



# CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina  
800.433.3036

## CERTIFICATE OF INSURANCE FOR NON-PARTICIPATING GROUP ACCIDENTAL INJURY POLICY

**This is accident-only coverage.  
It does not pay benefits for loss from sickness.**

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

THIS IS A LEGAL CONTRACT. PLEASE READ YOUR CONTRACT CAREFULLY.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the company.

**(Coverage for sickness may be included in a separate Rider,  
requiring additional premiums.)**

**Your Employer** (“the Policyholder”) applied for coverage under this Group Insurance Policy (the “Plan”). This Plan is issued by Continental American Insurance Company (the “Company,” “we,” “us,” or “our”). Based on the Application and based on the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. Your Application is maintained on a file and made part of this Certificate. (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 policy documents) in this document are capitalized. These refer to terms with very specific definitions as they apply to this insurance policy.

### **Please read your certificate carefully.**

We certify that you are insured under the Group Accidental Injury Policy (the “Plan”). The Plan was issued to your employer, the Policyholder. This coverage provides benefits for loss resulting from Accidental Injury. 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.

The Certificate Effective Date is shown in the Certificate Schedule. This Certificate will remain in effect for the period for which the premium has been paid. This Certificate may be continued for further periods as stated in the Plan.

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

**Important Cancellation Information — Please Read The Provision Entitled, “Plan Termination,” Found On Page “3.”**

**Notice: Insureds may be subject to a waiting period for certain covered services.**

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## **Section I – Eligibility, Effective Date, and Termination**

### **Eligibility**

You are an eligible Employee under this Plan if you meet the following three requirements. You are:

1. An Employee of the Policyholder,
2. Engaged in full-time work, **and**
3. Included in the class of Employees eligible for coverage, as shown on the Application.

Dependents are eligible for coverage under this Plan. A **Dependent** is:

- Your Spouse **or**
- The Dependent Child of you or your Spouse. **Dependent Children** are your or your Spouse's natural children, step-children, foster children, legally adopted children, or children placed for adoption who are younger than age 26 (details included in the **Definitions** section).

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

- **Employee Coverage** – We insure only the Employee.
- **Employee and Spouse Coverage** – We insure the Employee and Spouse.
- **Employee and Child Coverage** – We insure the Employee and any Dependent Children.
- **Family Coverage** – We insure the Employee, Spouse, and any Dependent Children.

Any other additions to the Insured class must be added by Endorsement after applying to the Company.

### **Effective Date**

Your Certificate Effective Date is the date your insurance takes effect. That date is either the date:

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

### **Plan Termination**

The Plan may terminate for any of the following reasons:

- The premium is not paid before the end of the Grace Period.
- The Company cancels the Plan any time after the end of the first premium year. To do this, the Company must give 45 days' written notice.
- The number of participating Employees is less than the number mutually agreed upon by the Company and the Policyholder in the signed master Application.

The Policyholder has the sole responsibility to notify you of the Plan's termination. 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. If the Plan terminates, we will provide coverage for claims arising from Covered Accidents that occurred while the Plan was in force.

### **Termination of an Employee's Insurance**

Your insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date, if the premium has not been paid.
- The date you no longer meet the Plan's definition of an Employee.
- The date you no longer belong to an eligible class.

If the Plan terminates, we will provide coverage for claims arising from Covered Accidents that occurred while the Plan was in force.

## **Reinstatement**

If any renewal premium is not paid on time (as outlined in the initial payment agreement) for the Plan, the Company (or an agent who is authorized by the Company) may accept the late premium and reinstate the Plan without requiring a new Application.

However, if the Company (or authorized agent) does require an Application for reinstatement and issues a conditional receipt for the premium tendered, the Plan will be reinstated:

- Upon the Company's approval, **or**
- Lacking such approval, upon the 45<sup>th</sup> day following the date of the conditional receipt (unless the Company has previously notified the Policyholder in writing of its disapproval of such Application).

The reinstated Plan covers only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects, the Policyholder and the Company will have the same rights they had under the Plan immediately before the due date of the defaulted premium (subject to any provisions endorsed with or attached to the reinstatement).

Any premium accepted with a reinstatement will:

- Be applied to a period for which premium has not been previously paid, **but**
- Not to any period more than 60 days prior to the date of reinstatement.

## **Section II – Premium Provisions**

### **Premium Calculations**

The Schedule of Premiums determines the premium amount payable on any premium due date. The rates shown in this Schedule can be changed annually. A change in premium rate will not take effect until after at least one year after the policy effective date. However, we may change premium rates at any time, though never more than every 6 months thereafter based upon 12 months of experience. The Company will give the Policyholder written notice 45 days before any change in rates becomes effective.

### **Premium Payments**

The first premium is due on this Plan's Effective Date. After that, premiums are due on the first day of each month that the Plan remains in effect.

Aggregate premiums for this Plan should be paid to the Company at its home office in Columbia, South Carolina. 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.

### **Grace Period**

This Plan has a 31-day Grace Period. If a renewal premium is not paid on or before its due date, the premium may be paid during the next 31 days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of its intention to discontinue the Plan.

## **Section III – Definitions**

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

***Accidental Injury or Injuries*** means bodily Injury or Injuries resulting from an unforeseen and unexpected traumatic event that meets the definition of *Covered Accident*.

**Actively at Work** is defined as 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 may be required to travel to perform the regular duties of your employment.

**Calendar Year** is defined as January 1 through December 31 of the same year.

**Covered Accident** means an unforeseen and unexpected traumatic event resulting in bodily Injury. An event meets the qualifications of Covered Accident if it:

- Occurs on or after the Plan's Effective Date,
- Occurs while coverage is in force, **and**
- Is not specifically excluded.

**Dependent** means your Spouse or your Dependent Child. **Dependent Children** are your or your Spouse's natural children, step-children, legally adopted children, foster children or children placed for adoption who are younger than age 26.

However, there is an exception to the age-26 limit listed above. This limit will not apply to any child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. You or your Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Child's 26th birthday, but not more frequently than annually.

A newborn child will be covered from the moment of birth, if the birth occurs while the plan is in force. Foster children and adopted children shall be treated the same as newborn infants and eligible for coverage on the same basis upon placement in the foster home or placement for adoption. Prior notification will not be required unless an additional premium charge to add the dependent is due. If an additional premium charge is due to cover the dependent, we will cover the newborn child, foster child or adopted child from the moment of birth or placement if the child is enrolled within 30 days after the date of birth or placement.

