



Coverage underwritten by

CONTINENTAL AMERICAN LIFE INSURANCE COMPANY

Columbia, South Carolina

800.433.3036

Endorsement to Policy and Certificate of Insurance

This Endorsement alters the Policy and the Certificate to which it is attached. Unless specifically addressed by this Endorsement, all other Policy and Certificate provisions, definitions, and terms continue to apply.

Continental American Insurance Company's mailing addresses for claims and premium payments are changed as listed below.

Notice of Claim and Proof of Loss should be mailed to the Company at:

P.O. Box 84075, Columbus, Georgia, 31993-9103

Premium Payments should be mailed to the Company at:

P.O. Box 84069, Columbus, Georgia, 31908-4069

If applicable, references to 2801 Devine Street, Columbia, SC 29205 are deleted.

Signed for the Company at its Home Office,

A handwritten signature in black ink, appearing to read "Teresa White".

Teresa White, President

A handwritten signature in black ink, appearing to read "J. Matthew Loudermilk".

J. Matthew Loudermilk, Secretary



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Please call the toll-free number above with any questions about this coverage.

Certificate of Insurance For Group Accidental Injury Insurance Policy

This limited Plan provides supplemental benefits only. It does not constitute comprehensive health insurance coverage and does not satisfy the requirement of Minimum Essential Coverage under the Affordable Care Act.

This Plan provides the benefits listed in the Benefit Schedule. Please read it carefully.

Your Employer (the "Policyholder") applied for coverage under this Group Accidental Injury Insurance Policy (the "Plan"). This Plan is issued by Continental American Insurance Company (the "Company," "CAIC," "we," "us," or "our"). For the purposes of this Plan, "you" (including "your" and "yours") refers to you. Based on the application process and the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. (Please note that male pronouns— such as "he," "him," and "his"—are used for both males and females, unless the context clearly shows otherwise.)

You will notice that certain words and phrases (including some medical terms and the names of Plan documents) in this document are capitalized. The capitalized words refer to terms with very specific definitions as they apply to this insurance Plan.

We certify that you are insured under the Group Accidental Injury Insurance Policy (the "Plan"). The Plan was issued to the Policyholder. The Certificate is subject to the Definitions, Exclusions, and other provisions of the Plan.

Certain provisions of the Plan are summarized in this Certificate. All provisions of the Plan, whether contained in your Certificate or not, apply to the insurance referred to by the Certificate.

This Certificate, on its Effective Date, automatically replaces any Certificate or Certificates previously issued to you under the Plan.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage.

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SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION

PRIMARY INSURED

Eligibility

You are eligible to be covered under this Plan if you are Actively at Work for the Policyholder and included in the class that is eligible for coverage, as shown on the Master Application.

If this coverage is offered to members of a union, references to “Employee” throughout the Plan documents shall be considered to refer to union members who are Actively at Work for their employer.

Insureds are defined as those who might be eligible for coverage under this Plan in the following categories:

- **Employee Coverage** – We insure only the Employee. The Employee is the *Primary Insured* under this Plan.
- **Employee and Spouse Coverage** – We insure the Employee and Spouse.
- **Employee and Children Coverage** – We insure the Employee and any Dependent Children.
- **Family Coverage** – We insure the Employee, Spouse, and any Dependent Children.

You should refer to *Type of Coverage* in your Certificate Schedule to determine who is covered under this Certificate.

Details for adding Insureds to Plan coverage are outlined in the Dependent Coverage – Effective Date provision.

Effective Date

Your Employee Effective Date is shown on the Certificate Schedule.

Your Employee Effective Date is the date your insurance takes effect. After we receive and approve the Application, that date is either:

- The date shown on the Certificate Schedule if you are Actively at Work on that date, or
- The date you return to an Actively-at-Work status if you were not Actively at Work on the date shown on the Certificate Schedule.

Termination of Your Insurance

Your insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date (the last day of the Grace Period), if the premium has not been paid.
- The date you no longer belong to an eligible class.

If an Insured's coverage terminates, we will provide benefits for valid claims that arose while his coverage was active.

DEPENDENT COVERAGE

Eligibility

Dependents may be eligible for coverage under this Plan. **You should refer to the Type of Coverage on the Certificate Schedule to determine Dependent eligibility.** A **Dependent** is your Spouse or Dependent Child. An eligible Spouse must be at least age 18.

Dependent Child or **Dependent Children** means your or your Spouse's natural children, step-children, grandchildren who are in your legal custody and residing with you, foster children, children subject to legal guardianship, legally adopted children, or Children Placed for Adoption, who are younger than age 26. However, we will continue coverage for Dependent Children insured under the Plan after the age of 26 if they are incapable of self-sustaining employment due to mental or physical handicap, and are chiefly dependent on a parent for support and maintenance. You or your Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Dependent Child's 26th birthday.

Children Placed for Adoption are children for whom you have entered a decree of adoption or for whom you have initiated adoption proceedings. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. You must continue to have custody pursuant to the decree of the court.

Effective Date

- A Dependent may be added to the Plan after the Employee's Effective Date within 31 days after a Life Event or during an approved enrollment period.
- If Employee and Children **or** Family Coverage is already in force, no additional notice or premium is required to add another Dependent Child.
- If Dependent Spouse or Dependent Child coverage is **not** in force, the Employee must complete an Application to add a Dependent to the Plan. The Company will assign a Dependent Effective Date for a Dependent's coverage after approving the Application. For Dependent coverage to become effective, the premium for the Dependent must be included in the premium payment. Spouse and Dependent Child coverage will begin on the date of the Life Event if notice was provided within 31 days after the Life Event.
- If Dependent Child coverage is not already in force, newborn children are automatically covered from the moment of birth for 60 days. Newly adopted children are automatically covered from the earlier of a) placement for adoption, b) the date of entry of an order granting custody of the child for the purposes of adoption, or c) the effective date of adoption, for 60 days. To extend coverage beyond 60 days with no gap in coverage, the Employee must apply to the Company within the 60-day time period following the child's birth or adoption. No premium is due for the first 60 days of newborn/newly adopted coverage.

