



# CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205  
800.433.3036

## CERTIFICATE OF INSURANCE FOR SUPPLEMENTAL HOSPITAL INDEMNITY POLICY

**THIS CERTIFICATE IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE  
IT IS DESIGNED TO SUPPLEMENT A MAJOR MEDICAL PROGRAM.**

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We certify that you are insured under the Supplemental Hospital Indemnity Policy (herein called the Plan) issued to your employer, the policyholder, subject to the definitions, exclusions and other provisions of the Plan against loss resulting from Hospital Confinement.

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 Effective Date of your certificate is as shown in the Certificate Schedule if you are on that date actively at work for the policyholder. If not, this certificate will become effective on the next date you are actively at work as an eligible Employee. 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 is issued in consideration of the payment in advance of the required premium and of your statements and representations in the application. A copy of your application is attached and made a part of this certificate.

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 "INDIVIDUAL TERMINATIONS" ON PAGE 4.**

**NO RECOVERY FOR PRE-EXISTING CONDITIONS – READ CAREFULLY. No benefits will be provided during the first twelve months of this certificate for conditions for which medical advice or treatment was received or recommended during the twelve month period prior to the effective date shown in the Certificate Schedule.**

## SECTION I

## DEFINITIONS

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

**We, Us, Our** - means Continental American Insurance Company.

**You and Your** - means the person named in the Certificate Schedule.

**Covered Person** - means you if this certificate is issued as Individual coverage.

If this certificate is issued as:

1. Employee/Spouse coverage Covered Person means you and your legal spouse.
2. Single Parent Family coverage Covered Person means you and your covered dependent children as defined in the applicable rider, that have been accepted for coverage.
3. Family coverage Covered Person means you, your spouse and covered dependent children, as defined in the applicable rider, that have been accepted for coverage.

**Injury or Injuries** - means accidental bodily injury or injuries caused solely by or as the result of a covered accident.

**Covered Accident** - means an accident, occurring on or after a covered person's Effective Date, while this certificate is in force, and which is not specifically excluded.

**Sickness** - means an illness, infection, disease or any other abnormal condition, which is not caused solely by or is not the result of an injury.

**Covered Sickness** - means an illness, infection, disease or any other abnormal physical condition which is not caused solely by or is not the result of any injury which:

1. Occurs while this certificate is in force; **and**
2. Was not treated or for which a covered person did not receive advice within 12 months before the effective date of his/her coverage; **and**
3. Is not excluded by name or specific description in this certificate.

**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.

**On-The-Job Benefits** - means the benefits we will pay if a covered accident occurs while you are working at any job for pay or benefits. These benefits are shown in the Benefit Schedule under On-The-Job.

**Off-The-Job Benefits** - means the benefits we will pay if a covered accident occurs while you are not working at any job for pay or benefits. These benefits are shown in the Benefit Schedule under Off-The-Job.

**Monthly Benefit** - means a specified amount paid for a period of one month. Periods of less than one month paid at the daily rate of 1/30th of the monthly amount.

**Doctor or Physician** - means a person, other than yourself, or a member of your immediate family, who:

1. Is licensed by the state to practice a healing art;
2. Performs services which are allowed by his or her license; **and**
3. Performs services for which benefits are provided by this certificate.

**Immediate Family** - means your spouse, son, daughter, mother, father, sister, or brother.

**Hospital** - means a place which:

1. Is legally licensed and operated as a hospital;
2. Provides overnight care of injured and sick people;
3. Is supervised by a doctor;
4. Has full-time nurses supervised by a registered nurse;
5. Has on-site or pre-arranged use of X-ray equipment, laboratory and surgical facilities (this requirement is not applicable to state tax-supported institutions); **and**
6. Maintains permanent medical history records.

**A hospital is not:**

1. A nursing home;
2. An extended care facility;
3. A convalescent home;
4. A rest home or a home for the aged;
5. A place for alcoholics or drug addicts; **or**
6. A mental institution.