If a parent is required by a court or administrative order to provide insurance for a child, and the parent is eligible for family insurance coverage, we;

- Will allow the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions.
- Will enroll the child under family coverage upon application of the child's other parent or the Department of Health and Human Services in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the parent is enrolled but fails to make application to obtain coverage for the child.
- Will not dis-enroll or eliminate coverage of the child unless we are provided satisfactory written evidence that:
  - a. The court or administrative order is no longer in effect; **or**
  - b. The child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect no later than the effective date of disenrollment.

We will not decline enrollment of a child on the grounds the child was born out of wedlock, the child was not claimed as dependent on the parent's federal tax return; or the child does not reside with the parent or the insurer's service area.

**Doctor** is defined as a person who is:

- Legally qualified to practice medicine,
- Licensed as a physician by the state where Treatment is received, **and**
- Licensed to treat the type of condition for which a claim is made.

A Doctor does not include you or your Family Member.

**Employee** is a person who meets eligibility requirements under **Section I – Eligibility**, and who is covered under this Plan. The Employee is the primary Insured under this Plan.

**Family Member** includes the Employee's *Spouse* (who is defined as an Employee's legal wife or husband) as well as the following members of the Insured's immediate family:

- Son.
- Daughter.
- Mother.
- Father.
- Sister.
- Brother.

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

**Full-time Work** means that you spend at least the minimum hours required by your employer per week performing your occupational duties.

**Hospital** refers to a place that:

- 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;
- Has on-site or pre-arranged use of X-ray equipment, laboratory, and surgical facilities;
- Maintains permanent medical history records; **and**
- Is a state supported institution even though it may not have an operating room and related equipment for the surgery.

A Hospital is **not**:

- A nursing home;
- An extended-care facility;
- A convalescent home;
- A rest home or a home for the aged;
- A place for alcoholics or drug addicts; **or**
- A mental institution.

**Hospital Intensive Care Unit** refers to a specifically designed Hospital facility that provides the highest level of medical care and is restricted to patients who are critically ill or injured. Hospital Intensive Care Units must be:

- Separate and apart from the surgical recovery room;
- Separate and apart from rooms, beds, and wards customarily used for patient confinement;
- Permanently equipped with special life-saving equipment to care for the critically ill or injured; **and**
- Under constant and continuous observation by nursing staffs assigned to the Intensive Care Unit on an exclusive, full-time basis.

**Treatment or Medical Treatment** is the consultation, care, or services provided by a Doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.

**Your Occupation** means the occupation in which you are regularly engaged at the time you become disabled.

## **Section IV – Benefit Provisions**

The language in this provision matches that of the Policy. As this Certificate is issued to you, the primary Insured, we included the use of "you" and "yours."

The benefit amounts payable under this section are shown in the Benefit Schedule.

## **Specific Injuries Benefits**

### **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 150% of the amount shown in the Benefit Schedule.

*Multiple fractures* refer 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 150% of the benefit amount for the bone fractured which 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 10% of the amount shown in the Benefit Schedule for the affected bone.

### **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 150% 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 you dislocated a joint before the Effective Date of your Certificate and then dislocate the same joint again, it will not be covered by this Certificate.

*Multiple dislocations* refer to more than one dislocation requiring either open or closed reduction in anyone Covered Accident. For each covered dislocation, we will pay the amounts shown in the Benefit Schedule. However, we will pay no more than 150% 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.

If you have **both** fracture and dislocation in the same Covered Accident, we will pay for both. However, we will pay no more than 150% of the benefit amount for the fractured bone or dislocated joint that has the higher dollar amount.

### **Laceration Benefit**

If you receive a laceration in a Covered Accident, we will pay the appropriate amount shown in the Benefit Schedule. The laceration must be repaired with stitches by a Doctor within 72 hours after the accident. The amount paid will be based on the length of the laceration.

You may receive a laceration that does not require stitches. However, if that laceration is treated by a Doctor within 72 hours after the Covered Accident, we will pay the appropriate amount shown in the Benefit Schedule. If you suffer multiple lacerations in a Covered Accident, and the lacerations are repaired with stitches by a Doctor within 72 hours after the accident, we will pay this benefit based on the largest single laceration which requires stitches, as shown in the Benefit Schedule.

### **Concussion Benefit**

A *concussion* or *Mild Traumatic Brain Injury (MTBI)* is defined as a disruption of brain function resulting from a traumatic blow to the head. (Note: *Concussion* and *MTBI* are used interchangeably.)

If you have a concussion from a Covered Accident, we will pay the amount shown for this benefit in the Benefit Schedule. The concussion must be diagnosed by a Doctor.

### **Coma Benefit**

*Coma* means a state of profound unconsciousness caused by a Covered Accident. If you are in a coma lasting 30 days or more as the result of a Covered Accident, we will pay this benefit as shown in the Benefit Schedule.

### **Emergency Dental Work Benefit**

We will pay this benefit if you have an Injury to sound 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.

### **Eye Injuries Benefit**

For eye injuries requiring surgical repair, we will pay the amount shown in the Benefit Schedule, if, because of a Covered Accident:

- You injure an eye,
- A Doctor repairs the eye through surgery, **and**
- The eye surgery occurs within 90 days after the Accident.

For eye injuries requiring removal of a foreign body, we will pay the amount shown in the Benefit Schedule if a Doctor removes a foreign body from the eye, with or without anesthesia.

### **Tendons and Ligaments Benefit**

We will pay the appropriate amount shown in the Benefit Schedule if a Covered Accident causes you to:

- Tear, sever, or rupture a tendon or ligament;
- Receive Treatment from a Doctor within 60 days; **and**
- Have surgical repair within 90 days after the accident.

The amount paid will be based on the number (single or multiple) of tendons or ligaments repaired.

### **Ruptured Disc Benefit**

We will pay the amount shown in the Benefit Schedule if a Covered Accident causes you to:

- Rupture a disc in your spine,
- Receive Treatment from a Doctor within 60 days after the accident, **and**
- Have surgical repair by a Doctor within one year after the accident.

The amount paid will be based on when the accident occurred. See the Benefit Schedule for details.

### **Torn Knee Cartilage Benefit**

We will pay the amount shown in the Benefit Schedule if you are injured in a Covered Accident and:

- Accidental injuries result in torn knee cartilage,
- This Injury requires Doctor Treatment within 60 days from the accident date, **and**
- This Injury requires surgical repair within one year from the accident date.

The amount paid will be based on when the accident occurred. See the Benefit Schedule for details.

### **Internal Injuries Benefit**

We will pay the amount shown in the Benefit Schedule if:

- A Covered Accident causes you to have internal Injuries, **and**
- Those internal Injuries require open abdominal or thoracic surgery.