Termination of Dependent Insurance

Dependent coverage will terminate on the earliest of the following:

- When the Certificate terminates,
- On the premium due date following the date we receive your written request to terminate Dependent coverage,
- When premiums are no longer paid for Dependent coverage (subject to the Grace Period),
- For Spouse coverage, when the Insured no longer meets the definition of Spouse because of annulment, divorce, or other reason, or
- For Dependent Child coverage, when the Child no longer qualifies as a Dependent because he reaches age 26 or other reason. (Dependent Children who reach age 26 will have coverage continued until the last day of the month in which they turn age 26.)

Plan Termination

The **Company** has the right to cancel the Plan on any premium due date for the following reasons:

- The premium is not paid before the end of the Grace Period,
- The number of participating Employees is less than the number mutually agreed upon by the Company and the Policyholder,
- The number of participating Employees changes by 25% or more,
- The Policyholder fails to perform any of the obligations that relate to this Policy or that are required by applicable law,
- The Policyholder no longer offers coverage to a particular class of Employees,
- The Policyholder no longer serves a class of Employees who reside in a particular geographical area, or
- The Policyholder does not provide timely information that is reasonably required.

The **Policyholder** has the right to cancel the Plan on any premium due date.

- To do this, the Policyholder must give the Company at least 31 days' written notice.
- The Plan will end on the date in the written notice or the date the Company receives the notice, whichever is later.

All outstanding premiums are due upon Plan termination. If the Company receives premium payments after the Plan terminates, this will not reinstate the Plan.

The Policyholder has the sole responsibility of notifying Certificateholders in writing of the Plan's termination as soon as reasonably possible. If the Plan terminates, it—and all Certificates and Riders issued under the Plan—will terminate on the specified termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

Portability Privilege

When you are no longer a member of an eligible class and your coverage would otherwise end, you may elect to continue your coverage under this Plan. You may continue the coverage you had on the date your Certificate would otherwise terminate, including any in-force Spouse or Dependent Child coverage, without any additional underwriting requirements.

To keep your coverage in force, you must:

- Notify the Company within 31 days after the date your coverage would otherwise terminate. You may notify us by sending written notice to P.O. Box 84078, Columbus, GA 31993 or by calling the Customer Service number at 800.433.3036, and
- Pay the required premium directly to the Company no later than 31 days after the date your coverage would otherwise terminate and on each premium due date thereafter.

Ported coverage will end on the earliest of the following dates:

- 31 days after the premium due date (the last day of the Grace Period), if the premium has not been paid, or
- The date the Group Plan is terminated.

If you qualify for this Portability Privilege, then the Company will apply the same Benefits, Premium Rate, and Plan Provisions as shown in your previously-issued Certificate. Notification of any changes in the Plan will be provided directly by the Company.

SECTION II – PREMIUM PROVISIONS

Premium Payments

Premiums should be paid to the Company at its Home Office in Columbia, South Carolina. The first premiums are due on the Plan's Effective Date. After that, premiums are due on the first day of each month that the Plan remains in effect.

Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period provision.

Premium Changes

Unless we have agreed in writing not to increase premiums, the premium may change:

- On the Group Policy Anniversary Date based on renewal underwriting. (The Group Policy Anniversary Date is shown on the Policy Schedule and falls on the same date each year thereafter.)
- Whenever the terms or conditions of the Plan are modified. The new premium rates will apply only to premiums due on or after the rate change takes effect.

We will provide the Policyholder a 31-day advance written notice of any change in premiums.

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SECTION III – DEFINITIONS

When the terms below are used in this Plan, the following definitions apply:

Accidental Injury means accidental bodily damage to an Insured resulting from an unforeseen and unexpected traumatic event. This must be the direct result of an accident and not the result of disease or bodily infirmity. A **Covered Accidental Injury** is an Accidental Injury that occurs while coverage is in force. A **Covered Accident** is an accident that occurs on or after an Insured's Effective Date while coverage is in force, and that is not specifically excluded by the Plan.

Actively at Work means an Employee's ability to perform his regular employment duties for a full normal workday. The Employee may perform these activities either at his employer's regular place of business or at a location where he is required to travel to perform the regular duties of his employment.

Ambulatory Surgical Center is defined as a licensed surgical center consisting of an operating room; facilities for the administration of general anesthesia; and a post-surgery recovery room in which the patient is admitted and discharged within a period of less than 24 hours.

Calendar Year means the period beginning on the Policy Effective Date and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

Claimant means a person who is authorized to make a claim under the Certificate.

Doctor is a person who is duly qualified as a practitioner of the healing arts acting within the scope of his license, and:

- Is licensed to practice medicine; prescribe and administer drugs; or to perform surgery, or
- Is a duly qualified medical practitioner according to the laws and regulations in the state in which Treatment is made.

A Doctor **does not** include the Insured or an Insured's Family Member.

For the purposes of this definition, **Family Member** includes the Employee's Spouse as well as the following members of the Employee's immediate family:

- | | | |
|------------|----------|-----------|
| • Son | • Mother | • Sister |
| • Daughter | • Father | • Brother |

This includes step-Family Members and Family-Members-in-law.

Employee is a person who meets Eligibility requirements under **Section I – Eligibility, Effective Date, and Termination** and who is covered under this Plan. The Employee is the Primary Insured under this Plan.

Hospital means a place that meets all of the following criteria:

- Is legally licensed and operated as a Hospital,
- Provides overnight care of injured and sick people,
- Is supervised by a Doctor,
- Has full-time nurses supervised by a registered nurse, and
- Has on-site use of X-ray equipment, laboratory, and surgical facilities.

The term **Hospital** specifically excludes any facility not meeting the definition of Hospital as defined in this Plan, including but not limited to:

- A nursing home,
- An extended-care facility,
- A skilled nursing facility,
- A rest home or home for the aged,
- A Rehabilitation Facility,
- A facility for the Treatment of alcoholism or drug addiction, or
- An assisted living facility.

Hospital Intensive Care Unit means a place that meets all of the following criteria:

- Is a specifically designated area of the Hospital called a Hospital Intensive Care Unit;
- Provides the highest level of medical care;
- Is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- Is separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement;
- Is permanently equipped with special life-saving equipment for the care of the critically ill or injured;
- Is under close observation by a specially trained nursing staff assigned exclusively to the Hospital Intensive Care Unit 24 hours a day; and
- Has a Doctor assigned to the Hospital Intensive Care Unit on a full-time basis.

