



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 that reads "Teresa White".

Teresa White, President

A handwritten signature in black ink that reads "J. Matthew Loudermilk".

J. Matthew Loudermilk, Secretary



Coverage underwritten by

# CONTINENTAL AMERICAN LIFE INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205

800.433.3036

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

## **Certificate of Insurance For Group Supplemental Hospital Indemnity 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 IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.**

**This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law.**

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

**Your Employer** (the “Policyholder”) applied for coverage under this Group Supplemental Hospital Indemnity 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”) means 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 Supplemental Hospital Indemnity 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.*

**TABLE OF CONTENTS**

**Section I** - Eligibility, Effective Date, and Termination

**Section II** - Premium Provisions

**Section III** - Definitions

**Section IV** - Benefit Provisions

**Section V** - Exclusions

**Section VI** - General Provisions

## **SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION**

### **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.

*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.
- **Employee and Spouse Coverage** – We insure the Employee and spouse (as defined in the applicable rider).
- **Employee and Children Coverage** – We insure the Employee and any dependent children (as defined in the applicable rider).
- **Family Coverage** – We insure the Employee, spouse, and any dependent children (as defined in the applicable rider).

We will not insure anyone specifically excluded from coverage by Endorsement to the Certificate or by application, even if that person would otherwise be eligible for coverage.

Details for adding Insureds to your coverage are outlined in the Effective Date section.

### **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.

### **If Employee and Spouse, Employee and Children, or Family Coverage is offered:**

- A Dependent may be added to the Plan after the Employee's Effective Date within 31 days of a Life Event or during an approved enrollment period.
- If Dependent Child Rider coverage is **already in force**, no additional notice or premium is required to add another dependent child.
- If Dependent Spouse Rider or Dependent Child Rider coverage is **not** in force, the Employee must complete an Application to add a Dependent to the Plan. The Company will assign a Dependent Rider 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.
- If Dependent Child Rider 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 contact 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.

A day begins at 12:01 a.m. standard time at the Employee's place of residence.

## **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.

**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.

## **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 your coverage was active.

## **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 Dependent Spouse Rider or Dependent Child Rider 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 427, Columbia, South Carolina, 29202 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.

Your 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, Plan Provisions, and Premium Rate 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. 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 your ability to perform your regular employment duties for a full normal workday. You may perform these activities either at your Employer's regular place of business or at a location where you are required to travel to perform the regular duties of your employment.

**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.

**Dependent** means your spouse or dependent children, as defined in the applicable rider, who have been accepted for coverage.

**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 you or any of your Family Members.

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

- Son
- Daughter
- Mother
- Father
- Sister
- 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 you to make changes to benefits at times other than your 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.

**Related** – a Related Accidental Injury or Sickness is one that is in correlation to, or occurs as a result of, the initial Accidental Injury or Sickness, and would not otherwise have been sustained if that initial condition had not occurred.

**Sickness** means an illness, infection, disease, or any other abnormal physical condition or pregnancy that is not caused solely by, or the result of, any injury. A **Covered Sickness** is one that is not excluded by name, specific description, or any other provision in this Plan. For a benefit to be payable, loss arising from the Covered Sickness must occur while the applicable Insured's coverage is in force.

**Spouse** is your legal wife or husband who is listed on your Application. The term "Spouse" also includes a person who is in a legally recognized domestic partnership with you (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.

## **SECTION IV – BENEFIT PROVISIONS**

### **Hospitalization Benefits**

#### **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 or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, 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 shown in the Benefit Schedule. We will only pay this benefit once for each Covered Accident or Covered Sickness per Calendar Year. If an Insured is confined to the Hospital because of the same or Related Accidental Injury or Sickness, we will not pay this benefit again in the same Calendar Year.

#### **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 or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, 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 resulting from Covered Sickness or from Covered Accidental Injuries received in the same Covered Accident.

If we pay benefits for confinement and the Insured becomes confined again within six months because of the same or a Related condition, 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, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.

#### **Hospital Intensive Care Benefit**

If an Insured is confined in a Hospital Intensive Care Unit because of a Covered Accidental Injury or Covered Sickness, we will pay the daily benefit amount shown in the Benefit Schedule. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, 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, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.

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 or a Related condition, we will treat this confinement as the same period of confinement.

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

**Intermediate Intensive Care Step-Down Unit Benefit**

If an Insured is confined in an Intermediate Intensive Care Step-Down Unit because of a Covered Accidental Injury or Covered Sickness, we will pay the daily benefit amount shown on the Benefit Schedule. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, the Insured must be admitted to an Intermediate Intensive Care Step-Down Unit within six months of the date of the Covered Accident.