### **Exploratory Surgery Benefit**

We will pay the amount shown in the Benefit Schedule if a Covered Accident causes you to have exploratory surgery (without repair). The Exploratory Surgery must be required as the result of an Injury.



## **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:

- You are injured,
- The Injury causes paralysis which lasts more than 90 days, **and**
- The paralysis is diagnosed by a Doctor within 90 days after the accident.

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

If this benefit is paid and you later die as a result of the same Covered Accident, we will pay the appropriate Death Benefit, less any amounts paid under the Paralysis Benefit.

## **Burns Benefit**

We will pay the appropriate amount shown in the Benefit Schedule if you have burns in a Covered Accident. We will pay the Burns Benefit according to the percentage of body surface burned. You must be treated for burns by a Doctor within 72 hours after the accident. First-degree burns are not covered.

## **Dismemberment Benefit**

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

- Are injured **and**
- Lose a hand, a foot, or sight within 90 days after the accident as a result of the Injury.

If you lose one hand, one foot, or the sight of one eye in a Covered Accident, we will pay the single loss benefit shown in the Benefit Schedule.

If you lose both hands, both feet, the sight of both eyes, or a combination of any two, we will pay the double loss benefit shown in the Benefit Schedule.

If you lose one or more fingers or toes in a Covered Accident, we will pay the finger/toe benefit shown in the Benefit Schedule.

*Dismemberment* means:

- **Loss of a hand** – The hand is removed at or above the wrist joint; **or**
- **Loss of a foot** – The foot is removed at or above the ankle; **or**
- **Loss of sight** – At least 80% of the vision in one eye is lost (such loss of sight must be permanent and irrecoverable); **or**
- **Loss of a finger/toe** – The finger or toe is removed at or above the joint where it is attached to the hand or foot.

If you do not qualify for the Dismemberment Benefit but lose at least one joint of a finger or toe, we will pay the Partial Dismemberment Benefit shown in the Benefit Schedule.

If the Dismemberment Benefit is paid and you later die as a result of the same Covered Accident, we will pay the appropriate death benefit, less any amounts paid under this benefit.

## **Services Benefits**

### **Blood/Plasma Benefit**

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

- Are injured **and**
- Receive blood or plasma within 90 days after the accident.

### **Ambulance Benefit**

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

- Are injured **and**
- Require transportation to a Hospital by a professional ambulance service. This transportation must occur within 90 days after the accident.

Ambulance service includes air ambulance service.

### **Transportation Benefit**

We will pay the applicable amount shown in the Benefit Schedule for train, plane, or bus transportation. This benefit is payable if, because of a Covered Accident, you:

- Are injured **and**
- Require Doctor-recommended Hospital Treatment or diagnostic study that is not available in your resident city.

Use of such transportation must begin within 90 days from the Covered Accident date. The distance to the Hospital Treatment or diagnostic study must be greater than 50 miles from your residence.

### **Family Member Lodging Benefit**

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

- You must be confined to a Hospital for Treatment of an Injury,
- The Hospital and motel/hotel must be more than 100 miles from your residence, **and**
- The Treatment must be prescribed by your local Doctor.

### **Medical Fees Benefit**

We will pay the amount shown in the Benefit Schedule for the following medical fees:

- X-rays.
- Doctor services.

For benefits to be payable, because of a Covered Accident, you must:

- Be injured **and**
- Receive initial Treatment from a Doctor within 72 hours after the accident.

We will pay the Medical Fees Benefit:

- For Treatment received due to injuries from a Covered Accident **and**
- For each Covered Accident up to one year after the accident date.

We will not pay the Medical Fees Benefit and the Accident Emergency Room Treatment Benefit for the same Covered Accident. We will pay the highest eligible benefit amount.

### **Prosthesis Benefit**

Prosthetic devices must be used as the result of Injury from a Covered Accident. For Covered Accidents, we will pay the amount shown in the Benefit Schedule for each prosthetic device you use. Prosthetic devices **not** covered include:

- Hearing aids.
- Wigs.
- Dental aids (including, but not limited to, false teeth).

### **Appliances Benefit**

We will pay the amount shown in the Benefit Schedule if a Doctor advises you to use a medical 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. *Medical appliance* means crutches, wheelchairs, leg braces, back braces, and walkers.

### **Accident Follow-Up Treatment Benefit**

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

- You receive initial Treatment within 72 hours after the Covered Accident.
- You receive Doctor-prescribed follow-up Treatment.
- The follow-up Treatment begins within 30 days after the Covered Accident or discharge from the Hospital.

We will pay for a maximum of 6 Treatments per Covered Accident.

### **Physical Therapy Benefit**

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

- You receive initial Treatment within 72 hours after the Covered Accident.
- You receive Doctor-prescribed physical therapy Treatment.
- The physical therapy Treatment begins within 30 days after the Covered Accident or discharge from the Hospital.
- The physical therapy Treatment takes place within 6 months after the Covered Accident.

We will pay for a maximum of 6 physical therapy Treatments per Covered Accident. We will not pay this benefit for the same visit that the Accident Follow-up Treatment Benefit is paid.

### **Wellness Benefit**

We will pay the amount shown in the Benefit Schedule for the following:

- Annual physical exams.
- Mammograms.
- Pap smears.
- Eye examinations.
- Immunizations.
- Flexible sigmoidoscopy.
- PSA tests.
- Ultrasounds.
- Blood screening.

This benefit is only payable for Wellness Tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.

This benefit is payable once each 12-month period.

### **Emergency Room Treatment Benefit**

We will pay the amount shown in the Benefit Schedule for injuries received in a Covered Accident if you:

- Receive Treatment in a Hospital emergency room **and**
- Receive initial Treatment within 72 hours after the Covered Accident.

This benefit is payable only once per 24-hour period and only once per Covered Accident. We will not pay the Accident Emergency Room Treatment Benefit and the Medical Fees Benefit for the same Covered Accident. We will pay the highest eligible benefit amount.

### **Emergency Room Observation Benefit**

We will pay the amount shown in the Benefit Schedule for injuries received in a Covered Accident if you:

- Receive Treatment in a Hospital emergency room, **and**
- Are held in a Hospital for observation for at least 24 hours, **and**
- Receive initial Treatment within 72 hours after the accident.

This benefit is payable only once per 24-hour period and only once per Covered Accident. This benefit is paid in addition to Accident Emergency Room Treatment Benefit or the Medical Fees Benefit.

### **Rehabilitation Unit Benefit**

We will pay the appropriate amount shown in the Benefit Schedule for injuries received in a Covered Accident if you:

- Are admitted for a Hospital Confinement,
- Are transferred to a bed in a Rehabilitation Unit of a Hospital for Treatment, **and**
- Incur a charge.