The term *Hospital Intensive Care Unit* specifically excludes any type of facility not meeting the definition of Hospital Intensive Care Unit as defined in this Plan, including but not limited to private monitored rooms, surgical recovery rooms, observation units, and the following step-down units:

- A progressive care unit,
- A sub-acute intensive care unit, or
- An intermediate care unit.

Intermediate Intensive Care Step-Down Unit means any of the following:

- A progressive care unit,
- A sub-acute intensive care unit,
- An intermediate care unit, or
- A pre- or post-intensive care unit.

An Intermediate Intensive Care Step-Down Unit is **not** a Hospital Intensive Care Unit as defined in this Plan.

Life Event means an event that qualifies an Employee to make changes to benefits at times other than his enrollment period. Events qualifying as Life Events are established solely by the Policyholder.

Rehabilitation Facility is a unit or facility providing coordinated multidisciplinary physical restorative services. These services must be provided to inpatients under a Doctor's direction. The Doctor must be knowledgeable and experienced in rehabilitative medicine. Beds must be set up in a unit or facility specifically designated and staffed for this service. This is not a facility for the Treatment of alcoholism or drug addiction.

Spouse is an Employee's legal wife or husband who is listed on the Employee's Application. The term "Spouse" also includes a person who is in a legally recognized domestic partnership with the Employee (as defined in California Family Code 297), a partner of a civil union, or similar relationship.

Telemedicine Service means a medical inquiry with a Doctor via audio or video communication that assists with a patient's assessment, diagnosis, and consultation.

Treatment is the consultation, care, or services provided by a Doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines. Treatment does **not** include Telemedicine Services.

Urgent Care is a walk-in clinic that delivers ambulatory, outpatient care in a dedicated medical facility for illnesses or injuries that require immediate care but that are not serious enough to require a visit to an emergency room.

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SECTION IV – BENEFIT PROVISIONS

Initial Treatment Category

Initial Treatment Benefit

We will pay the amount shown in the Benefit Schedule if an Insured receives Initial Treatment for a Covered Accidental Injury. This benefit is payable for Initial Treatment received under the care of a Doctor when an Insured visits a(n):

- Hospital emergency room with X-Ray
- Hospital emergency room without X-Ray
- Urgent Care facility with X-Ray
- Urgent Care facility without X-Ray
- Doctor's office or facility (other than a Hospital emergency room or Urgent Care) with X-Ray
- Doctor's office or facility (other than a Hospital emergency room or Urgent Care) without X-Ray

Initial Treatment means the first Treatment an Insured receives for a Covered Accidental Injury.

The Initial Treatment must be received within 168 hours after the Covered Accident for benefits to be payable. This benefit is not payable for Telemedicine services.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Ambulance Benefit

We will pay the appropriate amount shown in the Benefit Schedule if, because of a Covered Accident, the Insured:

- Is injured, and
- Receives transportation by a professional ambulance service. This transportation must occur within 90 days after the accident for a benefit to be payable.

Ambulance service includes air ambulance service.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Major Diagnostic Testing Benefit

We will pay the amount shown in the Benefit Schedule if, because of Injuries sustained in a Covered Accident, the Insured requires one of the following exams:

- Computerized tomography (CT scan)
- Computerized axial tomography (CAT)
- Magnetic resonance imaging (MRI)
- Electroencephalography (EEG)

These exams must be performed in a Hospital, a Doctor's office, a Medical Diagnostic Imaging Center, or an Ambulatory Surgical Center. The exam must be performed within six months after the accident for a benefit to be payable.

For the purposes of this Plan, a **Medical Diagnostic Imaging Center** is defined as a facility with the equipment to produce various types of radiologic and electromagnetic images, and a professional staff to interpret the images obtained.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Pain Management Benefit

We will pay the amount shown in the Benefit Schedule when an Insured is prescribed and receives:

- A nerve ablation and/or block, or
- An epidural injection administered into the spine.

The benefit is only payable for pain management techniques (as shown above) that are administered in a Hospital or Doctor's office, and are due to a Covered Accidental Injury. For a benefit to be payable, the pain management technique must be administered within six months after the Covered Accident. This benefit is not payable for an epidural administered during a surgical procedure.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Blood/Plasma/Platelets Benefit

We will pay the amount shown in the Benefit Schedule for each day that an Insured receives blood, plasma, or platelets due to a Covered Accidental Injury. The Insured must receive the blood, plasma, or platelets within six months after the accident for a benefit to be payable.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Concussion Benefit

We will pay the amount shown in the Benefit Schedule if the Insured has a concussion due to a Covered Accident. The concussion must be diagnosed by a Doctor. The diagnosis must be made within six months after the accident for a benefit to be payable.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Burns Benefit

We will pay the amount shown in the Benefit Schedule if the Insured has burns in a Covered Accident. We will pay the Burns Benefit according to the percentage of body surface burned. The Insured must be treated for burns by a Doctor within six months after the accident for a benefit to be payable. First-degree burns are not covered.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Emergency Dental Work Benefit

We will pay the amount shown in the Benefit Schedule if the Insured has an Accidental Injury to natural teeth as the result of a Covered Accident. We will pay for extraction or repair with a crown as shown in the Benefit Schedule. The dental work must be performed within six months of the accident for a benefit to be payable.

Eye Injuries Benefit

We will pay the amount shown in the Benefit Schedule for eye injuries requiring removal of a foreign body if, because of a Covered Accident, a Doctor removes a foreign body from the eye, with or without anesthesia.

Dislocation Benefit

Dislocation refers to a completely separated joint. If a joint is dislocated in a Covered Accident, and it is diagnosed and treated by a Doctor within 90 days after the accident, we will pay the amount shown in the Benefit Schedule.

If the dislocation requires open reduction, we will pay 200% of the amount shown in the Benefit Schedule.

We will pay benefits only for the first dislocation of a joint. We will not pay for recurring dislocations of the same joint. If the Insured dislocated a joint before the Effective Date of his Certificate and then dislocates the same joint again, it will not be covered by this Plan.

Multiple dislocations refers to more than one dislocation requiring either open or closed reduction in any one Covered Accident. For each covered dislocation, we will pay the amounts shown in the Benefit Schedule. However, we will pay no more than 200% of the benefit amount for the dislocated joint that has the higher dollar amount.