**Hospital includes any duly licensed state tax supported institution**, including those community health centers and other health clinics which are certified as Medicaid providers

**Hospital Intensive Care Unit** - means a place which:

1. Is a specifically designated area of the hospital called an intensive care unit that provides the highest level of medical care;
2. Is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
3. Is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement;
4. Is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
5. Is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a twenty-four hour basis; **and**
6. Has a doctor assigned to the intensive care unit on a full-time basis.

**A hospital intensive care unit is not** any of the following step-down units:

1. A progressive care unit;
2. A sub-acute intensive care unit;
3. An intermediate care unit;
4. A private monitored room;
5. A surgical recovery room;
6. An observation unit; **or**
7. Any facility not meeting the definition of a hospital intensive care unit as defined in this policy.

**Your Occupation** - means the job in which you are regularly engaged at the time you become insured.

**Actively at Work** - to be considered actively at work, you must perform for a full normal workday the regular duties of your employment. These duties may be performed at your employer's regular place of business or at a location to which you may be required to travel to perform the regular duties of your employment.

**Full-Time Work** - means spending at least 20 hours per week performing your occupation.



If a covered person is not confined to the hospital for a full month, we will pay benefits on a daily basis. Daily benefits are paid at the rate of 1/30th of the monthly amount.

**Hospital Admission** - We will pay this benefit when a covered person is admitted to a hospital and confined as a resident bed patient because of an injury or a covered sickness. In order to receive this benefit for an injury, a covered person must be admitted to a hospital within 6 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 once for each covered accident or covered sickness. If a covered person is confined to the hospital because of the same or related injury or sickness, we will not pay this benefit again.

**Surgical Benefit** - If surgery due to an injury or because of a covered sickness is performed by a physician, we will pay the amount for the Surgical Operation shown opposite the procedure listed in the Schedule of Operations up to the maximum shown on the Benefit Schedule per surgical procedure. The surgery can be performed in a Hospital (on an inpatient or outpatient basis), in an Ambulatory Surgical Center, or in a Physician's office.

If an operation is not listed in the Schedule of Operations, we will pay an amount comparable to that which would be payable for the operation listed in the Schedule of Operations which is most nearly similar in severity and complexity.

If two or more surgical procedures are performed at the same time through the same or different incisions, only one benefit, the largest, will be provided.

**Anesthesia Benefits** - When a surgical procedure is performed that is covered under the Surgical Benefit, we will pay the amount shown in the Schedule of Operations for anesthesia administered by a physician in connection with such procedure. Benefits, however, will be 25% of the amount paid under Surgical Benefit.

#### **ADDITIONAL BENEFITS**

**Wellness Benefit** - We will pay the amount shown on the Benefit Schedule page per calendar year when a covered person visits a doctor and the covered person is neither injured nor sick.

#### **SECTION IV**

#### **LIMITATIONS AND EXCLUSIONS**

##### **PRE-EXISTING CONDITION LIMITATION**

**PRE-EXISTING CONDITION** - Pre-existing Condition means within the 12-month period prior to the Effective Date of this certificate those conditions for which medical advice or treatment was received or recommended.

We will not pay benefits for any loss or injury which is caused by, contributed to by, or resulting from a pre-existing condition for 12 months after the Effective Date of this certificate, or for 12 months from the date medical care, treatment, or supplies were received for the pre-existing condition, whichever is less.

A claim for benefits for loss starting after 12 months from the Effective Date of this certificate, as applicable, will not be reduced or denied on the grounds that it is caused by a pre-existing condition.

Pregnancy is a "pre-existing condition" if conception was before the effective date of this certificate.

This certificate may have been issued as a replacement for a certificate previously issued to you under the Plan. If so, then the pre-existing condition limitation provision of this certificate applies only to any increase in benefits over the prior certificate. Any remaining period of pre-existing condition limitation of the prior certificate would continue to apply to the prior level of benefits.

## **EXCLUSIONS**

We will not pay benefits for loss caused by pre-existing conditions (except as stated in the previous provision).