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

We will pay benefits for only one confinement in an Intermediate Intensive Care Step-Down Unit at a time, even if it is caused by more than one Covered Accidental Injury, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.

If we pay benefits for confinement in a Hospital's Intermediate Intensive Care Step-Down Unit and the Insured becomes confined to a Hospital's Intermediate Intensive Care Step-Down Unit again within six months because of the same or a Related condition, we will treat this confinement as the same period of confinement.

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

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**Mammography Benefit**

We will pay the amount shown in the Benefit Schedule for mammography tests performed while an Insured's coverage is in force. This benefit is payable as follows:

- A baseline mammogram for women ages 35 – 39, inclusive
- A mammogram for women ages 40 – 49, inclusive, every two years or more frequently based on the recommendation of the Insured's Doctor/Qualified Medical Professional.
- A mammogram every year for women ages 50 and over.

This benefit is limited to the maximum shown in the Benefit Schedule. We will pay this benefit regardless of the results of the test.

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## **SECTION V – EXCLUSIONS**

### **Exclusions**

We will not pay for loss due to:

- 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.
- 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.
- Custodial Care – this is non-medical care that helps individuals with the basic tasks of everyday life, the preparation of special diets, and the self-administration of medication which does not require the constant attention of medical personnel.
- Services performed by a Family Member.
- Dental Services or Treatment.
- Cosmetic surgery, except when due to:
  - Reconstructive surgery, when the service is related to or follows surgery resulting from a Covered Accidental Injury or a Covered Sickness; or when it is performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease.
  - Reconstructive surgery, when the service is related to or follows mastectomy or lymph node dissection. This includes surgery to restore and achieve symmetry for the patient incidental to a mastectomy.

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## **SECTION VI - GENERAL PROVISIONS**

### **Entire Contract; Changes**

This policy, and the Application of the Policyholder, if any, 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 three 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 three 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 three 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 three 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 three years.

No claim for loss incurred or disability commencing after three 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 31 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 Company 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 427, Columbia, South Carolina, 29202, or to any authorized agent of the Company, with information sufficient to identify the insured Employee, shall be deemed notice to the Company.

### **Claims 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**

Indemnities payable under this policy for any loss other than loss for which this policy provides periodic payments will be paid to the insured Employee as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which this policy provides periodic payment will be paid to the insured Employee monthly and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

### **Payment of Claims**

We will pay all benefits to you unless otherwise assigned. For any benefits that remain unpaid at the time of death, we will pay those benefits in the following order:

- To any approved assignee,
- To your beneficiary,
- To your surviving Spouse,
- To your estate.

### **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 and 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.

### **Misstatement of Age**

If the age of any individual covered under the 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.

### **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.

### **Claim Review**

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

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

### **Clerical Error**

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

### **Individual Certificates**

The Company will give the Policyholder a Certificate for each Employee. 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.

### **Successor Insured**

If you die while covered under this Certificate and your Spouse is also insured under this Plan at the time of your death, then your 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, your surviving Spouse must:

- Notify the Company in writing within 31 days after the date of your death; and
- Pay the required premium to the Company no later than 31 days after the date of your 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 your death.

### **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)**



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, Certificate of Insurance, and Dependent Child Rider for Group Supplemental Hospital Indemnity**

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, Certificate, and Dependent Child Rider 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 (including existing children of new domestic partners), 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.

Your natural Dependent Children born after the Effective Date of this Rider will be covered from the moment of live birth. No notice or additional premium is required.

### **The definition below is added to the Definitions section:**

*Observation Unit* means a unit in which observation services are given through Hospital outpatient services to help the Doctor decide if the patient needs to be admitted as an inpatient or can be discharged. Observation services may be given in the emergency department or another area of the Hospital.

## Hospitalization Benefits

**The Hospital Admission Benefit is deleted and replaced with the following:**

### **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 or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, 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 only pay this benefit if we receive Proof of Loss documenting the admission. Following birth, newborns are not generally admitted into the Hospital, but we will pay all applicable benefits for newborns for loss due to a Covered Accidental Injury or a Covered Sickness (including congenital defects, birth abnormalities, and/or premature birth).

We will pay this benefit once per period of Hospital Confinement. This benefit is limited to the maximum shown in the Benefit Schedule. We will only pay this benefit once for each Covered Accident or Covered Sickness per Calendar Year. If an Insured is confined to the Hospital because of the same or Related Accidental Injury or Sickness, we will not pay this benefit again in the same Calendar Year.

**The Individual Certificates provision is deleted and replaced with the following:**

### **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.

## **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

2801 Devine Street, Columbia, South Carolina 29205

800.433.3036

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

## **Dependent Spouse Benefit Rider To Certificate of Insurance for Group Supplemental Hospital Indemnity Policy**

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- We have accepted your Application, and
- You have paid the additional premium for this Rider.