This benefit is limited to 30 days per period of Hospital confinement. This benefit is also limited to a Calendar Year maximum of 60 days. We will not pay the Rehabilitation Unit Benefit for the same days that the Accident Hospital Confinement Benefit is paid. We will pay the highest eligible benefit.

### **Hospital Benefits**

#### **Hospital Admission Benefit**

We will pay the Hospital Admission Benefit amount shown in the Benefit Schedule. We will pay this benefit when, because of a Covered Accident, you:

- Are injured,
- Require hospital confinement, **and**
- Are confined to a hospital for at least 24 hours within 6 months after the accident date.

We will pay this benefit once per Calendar Year. We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room Treatment or outpatient surgery or Treatment.

#### **Hospital Confinement Benefit**

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

- You are injured, **and**
- Those injuries cause you to be confined to a Hospital for at least 24 hours within 90 days after the accident.

The Benefit Schedule shows the maximum period for which you can collect the Hospital Confinement Benefit for the same Injury.

This benefit is payable once per Hospital confinement even if the confinement is caused by more than one Accidental Injury.

We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room Treatment or outpatient surgery or Treatment.

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

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

- You are injured, **and**
- Those injuries cause you to be confined to a hospital intensive care unit.

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

### **Accidental-Death Benefits**

#### **Accidental-Death Benefit**

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

- You are injured, **and**
- The Injury causes you to die within 90 days after the accident.

We will pay the Accidental-Death Benefit in addition to the Accidental Common-Carrier Death Benefit.

## **Accidental Common-Carrier Death Benefit**

We will pay the amount shown in the Benefit Schedule if you:

- Are a fare-paying passenger on a common carrier, as defined below, **and**
- Are injured in a covered accident, **and**
- Die within 90 days after the covered accident.

*Common carrier* means:

- An airline carrier that is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports;
- A railroad train that is licensed and operated for passenger service only; **or**
- A boat or ship that is licensed for passenger service and operated on a regular schedule between established ports.

We will pay the Accidental Common-Carrier Death Benefit in addition to the Accidental-Death Benefit.

## **Section V – Exclusions**

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

- **War** –participating in war or any act of war, declared or not; participating in the armed forces of, or contracting with, any country or international authority. We will return the prorated premium for any period not covered by this Certificate when you are in such service. This does not include terrorism.
- **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 any related medical/surgical Treatment or diagnostic procedures for such illness. This exclusion does not exclude an accidental death from a bacterial infection resulting from an accidental injury.
- **Self-Inflicted Injuries** –injuring or attempting to injure yourself intentionally.
- **Racing** –riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.
- **Intoxication** –being legally intoxicated, or being under the influence of any narcotic, unless taken under the direction of a Doctor. *Legally intoxicated* means that condition as defined by the law of the jurisdiction in which the accident occurred.)
- **Illegal Acts** –participating or attempting to participate in an illegal activity, or working at an illegal job.
- **Sports** –participating in any organized sport –professional or semi-professional.
- **Cosmetic Surgery** –having cosmetic surgery or other elective procedures that are not medically necessary or having dental Treatment except as a result of a Covered Accident.

## **Section VI – Claim Provisions**

### **Notice of Claim**

You must give written notice of claim:

- Within 60 days after a Covered Accident, **or**
- As soon as reasonably possible.

Notice must include your name and the Certificate number. Notice can be mailed to the Company at:  
**P.O. Box 427, Columbia, South Carolina, 29202.**

The notice may also be given to an authorized agent of the company.

## **Claim Forms**

When the Company receives notice of a claim, we will send you forms so that you can file Proof of Loss (details included in the **Proof of Loss** section below). If the Company does not provide the forms within 15 working days, you can meet Proof of Loss requirements by providing a written statement about the nature and extent of the loss. You will also need to provide a statement by the treating Doctor. You must provide this information within the time limit stated in the **Proof of Loss** section.

## **Proof of Loss**

*Proof of Loss* refers to documentation that supports a claim (this information is often found in standardized medical documents, such as hospital bills and operative reports). You must provide Proof of Loss to the Company at:

**P.O. Box 427, Columbia, South Carolina, 29202.**

You must provide Proof of Loss documentation within 180 days after the date of the Covered Accident. However, the Company will not invalidate or reduce any claim if it was not reasonably possible for you to provide this proof within the required time. You must provide the proof as soon as reasonably possible. The Company will not accept proof any later than one year and three months after the Covered Accident, except in the absence of your legal mental capacity.

## **Claims Payment Timeframe**

Once we receive proper Proof of Loss, we will process your claim. If the claim can be paid, and a benefit provides for periodic payments, we will pay those benefits on a monthly basis. For other payable benefits, we will pay those claims after processing.

## **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:

1. To any approved assignee;
2. To your beneficiary;
3. To your surviving spouse;
4. To your estate.

If any indemnity of this Plan shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding \$3,000 to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be rightfully allowed.

## **A Change in Beneficiary**

You can ask us to change your beneficiary at any time. The request must be in writing and the change must be approved by us. If approved, it will go into effect the day you sign the request. The change will not have any bearing on payments made before we approved the request.

## **Unpaid Premium**

When a claim is paid, we may deduct any premium due and unpaid from the claim payment.

## **Physical Examination and Autopsy**

The Company may have an Insured examined as often as reasonably necessary while a claim is pending. In the case of death, the Company may also require an autopsy, unless prohibited by law. The Company will cover all costs for physical exams and/or autopsy.

## **Legal Action**

You cannot take legal action against us for benefits under this Plan:

- Within 60 days after you have sent us written Proof of Loss; **or**
- More than 3 years from the time written proof is required to be given.

## **Section VII – General Provisions**

### **Entire Contract Changes**

The *Entire Contract of Insurance* is made up of:

- This Policy,
- The Application,
- Certificates,
- Endorsements,
- Benefit agreements, **and**
- Riders (if any).

All statements (excluding fraudulent ones) that the Policyholder or an Insured have made in the Application will be considered representations, **not** warranties.

If statements on the Application require additional review, the Company will send a copy of the Application to:

- The Policyholder, **or**
- The Insured, **or**
- The Insured's beneficiary.

This will ensure that Policyholders have an opportunity to review the information they have provided in their Applications. The Company *will not* void insurance or reduce benefits (as a result of statements made on the Application) without sending Application copies as outlined above.

Changes to this Plan:

- Will not be valid unless approved in writing by an executive officer of the Company.
- Must be noted on or attached to the Contract.
- May not be made by any agent (nor can an agent waive any Plan provisions).

Any Rider, Endorsement, or Application that modifies, limits, or excludes coverage under this Plan must be signed by the Insured to be valid.