Partial dislocation is one in which the joint is not completely separated. If a Doctor diagnoses and treats the Accidental Injury as a partial dislocation, we will pay 25% of the amount shown in the Benefit Schedule for the affected joint. (*Partial dislocation* includes subluxation.)

Laceration Benefit

We will pay the amount shown in the Benefit Schedule if an Insured receives a laceration in a Covered Accident. The laceration must be repaired with stitches by a Doctor within 168 hours after the accident for a benefit to be payable. (*Stitches* can also include liquid skin adhesive.) The amount paid will be based on the length of the laceration. (Receiving stitches to repair a laceration is not payable under the Outpatient Surgery and Anesthesia Benefit or Inpatient Surgery and Anesthesia Benefit, if any.)

The Insured may receive Treatment for a laceration that does not require stitches. However, if that laceration is treated by a Doctor within 168 hours after the Covered Accident, we will pay the amount shown in the Benefit Schedule.

If the Insured suffers multiple lacerations in a Covered Accident, and the lacerations are repaired with stitches by a Doctor within 168 hours after the accident, we will pay this benefit based on the largest single laceration that requires stitches, as shown in the Benefit Schedule. However, we will pay no more than 200% of the benefit amount for the laceration that has the higher dollar amount.

Fracture Benefit

Fracture is a break in a bone that can be seen by X-ray. If a bone is fractured in a Covered Accident, and it is diagnosed and treated by a Doctor within 90 days after the accident, we will pay the appropriate amount shown in the Benefit Schedule.

If the fracture requires open reduction, we will pay 200% of the amount shown in the Benefit Schedule.

Multiple fractures refers to more than one fracture requiring either open or closed reduction. If these fractures occur in any one Covered Accident, we will pay the appropriate amounts shown in the Benefit Schedule for each fracture. However, we will pay no more than 200% of the benefit amount for the bone fractured that has the highest dollar amount.

Chip fracture refers to a piece of bone that is completely broken off near a joint. If a Doctor diagnoses the fracture as a chip fracture, we will pay 25% of the amount shown in the Benefit Schedule for the affected bone.

Fracture does not include stress fractures, which are tiny cracks in a bone that can arise by the repetitive application of force, or from normal use of a weakened bone. Benefits are not payable for stress fractures.

Outpatient Surgery and Anesthesia Benefit

We will pay the daily benefit amount shown in the Benefit Schedule when, due to a Covered Accidental Injury, an Insured has an outpatient surgical procedure performed by a Doctor. "Surgical procedure" does not include laceration repair. If an outpatient surgical procedure is covered under another benefit in this Plan, we will pay the **higher** of that benefit amount **or** the Outpatient Surgery and Anesthesia Benefit. For a benefit to be payable, the surgery must be performed within one year after the Covered Accident.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

The surgery can be performed:

- In a Hospital on an outpatient basis,
- In an Ambulatory Surgical Center,
- In a Doctor's office, including Urgent Care facilities, or
- In an emergency room.

Facilities Fee for Outpatient Surgery Benefit

We will pay the benefit amount shown in the Benefit Schedule if, due to a Covered Accidental Injury:

- An Insured has an outpatient surgical procedure performed in an Ambulatory Surgical Center or in a Hospital on an outpatient basis, and
- The Insured receives an Outpatient Surgery and Anesthesia Benefit under this Plan.

This benefit is payable in addition to any surgery benefits payable.

Inpatient Surgery and Anesthesia Benefit

We will pay the daily benefit amount shown in the Benefit Schedule when, due to a Covered Accidental Injury, an Insured has an inpatient surgical procedure performed by a Doctor. The surgery must be performed while the Insured is confined to a Hospital as an inpatient. If an inpatient surgical procedure is covered under another benefit in this Plan, we will pay the **higher** of that benefit amount **or** the Inpatient Surgery and Anesthesia Benefit. For a benefit to be payable, the surgery must be performed within one year after the Covered Accident.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Transportation Benefit

We will pay the amount shown in the Benefit Schedule for transportation. The amount payable will be based on the type of transportation taken. This benefit is payable if, because of a Covered Accident, the Insured:

- Is injured, and
- Requires Doctor-recommended Hospital Treatment or diagnostic study that is not available in the Insured's resident city.

Use of such transportation must begin within six months after the Covered Accident date. The distance to the Hospital Treatment or diagnostic study must be greater than 100 miles from the Insured's residence.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Coma Benefit

We will pay the amount shown in the Benefit Schedule if the Insured is in a Coma lasting 30 days or more as the result of a Covered Accident. For the purposes of this benefit, *Coma* means a profound state of unconsciousness caused by a Covered Accident.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Hospitalization Category

Hospital Admission Benefit

We will pay this benefit when an Insured is admitted to a Hospital and confined as an inpatient because of a Covered Accidental Injury. To be eligible to receive this benefit, an Insured must be admitted to a Hospital within six months of the date of the Covered Accident.

We will pay the Hospital Admission Benefit amount shown in the Benefit Schedule. We will not pay benefits for confinement to an observation unit, or for emergency room Treatment or outpatient Treatment. We will pay this benefit once per period of Hospital Confinement.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Hospital Confinement Benefit

We will pay the amount shown in the Benefit Schedule for each day that an Insured is confined to a Hospital as an inpatient as the result of a Covered Accidental Injury. To be eligible to receive this benefit, the Insured must be confined to a Hospital within six months of the date of the Covered Accident.

The length of time shown for Hospital Confinement in the Benefit Schedule is the maximum period for which an Insured can collect benefits for Hospital Confinements from Covered Accidental Injuries received in the same Covered Accident. This benefit is not payable for confinement to an observation unit or a Rehabilitation Facility.

If we pay benefits for confinement and the Insured becomes confined again within six months because of the same Accidental Injury, we will treat this confinement as the same period of confinement.

This benefit is payable for only one Hospital Confinement at a time, even if it is caused by more than one Covered Accidental Injury.

Hospital Intensive Care Benefit

If an Insured is confined in a Hospital Intensive Care Unit because of a Covered Accidental Injury, we will pay the daily benefit amount shown in the Benefit Schedule. To be eligible to receive this benefit an Insured must be admitted to a Hospital Intensive Care Unit within six months of the date of the Covered Accident.