We will not pay benefits for loss contributed to, caused by, or resulting from:

1. War - participating in war or any act of war, declared or not, or 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.
2. Suicide - committing or attempting to commit suicide, while sane or insane.
3. Self-Inflicted Injuries - injuring or attempting to injure yourself intentionally.
4. Traveling - traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, Virgin Islands, Bermuda, and Jamaica.
5. Racing - Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
6. Aviation - operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those which are not motor-driven.
7. Intoxication - being legally intoxicated, or being under the influence of any narcotic, unless such is taken under the direction of a physician.
8. Illegal Acts - participating or attempting to participate in an illegal activity, or working at an illegal job.
9. Sports - participating in any organized sport: professional or semi-professional.
10. Routine physical exams and rest cures.
11. Custodial care. This is care meant simply to help people who cannot take care of themselves.
12. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
13. Services performed by a relative.
14. Services related to sex change, sterilization, in vitro fertilization, reversal of a vasectomy or tubal ligation.
15. A service or a supply furnished by or on behalf of any government agency unless payment of the charge is required in the absence of insurance.
16. Elective abortion.
17. Treatment, services, or supplies received outside the United States and its possessions or Canada.
18. Injury or Sickness for which benefits are paid or payable by Worker's Compensation.
19. Dental services or treatment.
20. Cosmetic surgery, except when due to medically necessary reconstructive plastic surgery.

21. Mental or emotional disorders without demonstrable organic disease.
22. Alcoholism, drug addiction, or chemical dependency.

## SECTION V

## CLAIM PROVISIONS

**Notice of Claim** - Written notice of claim must be given to us within 60 days after the covered accident or covered sickness, or as soon as reasonably possible. The notice may be sent to us at our Home Office in Columbia, South Carolina or to any of our authorized agents. The notice should include the name of the covered person and the certificate number.

**Claim Forms** - When we receive notice of a claim, we will send you the forms for filing proof of loss. If these forms are not sent to you within 15 days, you will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated on the Proof of Loss Section.

**Proof of Loss** - You must give us written proof within 180 days after the loss for which you are seeking benefits. If it is not reasonably possible to give written proof in the time required, we shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one year from the covered loss unless you were legally incapacitated during that time.

**Time Of Payment Of Claims** - After we receive written proof of loss and process your claim, we will pay monthly all benefits then due for the claims providing a periodic payment. Benefits for any other loss covered by this certificate will be paid as soon as we receive proper written proof.

**Payment Of Claims** - Benefits will be paid to you. All of the benefits due will be paid to you unless you assign them elsewhere. Any benefits unpaid at the time of your death will be paid in the following order:

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

**Changing Your 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, any premium due and unpaid may be deducted from the claim payment.

**Physical Examination And Autopsy** - At our expense, we can require a covered person to have a physical examination as often as reasonably necessary while a claim is pending. In the case of death, we can require an autopsy where allowed by law. This will be done at our expense.

**Legal Action** - You cannot take legal action against us for benefits under this certificate:

1. Within 60 days after you have sent us written proof of loss; **or**
2. More than 6 years from the time written proof is required to be given.

## SECTION VI

## GENERAL PROVISIONS

**Entire Contract** - The entire contract consists of:

1. The Plan;
2. The application of the policyholder; **and**
3. Your application(s).

All statements made in such application(s) shall, in the absence of fraud, be deemed representations and not warranties. No statement will be used in defense of a claim under this certificate unless:

- a. The statement is in writing signed by the policyholder or by you; **and**
- b. A copy of that statement is given to the policyholder or to you or to your beneficiary.

**Contract Changes** - No change in this certificate is valid unless approved by our Home Office and unless such approval is endorsed by an officer and attached to this certificate. No agent has the authority to change this certificate or to waive any of its provisions.

**Misstatements of Age** - If you incorrectly stated your age in the application, the benefits will be such as the premium paid would have purchased at the correct age. If, based on your correct age, we would not have issued your certificate, then our responsibility will be to refund the excess premium paid, if any.

