available for sale in these two states.

1 Regardless of where the policy is issued.

2 These benefits can be selected by the group to either cover the condition only if it's due to an illness, or it may be included to also cover the condition when due to an accident or injury (where allowed by law). see your plan's enrollment materials for plan details.

*Check with your employer if you want more information about the number of employees in certain states.

This document is intended as a summary of information on exclusions and state-required plan variations. For complete details, please see the certificate of coverage that will be provided for those who enroll. If there is a discrepancy between this summary and the terms of the policy, the policy will govern.

Occupational HIV benefits will not be paid for HIV acquired via sexual transmission, via intravenous (IV) drug use, or via means determined not to be an accident. This benefit is not available for policies issued in CA, NH, NJ or NY. For policies issued in MD or for residents of MD[1], the exclusion regarding HIV acquired via intravenous (IV) drug use does not apply. For policies issued in MI, this exclusion is modified to reflect the word "accident" is replaced by "work-related exposure".

Stem Cell (Bone Marrow) Transplant benefits will not be paid for transplant of any other organs, parts of organs, tissues or cells not named in the certificate.

a. This benefit is not available for policies issued in NJ or in NY. However, for policies issued in NY, or when the majority of the employees reside in NY[*1], the Major Organ Failure benefit includes kidney/ renal failure and bone marrow failure.
b. This benefit is not available for policies sold in NJ or ID, or for ID residents, however, Stem Cell/ Bone Marrow transplant benefits are included within the Major Organ Failure benefit for policies sold in NJ or ID, and or for ID [1] residents.

State-Specific Benefit Disclosures

If the benefits below are included in your plan, the following state requirements may apply, depending on the state where you live or the policy issue state (as shown above). Apart from any state requirements, please see your plan's enrollment material to determine if these benefits are available.

Portability

Not available for policies issued in CO, ID, KY, LA, MI, MN, NH, NV, OR, UT, VT, WA or WV, or for residents of ID1, LA [1], MN[1], NH[1], VT[1], WA[1] or WV[1]. Portability is always included for policies issued in CT or when the majority of the group resides in CT [*1].

Health Screening Benefit

Not available for policies issued in CO, MI or MT. The Health Screening Benefit is always included for policies issued in NE.

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.

1 Regardless of where the policy is issued.
2 These benefits can be selected by the group to either cover the condition only if it's due to an illness, or it may be included to also cover the condition when due to an accident or injury (where allowed by law). see your plan's enrollment materials for plan details.
*Check with your employer if you want more information about the number of employees in certain states.

This document is intended as a summary of information on exclusions and state-required plan variations. For complete details, please see the certificate of coverage that will be provided for those who enroll. If there is a discrepancy between this summary and the terms of the policy, the policy will govern.

Rev. 11/23