We will pay this amount for each day of such confinement, but not to exceed the maximum benefit period shown on the Benefit Schedule during any one period of confinement.

We will pay benefits for only one confinement in a Hospital Intensive Care Unit at a time, even if it is caused by more than one Covered Accidental Injury.

If we pay benefits for confinement in a Hospital Intensive Care Unit and an Insured becomes confined to a Hospital Intensive Care Unit again within six months because of the same Accidental Injury, we will treat this confinement as the same period of confinement.

This benefit is payable in addition to the Hospital Confinement Benefit.

Family Member Lodging Benefit

We will pay this benefit in the amount and up to the maximum number of days shown in the Benefit Schedule. We will pay this benefit for each night's lodging in a motel/hotel/rental property for an adult member of the Insured's immediate family. For this benefit to be payable, because of a Covered Accident:

- The Insured must be confined to a Hospital for Treatment of an Accidental Injury,
- The Hospital and motel/hotel must be more than 100 miles from the Insured's residence, and
- The Treatment must be prescribed by the Insured's treating Doctor.

The Treatment must take place within six months after the Covered Accident for a benefit to be payable.

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After Care Category

Appliances Benefit

We will pay the amount shown in the Benefit Schedule if a Doctor advises the Insured to use a medical appliance.

Medical appliance means a cane, ankle brace, walking boot, walker, crutches, leg brace, wheelchair, knee scooter, body jacket, back brace, or cervical collar. (Refer to the Benefit Schedule for the amount payable for each type of appliance.) The medical appliance must be used as the result of an Injury received in a Covered Accident. It must be used as an aid in personal locomotion. Proof of Loss for this benefit must include discharge instructions.

For a benefit to be payable, the Doctor's advice to use a medical appliance must be within six months after the Covered Accident.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Accident Follow-Up Treatment Benefit

For injuries received in a Covered Accident, we will pay this benefit under the following conditions:

- The Insured receives initial Treatment within 168 hours after the Covered Accident.
- The Insured receives Doctor-prescribed follow-up Treatment.
- The follow-up Treatment begins within six months after the Covered Accident or discharge from the Hospital.

Follow-up Treatments do not include physical, occupational, or speech therapy. Chiropractic or Acupuncture procedures are not considered Follow-up Treatment.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Rehabilitation Unit Benefit

We will pay the daily benefit amount shown in the Benefit Schedule for each day that, due to a Covered Accidental Injury, an Insured receives Treatment as an inpatient at a Rehabilitation Facility. For this benefit to be payable, the Insured must be transferred to the Rehabilitation Facility for Treatment following an inpatient Hospital Confinement.

This benefit is limited to the Calendar Year Maximum and maximum days per Hospital Confinement shown in the Benefit Schedule. We will not pay the Rehabilitation Facility Benefit for the same days that the Hospital Confinement Benefit is paid. We will pay the highest eligible benefit.

Therapy Benefit

For injuries received in a Covered Accident, we will pay this benefit under the following conditions:

- The Insured receives initial Treatment within 168 hours after the Covered Accident.
- The Insured receives Doctor-prescribed therapy Treatment in one of the following categories: physical therapy provided by a licensed physical therapist, occupational therapy provided by a licensed occupational therapist, or speech therapy provided by a licensed speech therapist.
- The therapy Treatment begins within 90 days after the Covered Accident or discharge from the Hospital.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Chiropractic or Alternative Therapy Benefit

For injuries received in a Covered Accident, we will pay this benefit under the following conditions:

- The Insured receives initial Treatment within 168 hours after the Covered Accident.
- The Insured receives acupuncture or chiropractic Treatment for the Covered Accident.
- The Treatment begins within 90 days after the Covered Accident or discharge from the Hospital.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

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Life Change Events Category

Paralysis Benefit

Paralysis means the permanent loss of movement of two or more limbs. We will pay the appropriate amount shown in the Benefit Schedule if, because of a Covered Accident:

- The Insured is injured,
- The Accidental Injury causes paralysis which lasts more than 90 days, and
- The paralysis is diagnosed by a Doctor within six months after the accident.

The amount paid will be based on the number of limbs paralyzed.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Prosthesis Benefit

We will pay the amount shown in the Benefit Schedule when an Insured receives a Prosthetic Device, prescribed by a Doctor, as a result of a Covered Accidental Injury.

For the purposes of this benefit, ***Prosthetic Device/Prosthesis*** means an artificial device designed to replace a missing part of the body.

This benefit is not payable for:

- Hearing aids, wigs, or dental aids (to include false teeth).
- Repair or replacement of Prosthetic Devices.*
- Joint replacements.

The amount paid will be based on the number (single or multiple) of Prosthetics received.

* We will pay this benefit again **once** to cover the replacement of a Prosthesis for which a benefit has been paid, provided the replacement takes place within three years of the initial benefit payment.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Residence/Vehicle Modification Benefit

We will pay the amount shown on the Benefit Schedule for a permanent structural modification to an Insured's primary residence or vehicle when the Insured suffers total and permanent or irrevocable loss of one of the following, due to a Covered Accidental Injury:

- The sight of one eye;
- The use of one hand/arm; or
- The use of one foot/leg.

The modification must occur within one year after the accident.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

SECTION V – EXCLUSIONS

We will not pay benefits for Accidental Injury, disability, or death contributed to, caused by, or resulting from:

- **War** – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the Insured is in such service.) War also includes voluntary participation in an insurrection or riot.
- **Suicide** – committing or attempting to commit suicide, while sane or insane.
- **Sickness** – having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for:
 - Allergic reactions
 - Any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings
 - An error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure for any sickness
 - Any related medical/surgical Treatment or diagnostic procedures for such illness
- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally.
- **Racing** – riding in or driving any motor-driven vehicle in a race, stunt show, or speed test in a professional or semi-professional capacity.
- **Illegal Occupation** – voluntarily participating in, committing, or attempting to commit a felony, or voluntarily working at, or being engaged in, an illegal occupation or job.
- **Sports** – participating in any organized sport in a professional capacity for pay or profit.
- **Cosmetic Surgery** – having cosmetic surgery or other elective procedures that are not medically necessary (“*cosmetic surgery*” does not include reconstructive surgery when the service is related to or follows surgery resulting from a Covered Accident); or having dental Treatment except as a result of a Covered Accident.