### **Misstatement of Age**

If an age has been misstated on the Application, the benefits will be those that the paid premium would have purchased at the correct age.

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

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

### **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 Certificate**

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 furnish all information and proofs which the Company may reasonably require with regard to the Plan.

### **Conformity With State Statutes**

Any Plan provision that conflicts with state statutes where this Plan was issued on its Effective Date is hereby amended to conform to the minimum requirements of those statutes.



## Section VIII – Benefit Schedule

<b><u>Specific Injuries Benefits</u></b>	<b>Plan I</b>
<b>Fracture</b>	
Hip/thigh	\$4,500
Vertebrae	4,050
Pelvis	3,600
Skull (depressed)	3,375
Skull (simple)	1,575
Leg	2,700
Foot/ankle/knee cap	2,250
Forearm/hand	2,250
Lower jaw	1,800
Shoulder blade/collar bone	1,800
Upper arm/upper jaw	1,575
Facial bones (except teeth)	1,350
Vertebral processes	900
Coccyx/rib/finger/toe	360
<b>Dislocation</b>	
Hip	4,000
Knee (not knee cap)	2,600
Shoulder	2,000
Foot/ankle	1600
Hand	1,400
Lower jaw	1,200
Wrist	1,000
Elbow	800
Finger/toe	320
<b>Laceration</b>	
Over 6"	400
2" to 6"	200
Under 2"	50
Lacerations not requiring stitches	25
<b>Concussion</b>	200
<b>Coma</b>	10,000
<b>Emergency Dental Work</b>	
Repair with crown	150
Extraction	50
<b>Eye Injuries</b>	
Requiring surgical repair	250
Removal of foreign body	50
<b>Tendons/Ligaments</b>	
Single	400
Multiple	600
CAI7801NC	17

<b>Ruptured Disc</b>		
	Injury occurs during first Certificate year	100
	Injury occurs after first Certificate year	400
<b>Torn Knee Cartilage</b>		
	Injury occurs during first Certificate year	100
	Injury occurs after first Certificate year	400
<b>Internal Injuries</b>		1,000
<b>Exploratory Surgery</b> (without repair)		250
<b>Paralysis</b>		
	Four limbs (quadriplegia)	10,000
	Two limbs (paraplegia)	5,000
<b>Burns</b>		
<b>Second Degree</b>		
	Less than 10%	100
	At least 10% but less than 25%	200
	At least 25% but less than 35%	500
	35% or more	1,000
<b>Third Degree</b>		
	Less than 10%	1,000
	At least 10% but less than 25%	5,000
	At least 25% but less than 35%	10,000
	35% or more	20,000
<b>Dismemberment</b>		
	Loss of hand, foot, or sight	
	Single loss	12,500
	Double loss	25,000
	Loss of one or more fingers or toes	1,250
	Partial amputation of finger or toe	100
<b><u>Services Benefits</u></b>		
<b>Blood/Plasma</b>		100
<b>Ambulance</b>		100
<b>Air Ambulance</b>		500
<b>Transportation</b>		
	Train or Plane	300
	Bus	150
<b>Family Member Lodging</b>		100/per night
	Maximum Benefit Period: 30 days	
<b>Medical Fees</b>		125

<b>Prosthesis</b>	500
<b>Appliances</b>	100
<b>Accident Follow-Up Treatment</b>	25
Maximum of 6 Treatments per Covered Accident	
<b>Physical Therapy</b>	25
Maximum of 6 Treatments per Covered Accident	
<b>Wellness</b>	60
Once per 12-month period	
<b>Emergency Room Treatment</b>	125
<b>Emergency Room Observation</b>	75
<b><u>Hospital Benefits</u></b>	
<b>Hospital Admission</b>	1,000
Payable once per Calendar Year	
<b>Hospital Confinement</b>	200/day
Maximum Benefit Period: 365 days	
<b>Hospital Intensive Care</b>	400/day
Maximum Benefit Period: 30 days	
<b><u>Accidental-Death Benefits</u></b>	
<b>Accidental Death</b>	50,000
<b>Accidental Common-Carrier Death</b>	100,000



# CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina  
800.433.3036

## **Portability Privilege Amendment**

This Amendment is part of the form to which it is attached. Unless amended by this document, all definitions, exclusions, limitations, terms, and other provisions apply. For the purpose of this Amendment, “you” (including “your” and “yours”) refers to the Insured named in the Certificate Schedule.

### **Effective Date**

This Amendment becomes effective on the Effective Date of the form to which it is attached.

### **Portability Privilege**

The following language replaces the ELIGIBILITY provision found under SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION of the Master Policy and the Certificate of Insurance:

#### **ELIGIBILITY — CLASSES OF COVERAGE**

##### **Class I**

All full-time and part-time benefit-eligible Employees are eligible for Class I coverage. That eligibility extends to their spouses and children under age 26.

##### **Class II**

A Class I primary insured is eligible for Class II coverage if he:

- Was previously insured under Class I; **and**
- Is no longer employed by the Policyholder.

The Employee must elect Class II coverage under the Portability Privilege within 31 days after the date for which his class I eligibility would otherwise terminate.

Only Dependents covered under Class I coverage are eligible for continued coverage under Class II.

Class II insureds cannot continue coverage through the employer’s payroll deduction process. They must remit premiums directly to the Company.

The following language replaces the TERMINATION OF THE PLAN provision found under SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION of the Master Policy.

#### **TERMINATION OF THE PLAN**

The Plan will cease if the premium is not paid before the end of the Grace Period.

After the end of the first Plan year, the Company has the right to cancel the Plan. To do so, the Company must give 45 days’ written notice that the plan will end on the date before the next premium due date.

The Policyholder has the right to cancel the Plan on the date before any premium due date by giving 45 days’ written notice.

Upon such termination, Class I and Class II coverage will be affected as follows:

**Class I**

If terminated, this Plan and all certificates issued under this class will terminate on such date at 12:01 a.m. Standard Time at the Policyholder's address. This will be without prejudice to the rights of any Insured regarding any claim arising while the Plan is in force.

The Policyholder has the sole responsibility to notify Class I Employees of such termination. When notice of termination is received by the Company, the Portability Privilege under Class I coverage is no longer available.

**Class II**

The group policy will remain active, and coverage under Class II will continue as long as premiums are paid, subject to the premium grace period. Notification of any changes in the plan will be provided directly to each insured by the Company. The Policyholder will lose any rights and obligations under the Plan.

The following language replaces the TERMINATION OF AN EMPLOYEE'S INSURANCE provision found under SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION of the Master Policy and the Certificate of Insurance.