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

### **EFFECTIVE DATE**

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date. Dependent Spouse coverage will become effective on the Effective Date of the Rider if the Dependent Spouse is Active on that date. Otherwise, the Effective Date will be deferred until the day following the date he becomes Active.

### **DEFINITIONS**

When the terms below are used in this Rider, the following definitions apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

*Active* means a Dependent Spouse who is not confined in a Hospital and who is able to carry on regular activities customary of a person in good health of the same age and gender.

*Dependent Spouse* is your legal wife or husband, as well as a person who is in a legally recognized domestic partnership with you (as defined in California Family Code 297), a partner of a civil union, or similar relationship, who is at least age 18 and is listed on your Application.

### **BENEFITS**

If a Dependent Spouse qualifies for benefits under the Certificate to which this Rider is attached because of a Covered Accidental Injury or Covered Sickness, we will provide the benefits shown in the Certificate under the **Benefit Provisions** section.

**GENERAL PROVISIONS**

If your Dependent Spouse’s coverage terminates, we will provide benefits for valid claims that arose while Dependent Spouse coverage was active.

**Time Limit on Certain Defenses**

After two years from the Insured’s Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Application. This does not apply to fraudulent misstatements.

**CONTRACT**

This Rider is part of the Group Supplemental Hospital Indemnity Certificate. It will terminate:

- When the Certificate terminates,
- On the premium due date following the date the covered Spouse no longer qualifies as a Dependent,
- On the premium due date following the date we receive your written request to terminate coverage for your Spouse, or
- When premiums are no longer paid for this Rider.

Signed for the Company at its Home Office,



Teresa White, President



J. Matthew Loudermilk, Secretary



Coverage underwritten by

# CONTINENTAL AMERICAN LIFE INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205

800.433.3036

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

## **Dependent Children Benefit Rider To Certificate of Insurance for Group Supplemental Hospital Indemnity Policy**

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- We have accepted your Application, and
- You have paid the additional premium for this Rider.

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

### **EFFECTIVE DATE**

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date. Dependent Child coverage will become effective on the Effective Date of the Rider if the Dependent Child is Active on that date. Otherwise, the Effective Date will be deferred until the day following the date he becomes Active.

### **DEFINITIONS**

When the terms below are used in this Rider, the following definitions apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

**Active** means a Dependent Child who is not confined in a Hospital and who is able to carry on regular activities customary of a person in good health of the same age and gender.

**Dependent Child or Dependent Children** means your or your Spouse's natural children, step-children (including existing children of new domestic partners), 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. Dependent Children must be younger than age 26.

**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.

There is an exception to the age-26 limit above. This limit will not apply to any Dependent Child who is incapable of self-sustaining employment due to mental or physical handicap and is 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.

Your natural Dependent Children born after the Effective Date of this Rider will be covered from the moment of live birth. No notice or additional premium is required.

## **BENEFITS**

If a Dependent Child qualifies for benefits under the Certificate to which this Rider is attached because of a Covered Accidental Injury or Covered Sickness, we will provide the benefits shown in the Certificate under the **Benefit Provisions** section.

## **GENERAL PROVISIONS**

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

### **Time Limit on Certain Defenses**

After two years from the Insured's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Application. This does not apply to fraudulent misstatements.

## **CONTRACT**

This Rider is part of the Group Supplemental Hospital Indemnity Certificate. It will terminate:

- When the Certificate terminates,
- On the premium due date following the date the covered Child no longer qualifies as a Dependent,
- When the covered Dependent Child reaches age 26 (details in the **Definitions** section of this Rider),
- On the premium due date following the date we receive your written request to terminate coverage for your Child, or
- When premiums are no longer paid for this Rider.

Signed for the Company at its Home Office,



**Teresa White, President**



**J. Matthew Loudermilk, Secretary**



Coverage underwritten by

# **CONTINENTAL AMERICAN LIFE INSURANCE COMPANY**

2801 Devine Street, Columbia, South Carolina 29205  
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](http://www.insurance.ca.gov)**



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](http://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](http://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.**

## **HOSPITAL INDEMNITY 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>.

# Comprehensive Health Benefits Notification

**Only persons that have comprehensive health benefits from an insurance policy, an HMO plan, an employer health benefit plan, or other coverage that satisfies minimum essential coverage under the Affordable Care Act are eligible for this Aflac Group insurance coverage.**

**[aflacgroupinsurance.com](http://aflacgroupinsurance.com) | 1.800.433.3036 | 1.866.849.2970 fax**



**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. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups situated in California, group coverage is underwritten by Continental American Life Insurance Company.

Continental American Insurance Company • Columbia, South Carolina