**Time Limit On Certain Defenses** - We rely of the statements you made in the application when issuing this certificate. After this certificate has been in force for two years, we cannot cancel it or refuse to pay benefits because of any misstatements in the application.

**Conformity With State Statutes** - Any provision of this certificate which, on the Effective Date, is in conflict with the laws of the state, in which it was issued, will be amended to conform to the minimum requirements of those laws.



**SECTION VII**

**BENEFIT SCHEDULE  
LOW PLAN**

HOSPITAL CONFINEMENT Maximum 180 days per confinement	\$100	per day
HOSPITAL ADMISSION Payable once per admission	\$500	per admission
SURGICAL BENEFIT Maximum \$750 per surgical procedure	See Surgical Schedule	
ANESTHESIA BENEFIT Maximum \$187.50 per surgical procedure	25% of the amount paid under Surgical Benefit	
WELLNESS BENEFIT Maximum per calendar year	\$50	



## SECTION VIII

## SCHEDULE OF OPERATIONS

## LOW PLAN

<b>INTEGUMENTARY SYSTEM</b>	<b>Maximum</b>			<b>Maximum</b>
	<b>Surgical</b>			<b>Surgical</b>
	<b>Benefit</b>			<b>Benefit</b>
<b>SKIN</b>			<b>JOINTS</b>	
Incision and Drainage of Cyst	\$ 7.50		Shoulder or Elbow Arthrotomy	\$ 187.50
Acne Surgery	\$ 5.63		Arthroplasty	\$ 300.00
Biopsy	\$ 11.25		Wrist Arthrotomy	\$ 150.00
Excision of Benign Tumor	\$ 15.00		Arthroplasty	\$ 300.00
Excision of Malignant Tumor	\$ -		Hip Arthrotomy	\$ 262.50
(Trunk, Arms or Legs)	\$ 22.50		Arthroplasty	\$ 375.00
Excision of Malignant Tumor	\$ -		Knee Arthrotomy	\$ 187.50
(Face, Scalp, Ears, Neck, Hands	\$ -		Arthroplasty	\$ 375.00
Feet, Genitalia)	\$ 37.50		Ankle Arthrotomy	\$ 187.50
Excision of Malignant Tumor	\$ -		Arthroplasty	\$ 281.25
(Eyelids, Nose, Lips, Mucous	\$ -		Hammertoe	\$ 75.00
Membrane)	\$ 56.25			\$ -
Excision of Nail	\$ 37.50		<b>DISLOCATIONS</b>	\$ -
Repair – Simple Wounds	\$ 7.50		Jaw	\$ 18.75
Repair – Complex Wounds (Linear Repair)	\$ 26.25		Collar Bone (requiring reduction)	\$ 37.50
Repair – Skin Grafts (Single Stage)	\$ 18.75		Shoulder (humerus with anesthesia)	\$ -
Repair – Skin Grafts (Multiple Stage)	\$ 56.25		Or Elbow	\$ 18.75
Electro – surgical destruction of	\$ -		Wrist	\$ 18.75
Chemocautery	\$ 7.50		Fingers or Toes	\$ 7.50
Chemosurgery – malignancies of skin	\$ 75.00		Hip or Knee	\$ 75.00
	\$ -		Ankle	\$ 37.50
<b>BREAST</b>	\$ -			\$ -
Biopsy	\$ 56.25		<b>TENDONS</b>	\$ -
Excision of Cyst or Benign Tumor	\$ 56.25		Repair or Suture	\$ 45.00
Excision of Chest Wall Tumor	\$ 262.50		Lengthening or Shortening	\$ -
Mastectomy, simple	\$ 112.50		(e.g. Achilles tendon)	\$ 112.50
Mastectomy, radical	\$ 262.50			\$ -
Mammoplasty, Reconstructive	\$ 562.50		<b>AMPUTATIONS</b>	\$ -
	\$ -		Arm at Shoulder Joint	\$ 281.25
<b>MUSCULOSKELETAL SYSTEM</b>	\$ -		Arm below Shoulder Joint	\$ 131.25
	\$ -		Finger	\$ 56.25
<b>BONE OR CARTILAGE GRAFT</b>	\$ -		Leg at Hip Joint	\$ 300.00
Spinal Fusion	\$ 300.00		Leg at Knee	\$ 150.00
Spinal Fusion with removal of	\$ -		Leg above or below knee	\$ 187.50
Intervertebral disc	\$ 300.00		Toe	\$ 37.50
Spinal Fusion of Scoliosis	\$ 450.00			\$ -
	\$ -			\$ -
	\$ -		<b>RESPIRATORY SYSTEM</b>	\$ -
<b>FRACTURES (Requiring Reduction)</b>	\$ -			\$ -
Skull	\$ 281.25		<b>NOSE</b>	\$ -
Nose	\$ 18.75		Excision of Nasal Polyps	\$ 11.25
Jaw	\$ 112.50		Submucous resection, Classic Nasal Sept	\$ 112.50
Vertabrae, one or more	\$ 112.50			\$ -
Collar Bone	\$ 56.25		<b>SINUSES</b>	\$ -
Shoulder blade (Scapula)	\$ 206.25		Frontal Sinusotomy – simple	\$ 75.00
Upper Arm	\$ 93.75		Frontal Sinusotomy – radical	\$ 225.00
	\$ -			\$ -
Lower Arm	\$ 56.25		<b>LARYNX</b>	\$ -
Hand	\$ 37.50		Laryngectomy	\$ 375.00
Fingers or Toes	\$ 18.75		Laryngoscopy	\$ 15.00
Upper Leg	\$ 150.00			\$ -
Lower Leg	\$ 56.25			\$ -
Ankle	\$ 93.75			\$ -
Foot	\$ 37.50			\$ -
	\$ -			\$ -