**TERMINATION OF AN EMPLOYEE'S INSURANCE**

An Employee's insurance will terminate on the earliest of the following:

1. The date the Plan is terminated, for Class I insureds;
2. The 31<sup>st</sup> day after the premium due date if the required premium has not been paid;
3. The date he ceases to meet the definition of an Employee as defined in the Plan, for Class I insureds; **or**
4. The date he is no longer a member of the Class eligible for coverage.

Insurance for Dependents will terminate on the earliest of the following:

1. The date the Plan is terminated, for Dependents of Class I insureds;
2. The 31<sup>st</sup> day after the premium due date, if the required premium has not been paid;
3. The date the Spouse or Dependent Child ceases to be a dependent; **or**
4. The premium due date following the date we receive the Employee's written request to terminate coverage for his Spouse and/or all Dependent Children.

Termination of the insurance on any Insured will not prejudice his rights regarding any claim arising prior to termination.

The following language replaces the PORTABILITY PRIVILEGE provision found under SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION of the Master Policy and the Certificate of Insurance.

**PORTABILITY PRIVILEGE**

Under the Portability Privilege provision, when coverage would otherwise terminate because an Employee ends his employment, coverage may be continued. He may exercise the Portability Privilege when there is a change to his coverage class. The Employee — and any covered dependents — will continue the coverage that is in-force on the date employment ends. The continued coverage will be provided under Class II.

The premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least 45 days before any change is to take effect.

The Employee may continue the coverage until the earlier of:

- The date he fails to pay the required premium; **or**
- The date the class of coverage is terminated.

Coverage may not be continued:

- If the Employee fails to pay any required premium; **or**
- If the Company receives notice of Class I plan termination.

## **General Provisions**

### **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 Insured's Application. This does not apply to fraudulent misstatements.

### **Contract**

This Amendment is part of the form to which it is attached. It will terminate when that form terminates.

This Amendment is subject to all of the terms of the form to which it is attached unless those terms are inconsistent with this Amendment.

Signed for the Company at its Home Office,



Paul S. Amos II, President



J. Matthew Loudermilk, Secretary



# CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina

800.433.3036

## AMENDMENT TO CERTIFICATE OF INSURANCE FOR NON-PARTICIPATING GROUP ACCIDENTAL INJURY POLICY

This Amendment alters the policy and the certificate to which it is attached. Unless specifically addressed by this Amendment, all other policy and certificate provisions, definitions, and other terms apply.

**Effective Date** – This Amendment is effective on the date it is issued.

### ***The Laceration Benefit is deleted and replaced with the following:***

If you receive a laceration in a Covered Accident, we will pay the appropriate amount shown in the Benefit Schedule. The laceration must be repaired with stitches by a Doctor within 14 days after the accident. The amount paid will be based on the length of the laceration.

You may receive a laceration that does not require stitches. However, if that laceration is treated by a Doctor within 14 days after the Covered Accident, we will pay the appropriate amount shown in the Benefit Schedule.

If you suffer multiple lacerations in a Covered Accident, and the lacerations are repaired with stitches by a Doctor within 14 days after the accident, we will pay this benefit based on the largest single laceration which requires stitches, as shown in the Benefit Schedule.

### ***The Burns Benefit is deleted and replaced with the following:***

We will pay the appropriate amount shown in the Benefit Schedule if you have burns in a Covered Accident. We will pay the Burns Benefit according to the percentage of body surface burned. You must be treated for burns by a Doctor within 14 days after the accident. First-degree burns are not covered.

### ***The Medical Fees Benefit is deleted and replaced with the following:***

We will pay the amount shown in the Benefit Schedule for the following medical fees:

- X-rays.
- Doctor services.

For benefits to be payable, because of a Covered Accident, you must:

- Be injured and
- Receive initial Treatment from a Doctor within 14 days after the accident.

We will pay the Medical Fees Benefit:

- For Treatment received due to injuries from a Covered Accident and
- For each Covered Accident up to one year after the accident date.

We will not pay the Medical Fees Benefit and the Accident Emergency Room Treatment Benefit for the same Covered Accident. We will pay the highest eligible benefit amount.

***The Accident Follow-Up Treatment Benefit is deleted and replaced with the following:***

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

- You receive initial Treatment within 14 days after the Covered Accident.
- You receive Doctor-prescribed follow-up Treatment.
- The follow-up Treatment begins within 30 days after the Covered Accident or discharge from the Hospital.

We will pay for a maximum of 6 Treatments per Covered Accident.

***The Physical Therapy Benefit is deleted and replaced with the following:***

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

- You receive initial Treatment within 14 days after the Covered Accident.
- You receive Doctor-prescribed physical therapy Treatment.
- The physical therapy Treatment begins within 30 days after the Covered Accident or discharge from the Hospital.
- The physical therapy Treatment takes place within 6 months after the Covered Accident.

We will pay for a maximum of 6 physical therapy Treatments per Covered Accident. We will not pay this benefit for the same visit that the Accident Follow-up Treatment Benefit is paid.

***The Emergency Room Treatment Benefit is deleted and replaced with the following:***

We will pay the amount shown in the Benefit Schedule for injuries received in a Covered Accident if you:

- Receive Treatment in a Hospital emergency room and
- Receive initial Treatment within 14 days after the Covered Accident.

This benefit is payable only once per 24-hour period and only once per Covered Accident. We will not pay the Accident Emergency Room Treatment Benefit and the Medical Fees Benefit for the same Covered Accident. We will pay the highest eligible benefit amount.

***The Emergency Room Observation Benefit is deleted and replaced with the following:***

We will pay the amount shown in the Benefit Schedule for injuries received in a Covered Accident if you:

- Receive Treatment in a Hospital emergency room,
- Are held in a Hospital for observation for at least 24 hours, and
- Receive initial Treatment within 14 days after the accident.

This benefit is payable only once per 24-hour period and only once per Covered Accident. This benefit is paid in addition to Accident Emergency Room Treatment Benefit or the Medical Fees Benefit.

**GENERAL PROVISIONS**

This Amendment is part of the Non-Participating Group Accidental Injury Policy and Certificate and will terminate when that Policy and Certificate terminates, or when premiums are no longer paid for this Amendment.

This Amendment is subject to all of the terms of the Non-Participating Group Accidental Injury Policy and Certificate to which it is attached unless any such items are inconsistent with the terms of this Amendment.