(This space left intentionally blank.)

SECTION VI – GENERAL PROVISIONS

Entire Contract, Changes

This Policy (and the Application of the Policyholder, if any, and the individual applications, if any, of the Employees) constitute the entire contract between the parties, and any statement made by the Policyholder or by an Employee shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall avoid the insurance or reduce benefits under this Policy or be used in defense to a claim hereunder unless it is contained in a written application, nor shall any such statement of the Policyholder, except a fraudulent misstatement, be used at all to void this Policy after it has been in force for two years from the date of its issue, nor shall any such statement of any Employee eligible for coverage under the Policy, except a fraudulent misstatement, be used at all in defense to a claim for loss incurred or disability commencing after the insurance coverage with respect to which claim is made has been in effect for two years from the date it became effective.

No change in this Policy shall be valid unless approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or waive any of its provisions.

Time Limit on Certain Defenses

After two years from the date of issue of this Policy, no misstatement of the Policyholder, except a fraudulent misstatement, made in his Application shall be used to void the Policy; and after two years from the effective date of the coverage with respect to which any claim is made no misstatement of any Employee eligible for coverage under the Policy, except a fraudulent misstatement, made in an application under the Policy shall be used to deny a claim for loss incurred or disability commencing after expiration of such two years.

No claim for loss incurred or disability commencing after two years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which the claim is made.

Grace Period

A grace period of 60 days will be granted for the payment of premiums accruing after the first premium, during which grace period the Policy shall continue in force, but the Policyholder shall be liable to the insurer for the payment of the premium accruing for the period the Policy continues in force.

Notice of Claim

Written notice of claim must be given to us within 20 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Claimant to the Company at **P.O. Box 84075, Columbus, Georgia, 31993**, or to any authorized agent of the Company, with information sufficient to identify the insured Employee, shall be deemed notice to the Company.

Claim Forms

The Company, upon receipt of a written notice of claim, will furnish to the Claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the Claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proofs of Loss

Written proof of loss must be furnished to the Company, in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which the Company is liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Employee, later than one year from the time proof is otherwise required.

Time of Payment of Claims

Subject to due written proof of loss, all indemnities for loss for which this Policy provides payment will be paid as they accrue and any balance remaining unpaid at the termination of the period of liability will be paid immediately upon receipt of due written proof.

Payment of Claims

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be described herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured Employee. Any other accrued indemnities unpaid at the insured Employee's death may, at the option of the Company, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured Employee.

Physical Examination and Autopsy

The Company, at its own expense, shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as it may reasonably require during the pendency of a claim hereunder. The Company shall also, at its own expense, have the right and opportunity to make an autopsy in case of death, where it is not forbidden by law.

Legal Action

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Changing of Beneficiary

The right to change of beneficiary is reserved to the insured Employee, and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary.

Claim Review

If a claim is denied, the Employee will be given written notice of:

- The reason for the denial,
- The Plan provision that supports the denial, and
- His right to ask for a review of the claim.

Misstatement of Age

If the age of any individual covered under this Policy has been misstated, the amount payable shall be such as the premium paid for the coverage of such individual would have purchased at the correct age.

Successor Insured

If an Employee dies while covered under his Certificate and his Spouse is also insured under this Plan at the time of the Employee's death, then his surviving Spouse may elect to become the Primary Insured. This would include continuation of any Dependent Child Rider coverage that is in force at that time.

To become the Primary Insured and keep coverage in force, the surviving Spouse must:

- Notify the Company in writing within 31 days after the date of the Employee's death; and
- Pay the required premium to the Company no later than 31 days after the date of the Employee's death, and on each premium due date thereafter.

If the Certificate does not cover a surviving Spouse, the Certificate will terminate on the next premium due date following the Employee's death.

Clerical Error

Clerical error by the Policyholder will not end coverage or continue terminated coverage. In the event of a clerical error, the Company will make a premium adjustment.

Individual Certificates

The Company will make available to the Policyholder a Certificate for Employees. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, and
- The rights and privileges under the Plan.

Required Information

The Policyholder will be responsible for furnishing all information and proofs that the Company may reasonably require with regard to the Plan.

Conformity with State Statutes

This Plan was issued on its Effective Date in the state noted on the Master Application. Any Plan provision that conflicts with that state's statutes is amended to conform to the minimum requirements of those statutes.

California Department of Insurance Contact Information

Please contact the California Department of Insurance if you have an issue that cannot be solved with Continental American Life Insurance Company.

**California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013**

**Consumer Hotline
1-800-927-Help (4357)
or
1-213-897-8921
TDD Number
1- 800-482-4TDD (4833)**

BENEFIT SCHEDULE

	Primary Insured	Spouse	Child(ren)
Initial Treatment Category			
Initial Treatment Benefit			
<i>Hospital emergency room with X-Ray</i>	\$350	\$350	\$350
<i>Hospital emergency room without X-Ray</i>	\$150	\$150	\$150
<i>Urgent Care facility with X-Ray</i>	\$350	\$350	\$350
<i>Urgent Care facility without X-Ray</i>	\$150	\$150	\$150
<i>Office or facility (other than a Hospital emergency room or Urgent Care) with X-Ray</i>	\$275	\$275	\$275
<i>Office or facility (other than a Hospital emergency room or Urgent Care) without X-Ray</i>	\$75	\$75	\$75
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Ambulance Benefit	\$400	\$400	\$400
<i>Maximum number of payments per Covered Accident, per Insured</i>	No Max	No Max	No Max
Air Ambulance Benefit	\$1,500	\$1,500	\$1,500
<i>Maximum number of payments per Covered Accident, per Insured</i>	No Max	No Max	No Max
Major Diagnostic Testing Benefit	\$300	\$300	\$300
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Pain Management Benefit	\$100	\$100	\$100
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Blood/Plasma/Platelets Benefit	\$400	\$400	\$400
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Concussion Benefit	\$300	\$300	\$300
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Burns Benefit			
<i>Second Degree</i>			
Less than 10%	\$100	\$100	\$100
At least 10% but less than 25%	\$200	\$200	\$200
At least 25% but less than 35%	\$500	\$500	\$500
35% or more	\$1,000	\$1,000	\$1,000
<i>Third Degree</i>			
Less than 10%	\$1,000	\$1,000	\$1,000
At least 10% but less than 25%	\$5,000	\$5,000	\$5,000
At least 25% but less than 35%	\$10,000	\$10,000	\$10,000
35% or more	\$20,000	\$20,000	\$20,000
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Emergency Dental Work Benefit			
Repair with crown	\$300	\$300	\$300
Extraction	\$100	\$100	\$100
Eye Injuries Benefit	\$300	\$300	\$300