Signed for the Company at its Home Office,



Paul S. Amos II, President



J. Matthew Loudermilk, Secretary



## NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

**The North Carolina Life and Health Insurance Guaranty Association  
Post Office Box 10218  
Raleigh, North Carolina, 27605**

**North Carolina Department of Insurance, Consumer Services Division  
1201 Mail Service Center  
Raleigh, NC 27699-1201**

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. *On the back of this page* is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

## COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

## EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- 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 a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed the average rate specified in the law;
- dividends;
- experience or other credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contract holders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.
- A policy or contract commonly known as Medicare Part C or Part D or any regulations issued pursuant thereto.

## LIMITS ON AMOUNT OF COVERAGE

(1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.

(2) Except as provided in (3), (4), and (5) below, the guaranty association will pay a maximum of \$300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.

(3) The guaranty association will pay a maximum of \$500,000 with respect to basic hospital, medical and surgical insurance and major medical insurance.

(4) The guaranty association will pay a maximum of \$1,000,000 with respect to the payee of a structured settlement annuity.

(5) The guaranty association will pay a maximum of \$5,000,000 to any one unallocated annuity contract holder.

## **IMPORTANT NOTICE**

Under North Carolina General Statute Section 58-50-40, no person, employer, principal, agent, trustee, or third party administrator, who is responsible for the payment of group health or life insurance or group health plan premiums, shall: (1) cause the cancellation or non-renewal of group health or life insurance, hospital, medical, or dental service corporation plan, multiple employer welfare arrangement, or group health plan coverages and the consequential loss of the coverages of the persons insured, by willfully failing to pay those premiums in accordance with the terms of the insurance or plan contract, and (2) willfully fail to deliver, at least 45 days before the termination of those coverages, to all persons covered by the group policy written notice of the person's intention to stop payment of premiums.

Please note that persons insured under group health or life insurance or group health plans may be entitled to conversion of their coverage under Article 53 of Chapter 58 of the General Statutes or entitled to purchase individual policies under the Federal Health Insurance Portability and Accountability Act and Under Article 68 of Chapter 58 of the General Statutes. Check your Certificate for additional information on conversion.

Violation of this law is a felony. Any person violating this law is also subject to a court order requiring the person to compensate persons insured for expenses or losses incurred as a result of the termination of the insurance.

## **NOTICE OF PRIVACY PRACTICES – PROTECTED HEALTH INFORMATION**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.** The terms of this Notice of Privacy Practices – Protected Health Information (“Notice”) apply to Protected Health Information (defined below) associated with Health Plans (defined below) issued by American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, Continental American Insurance Company (CAIC), and Continental American Life Insurance Company (collectively, “we,” “our,” or “Aflac”). This Notice describes how CAIC may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) to maintain the privacy of Protected Health Information and to provide our policyholders and certificateholders with notice of our legal duties and privacy practices concerning Protected Health Information. In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of Protected Health Information, as set forth below, we will restrict our uses or disclosure of your Protected Health Information in accordance with the more stringent standard. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, we will mail copies of revised notices to all policyholders and certificateholders then covered by a Health Plan. Copies of our current Notice may be obtained by contacting CAIC at the telephone number or address below, or on our Web site at [www.aflacgroupinsurance.com](http://www.aflacgroupinsurance.com).

### **DEFINITIONS**

**Health Plan** means, for purposes of this Notice, the following plans issued by CAIC: dental, specified disease (e.g., cancer), hospital indemnity and other coverages that meet the definition of Health Plan contained in HIPAA. The following products are not considered Health Plans: coverage only for accident, or disability income insurance, or any combination thereof, life insurance, and other coverages that do not meet the definition of Health Plan contained in HIPAA.

**Protected Health Information (“PHI”)** means individually identifiable health information, as defined by HIPAA, that is created or received by CAIC and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased, unless the person has been deceased more than 50 years.

### **USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION**

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

**Uses and Disclosures for Payment** – We may make requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims. We may also disclose your PHI for the payment purposes of a health care provider or another Health Plan.

**Uses and Disclosures for Health Care Operations** – We may use and disclose your PHI as necessary for our health care operations. Examples of health care operations include underwriting, premium rating, or other activities relating to the creation, renewal, or replacement of a Health Plan, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance, and other functions related to your Health Plan. Although underwriting falls within the definition of health care operations, we will not use or disclose genetic information for purposes of underwriting. Genetic information is defined under the Genetic Information Nondiscrimination Act (GINA).

**Family and Friends Involved in Your Care** – If you are available and do not object, we may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share limited PHI with such individuals. For example, we may use our professional judgment to disclose PHI to your spouse concerning the processing of a claim. If you do not wish CAIC to share PHI with your spouse or others, you may exercise your right to request a restriction on CAIC’s disclosures of your PHI (see below).

**Business Associates** – Certain aspects and components of our services are performed through contracts with outside persons or organizations. Examples of these outside persons and organizations include our duly-appointed insurance agents and vendors that help us process your claims. At times it may be necessary for us to provide certain of your PHI to one or more of these outside persons or organizations.

**Other Products and Services** – We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your PHI for the purpose of communicating to you about our health insurance products that could enhance or substitute for existing Health Plan coverage, and about health-related products and services that may add value to your Health Plan.

**Other Uses and Disclosures** – We may make certain other uses and disclosures of your PHI without your authorization:

- We may use or disclose your PHI for any purpose required by law. For example, CAIC may be required by law to use or disclose your PHI to respond to a court order.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for cadaveric organ, eye or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose your PHI to workers' compensation agencies for your workers' compensation benefit determination.
- We will, if required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.

**Your Authorization** – Except as outlined above, we will not use or disclose your PHI unless you have signed a form authorizing the use or disclosure. Specifically, most uses and disclosures of psychotherapy notes, uses or disclosures for marketing purposes and disclosures that constitute a sale of PHI require an authorization. You have the right to revoke that authorization in writing except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining insurance, and we have the right, under other law, to contest a claim under the plan itself.

- The following are examples of when your authorization would be required prior to use and disclosure:
  - Most uses and disclosures of your psychotherapy notes.
  - Uses and disclosures of your PHI for marketing purposes.
  - Uses and disclosures that constitute a sale of PHI.

**Breach of Unsecured PHI** – If CAIC or a Business Associate of CAIC causes a breach to occur that involved your unsecured PHI, we are required by law to notify you of the incident.

### **RIGHTS THAT YOU HAVE**

**Access to Your PHI** – You have the right to copy and/or inspect certain PHI that we maintain about you. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI and must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). We must provide you with access to your PHI in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a form or format agreed upon by you and CAIC. Access request forms are available from CAIC at the address below. We may charge you a fee for copying and postage. We may deny your request for access in certain very limited circumstances, such as request to access psychotherapy notes.

**Amendments to Your PHI** – You have the right to request that PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your representative, and must state the reasons for the amendment/correction request. Amendment request forms are available from CAIC at the address below.