Dislocation Benefit			
Hip	\$4,000	\$4,000	\$4,000
Knee (not knee cap)	\$2,600	\$2,600	\$2,600
Shoulder	\$2,000	\$2,000	\$2,000
Foot/ankle	\$1,600	\$1,600	\$1,600
Hand	\$1,400	\$1,400	\$1,400
Lower jaw	\$1,200	\$1,200	\$1,200
Wrist	\$1,000	\$1,000	\$1,000

Elbow	\$800	\$800	\$800
Finger/toe	\$320	\$320	\$320
Laceration Benefit			
Over 15 centimeters	\$600	\$600	\$600
5 to 15 centimeters	\$300	\$300	\$300
Under 5 centimeters	\$75	\$75	\$75
Lacerations not requiring stitches	\$25	\$25	\$25
Fracture Benefit			
Hip/thigh	\$4,750	\$4,750	\$4,750
Vertebrae	\$4,275	\$4,275	\$4,275
Pelvis	\$3,800	\$3,800	\$3,800
Skull (depressed)	\$3,562.50	\$3,562.50	\$3,562.50
Skull (simple)	\$1,662.50	\$1,662.50	\$1,662.50
Leg	\$2,850	\$2,850	\$2,850
Foot/ankle/knee cap	\$2,375	\$2,375	\$2,375
Forearm/hand/wrist	\$2,375	\$2,375	\$2,375
Lower jaw	\$1,900	\$1,900	\$1,900
Shoulder blade/collar bone	\$1,900	\$1,900	\$1,900
Upper arm/upper jaw	\$1,662.50	\$1,662.50	\$1,662.50
Facial bones (except teeth)	\$1,425	\$1,425	\$1,425
Vertebral processes	\$950	\$950	\$950
Coccyx/rib/finger/toe	\$380	\$380	\$380
Sternum	\$4,275	\$4,275	\$4,275
Sacral/Sacrum	\$950	\$950	\$950
Outpatient Surgery and Anesthesia Benefit			
<i>Hospital Outpatient or Ambulatory Surgical Center</i>	\$400/day	\$400/day	\$400/day
<i>Doctor's Office or Emergency Room</i>	\$50/day	\$50/day	\$50/day
<i>(Maximum is applicable only to Doctor's office or Emergency Room)</i>			
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Facilities Fee for Outpatient Surgery Benefit	\$300	\$300	\$300
<i>Payable once per each eligible Outpatient Surgery and Anesthesia Benefit</i>			
Inpatient Surgery and Anesthesia Benefit	\$1,500/day	\$1,500/day	\$1,500/day
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Transportation Benefit			
Plane	\$500	\$500	\$500
Any Ground Transportation	\$200	\$200	\$200
<i>Maximum number of payments per Covered Accident, per Insured</i>	3	3	3
Coma Benefit	\$10,000	\$10,000	\$10,000
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1

BENEFIT SCHEDULE

	Primary Insured	Spouse	Child(ren)
Hospitalization Category			
Hospital Admission Benefit	\$1, 000	\$1,000	\$1,000
Maximum number of payments per Covered Accident, per Insured	1	1	1
Hospital Confinement Benefit	\$200/day	\$200/day	\$200/day
Maximum Benefit Period: 365 days			
Hospital Intensive Care Benefit	\$500/day	\$500/day	\$500/day
Maximum Benefit Period: 15 days			
Family Member Lodging Benefit	\$150/day	\$150/day	\$150/day
Maximum Benefit Period: 30 days			

BENEFIT SCHEDULE

	Primary Insured	Spouse	Child(ren)
After Care Category			
Appliances Benefit			
<i>Cane</i>	\$100	\$100	\$100
<i>Ankle Brace</i>	\$100	\$100	\$100
<i>Walking Boot</i>	\$100	\$100	\$100
<i>Walker</i>	\$100	\$100	\$100
<i>Crutches</i>	\$100	\$100	\$100
<i>Leg Brace</i>	\$100	\$100	\$100
<i>Wheelchair</i>	\$100	\$100	\$100
<i>Knee Scooter</i>	\$100	\$100	\$100
<i>Body Jacket</i>	\$100	\$100	\$100
<i>Back Brace</i>	\$100	\$100	\$100
<i>Cervical Collar</i>	\$100	\$100	\$100
<i>Maximum number of payments per Covered Accident, per Insured</i>	No Max	No Max	No Max
Accident Follow-Up Treatment Benefit	\$75	\$75	\$75
<i>Maximum number of payments per Covered Accident, per Insured</i>	2	2	2
Rehabilitation Unit Benefit	\$100/day	\$100/day	\$100/day
<i>Maximum Benefit Period per Hospital confinement</i>	31 days	31 days	31 days
<i>Calendar Year Maximum</i>	62 days	62 days	62 days
Therapy Benefit	\$50	\$50	\$50
<i>Maximum number of payments per Covered Accident, per Insured</i>	10	10	10
Chiropractic or Alternative Therapy Benefit	\$50	\$50	\$50
<i>Maximum number of payments per Covered Accident, per Insured</i>	3	3	3

BENEFIT SCHEDULE

	Primary Insured	Spouse	Child(ren)
Life Change Events Category			
Paralysis			
Four limbs (quadriplegia)	\$10,000	\$10,000	\$10,000
Two limbs (paraplegia)	\$5,000	\$5,000	\$5,000
Maximum number of payments per Covered Accident, per Insured	1	1	1
Prosthesis Benefit			
Single	\$1,000	\$1,000	\$1,000
Multiple	\$2,000	\$2,000	\$2,000
Maximum number of payments per Covered Accident, per Insured	1	1	1
Residence/Vehicle Modification Benefit	\$1,000	\$1,000	\$1,000
Maximum number of payments per Covered Accident, per Insured	1	1	1



Coverage underwritten by

CONTINENTAL AMERICAN LIFE INSURANCE COMPANY

Columbia, South Carolina

800.433.3036

Please call the toll-free number above with any questions about this coverage.