**Accounting for Disclosures of Your PHI** – You have the right to receive an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. To be considered, your accounting requests must be in writing and signed by you or your representative. Accounting request forms are available from CAIC at the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request within the same 12-month period.

**Restrictions on Use and Disclosure of Your PHI** – You have the right to request restrictions on certain of our uses and disclosures of your PHI for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that we not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. HIPAA does not require us to agree to your request but we will accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. Requests for a restriction (or termination of an existing restriction) may be made by contacting CAIC at the telephone number or address below.

However, we are authorized by law to refuse to honor any request to restrict disclosures for treatment, payment or health care operations. Nonetheless, we will comply with a restriction request if (i) the disclosure is to the Health Plan for purposes of carrying out payment or healthcare operations, except as otherwise required by law, (ii) the PHI relates solely to a health care item or service for which the healthcare provider involved has been paid out-of-pocket in full.

**Request for Confidential Communications** – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to CAIC at the address below.

**Right to a Copy of the Notice** – You have the right to a paper copy of this Notice upon request by contacting CAIC at the telephone number or address below.

**Complaints** – If you believe your privacy rights have been violated, you can file a complaint with CAIC in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

**FOR FURTHER INFORMATION**

If you have questions or need further assistance regarding this Notice, you may contact CAIC's Privacy Office by writing to: CAIC, Attn: Privacy Office, P.O. Box 427, Columbia, SC 29202, or by calling 1-800-433-3036.

**EFFECTIVE DATE**

This Notice is effective August 16, 2013.

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, coverage is underwritten by Continental American Life Insurance Company. For groups situated in New York, coverage is underwritten by American Family Life Assurance Company of New York.



## **PRIVACY PRACTICES**

Protecting the privacy and confidentiality of information about our customers is very important to American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, Continental American Insurance Company (CAIC), and Continental American Life Insurance Company collectively, "Aflac". Accordingly, we strive to comply with each of the following practices in everything we do:

- **We do not sell, rent, lease or otherwise disclose personal information of our customers for purposes unrelated to our products and services.** The personal information of our customers is of paramount importance to us. Therefore, we provide this information only to our employees, agents and third parties as required to allow them to help us develop and provide our insurance and employee benefit products and services.
- **We work to ensure information integrity and security.** We use technology tools and design our business practices to help ensure that the personal information of our customers is properly gathered, stored and processed. We also work to maintain the security of, and internal and external access to, the personal information of our customers through the use of technology and our business practices.
- **We expect our agents and employees to respect the personal information of our customers.** Aflac has business policies and practices in place to help ensure that our employees and agents carry out these practices and otherwise protect personal information about our customers. Both employees and agents are subject to censure, dismissal, or termination for violation of these policies.

These Privacy Practices apply to our U.S. customers. Due to legal and cultural differences, our practices may vary outside the United States.

## **PRIVACY NOTICE**

Aflac and our agents provide this notice to let you know about the current privacy practices of Aflac and our agents. **You do not need to do anything in response to this notice. This notice is merely to inform you about how we safeguard your information.**

### **Collection of Information**

As part of Aflac's normal underwriting and operating procedures, Aflac (and our agents acting on our behalf) needs to obtain information to determine an individual's eligibility for our products and services, and to perform our insurance functions. Aflac and our agents may collect nonpublic personal information (which includes both nonpublic personal financial information and nonpublic personal health information) about Aflac's customers, including:

- Information from our customers (including names, addresses, financial and health information).
- Information about the customers' transactions with Aflac or our agents (including claims and payment information).
- Information from consumer reporting agencies (including creditworthiness and credit history); motor vehicle records agencies (including accident reports and violations); investigators (including information regarding general character and participation in hazardous activities); insurance support organizations such as the Medical Information Bureau, Inc. (including claims, and health and insurance application histories); and the customers' health care providers (including health history), employers (including salary and benefits information), and family members.

### **Disclosure of Information**

Aflac may disclose the nonpublic personal financial information we collect, as described above, as well as information about your transactions with us (such as your plan coverage, premiums, and payment history) to our agents or other third parties who perform services or functions on our behalf, including in some circumstances the marketing of Aflac products. We may also disclose the nonpublic personal financial information we collect to other third parties as authorized by you, or as required or permitted by law.

Our agents will make disclosures of our customers' nonpublic personal financial information only while acting on Aflac's behalf and, furthermore, will make such disclosures only as Aflac itself is permitted to make.

Neither Aflac nor our agents will use or share with other parties any nonpublic personal health information about Aflac customers for any purpose other than disclosures for the performance of insurance functions by Aflac or on our behalf, disclosures that are permitted or required by law, or disclosures that the customer has authorized.

Neither Aflac nor our agents will further disclose any nonpublic personal information about a former customer of Aflac other than as may be required or permitted by law.

### **Confidentiality and Security**

Aflac and our agents will safeguard, according to strict standards of security and confidentiality, any information we collect, receive or maintain about Aflac's customers. Aflac maintains administrative, technical, and physical safeguards to ensure the security and confidentiality of our customer information and records, to protect against anticipated threats or hazards to such records, and to protect against unauthorized access to or use of such information or records.

Internally, Aflac limits access to our customers' information to only those employees who need access to the information to perform their job functions. Employees who misuse information are subject to disciplinary actions. Externally, we do not disclose customer information to any third parties unless we have previously informed the customer of the disclosure, have been authorized to do so by the customer, or are required or permitted to make the disclosure by law or our regulators.

### **NOTICE OF INFORMATION PRACTICES**

Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia require insurers and agents to describe their information practices in addition to providing a Privacy Notice. There is significant overlap between the two notices, but in general our Information Practices include the following: Aflac may obtain information about you and any other persons proposed for insurance. Some of this information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. Residents of these states have the right to access and correct the information collected about them except information that relates to a claim or to a civil or criminal proceeding. They also have the right to receive the specific reason for an adverse underwriting decision in writing. If you wish to have a more detailed explanation of our information practices required by your state, please submit a written request to: Continental American Insurance Company, ATTN: Privacy Office, P.O. Box 427, Columbia, SC 29202.

### **NOTICE OF PRIVACY PRACTICES - PROTECTED HEALTH INFORMATION**

If you would like a copy of Aflac's Notice of Privacy Practices - Protected Health Information, issued pursuant to the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), copies are available by sending a written request to: Continental American Insurance Company, ATTN: Privacy Office, P.O. Box 427, Columbia, SC 29202.

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

Continental American Insurance Company • P.O. Box 427 • Columbia, South Carolina 29202 1-800-433-3036 toll-free