Amendment to Policy and Certificate of Insurance for Group Accidental Injury

This Amendment is subject to all of the provisions of the Policy and Certificate to which it is attached. Additions or changes have been made to the Policy and Certificate and are indicated below.

EFFECTIVE DATE

If issued at the same time as the Certificate, this Amendment becomes effective at the same time as the Certificate. If issued after the Certificate, this Amendment will have a later Effective Date.

The definition of Dependent Child or Dependent Children is deleted and replaced with the following:

Dependent Child or **Dependent Children** means your or your Spouse's natural children, step-children, grandchildren who are in your legal custody and residing with you, foster children, children subject to legal guardianship, legally adopted children, or Children Placed for Adoption, who are younger than age 26. However, we will continue coverage for Dependent Children insured under the Plan after the age of 26 if they are incapable of self-sustaining employment due to mental or physical handicap, and are chiefly dependent on a parent for support and maintenance. You or your Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Dependent Child's 26th birthday.

The insurance on any Dependent Child will terminate on the last day of the month in which the Dependent Child turns age 26; it is your responsibility to notify us in writing when coverage on a Dependent Child terminates. Termination will be without prejudice to any claim originating prior to the date of termination. Our acceptance of premium after such date will be considered as premium for only the remaining persons who qualify as Insureds under this Plan. When coverage on all Dependent Children terminates, you must notify the Company, in writing, and elect whether to continue this Plan on an Employee or Employee and Spouse Coverage basis. After such notice, we will arrange for the payment of the appropriate premium due, including returning any unearned premium.

Children Placed for Adoption are children for whom you have entered a decree of adoption or for whom you have initiated adoption proceedings. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. You must continue to have custody pursuant to the decree of the court.

CONTRACT

This Amendment is part of the Policy and Certificate and will terminate when the Policy or Certificate terminates.

Signed for the Company at its Home Office,

Teresa White, President

J. Matthew Loudermilk, Secretary



Coverage underwritten by

CONTINENTAL AMERICAN LIFE INSURANCE COMPANY

Columbia, South Carolina

800.433.3036

Please call the toll-free number above with any questions about this coverage.

Continuation of Coverage Endorsement

This Endorsement is part of the Policy and Certificate to which it is attached. This Endorsement is subject to all the definitions, terms, and other provisions of the Policy and Certificate to which it is attached, unless those terms are inconsistent with this Endorsement.

EFFECTIVE DATE

If issued at the same time as the Certificate, this Endorsement becomes effective when the Certificate becomes effective.

If issued after the Certificate, this Endorsement will have a later Effective Date.

The following provisions are added after the Portability Privilege provision in your Certificate:

CONTINUATION OF COVERAGE

If the Group Policy is terminated by the Policyholder and is not replaced with another group policy you may apply to continue the coverage you had on the Group Policy termination date. This includes any in-force Spouse or Dependent Child coverage. The Group Policy will be continued as if the Group Policy is in force for those who have applied to continue their coverage under this provision. The members will continue to have coverage, with their Certificates remaining in force.

The Company will apply the same benefits and plan provisions as shown in your Certificate on the date you are eligible to continue coverage under this provision. Your continued coverage is subject to all of the provisions, exclusions and limitations of the Group Policy.

To keep your Certificate in force, you must:

- Apply to the Company in writing under this Continuation of Coverage provision within 31 days after the date your Certificate would terminate, **and**
- Pay the required premium no later than 31 days after the date the Certificate would terminate and on each premium due date thereafter to the Company at our Customer Service Center in Columbus, Georgia.

PREMIUMS

Initial premium rates will be based on the rates in effect at the time you apply to continue your coverage. Premium rates can be changed by the Company at any time upon 31 days written notice to you. Any such change will be applied to all Certificates in your class and will not be based on your or your Spouse and Dependent Children's health or other individual factors.

You may decrease, but not increase, the amount of your coverage, and the amount of your Spouse's coverage, if any.

TERMINATION

Your continued coverage, including any in-force Spouse or Dependent Child coverage, will end:

- 31 days after the date you fail to pay any required premium.
- When coverage is terminated by the Company. We will provide you a 31-day advance written notice of any termination.
- On the date you die (unless your Spouse elects to become the Primary Insured under the Successor Insured provision, if applicable).

Once continued coverage is cancelled it cannot be reinstated. If your coverage terminates, we will provide benefits for valid claims that arose while your coverage was active.

CONTRACT

This Endorsement is part of the Certificate. It will terminate when:

- The Certificate terminates.

Signed for the Company at its Home Office,



Teresa White, President



J. Matthew Loudermilk, Secretary



Coverage underwritten by
CONTINENTAL AMERICAN LIFE INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage. Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

• Persons Covered

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives **in** California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

• Amounts of Coverage

The basic coverage protections provided by the Association are as follows.

• Life Insurance, Annuities and Structured Settlement Annuities

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

• Life Insurance

80% of death benefits but not to exceed \$300,000

80% of cash surrender or withdrawal values but not to exceed \$100,000

• Annuities and Structured Settlement Annuities

80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed \$250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is \$300,000, regardless of the number of policies or contracts covering the individual.

• Health Insurance

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is \$546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section I 067.02(b)(2)(C)

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O. Box 16860
Beverly Hills, CA 90209-33 19
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 900 13
(800) 927- 4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.



Coverage underwritten by

CONTINENTAL AMERICAN LIFE INSURANCE COMPANY

Columbia, South Carolina

800.433.3036

Please contact the California Department of Insurance if you have an issue that can not be solved with Continental American Life Insurance Company.

**California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013**

**Consumer Hotline
1-800-927-Help (4357) or 1-213-897-8921**

**TDD Number
1- 800-482-4TDD (4833)**

**Internet Web Site
www.insurance.ca.gov**

ACCIDENT CERTIFICATE SCHEDULE

Occupational Classifications

The University establishes its own plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations and any corresponding Administrative Supplements. Complete information can be found on UCnet at <https://ucnet.universityofcalifornia.edu/tools-and-services/administrators/health-welfare-benefits.html>.