	\$ -			\$ -
<b>LUNGS</b>	\$ -		<b>TRACHEA AND BRONCH</b>	\$ -
Thoracotomy	\$ 187.50		Tracheotomy	\$ 75.00
Pneumonotomy	\$ 225.00		Bronchoscopy	\$ 56.25
Pneumonocentesis	\$ 18.75		Closure of Tracheotomy	\$ 93.75
Thoracentesis	\$ 11.25			\$ -
Pneumonectomy, total	\$ 375.00			\$ -
Wedge Resection of Lung, Single or Multiple	\$ - \$ 300.00		Fistulotomy	\$ 37.50
Thoracoscopy (including biopsy)	\$ 75.00		Sphincterotomy	\$ 18.75
	\$ -		Fissurectomy or Hemorrhoidectomy	\$ 75.00
<b>CARDIOVASCULAR SYSTEM</b>	\$ -		Removal of External Hemorrhoids	\$ 11.25
	\$ -		Aspiration biopsy of liver, pancreas Or bile duct	\$ - \$ 18.75
<b>HEART</b>	\$ -		Cholecystotomy	\$ 187.50
Heart Transplant	\$ 750.00		Cholecystectomy	\$ 225.00
Catheterization of Heart	\$ 56.25		Pancreatectomy – partial	\$ 300.00
Suture of Heart wound or injury	\$ 375.00		Pancreatectomy – total	\$ 525.00
Valvotomy, aortic and pulmonic valve	\$ 562.50		Laparotomy	\$ 150.00
Valvotomy, mitral valve	\$ 525.00		Hemiotomy	\$ 131.25
Valvutoplasty or Replacement Aortic and mitral valve	\$ - \$ 750.00			\$ -
Coronary Bypass, single or multiple	\$ 750.00		<b>URINARY SYSTEM</b>	\$ -
Repair of Myocardial Aneurysm	\$ 750.00		Nephrolithotomy	\$ 300.00
Repair of Septal Defect	\$ 675.00		Renal Biopsy	\$ 18.75
Angioplasty, percutaneous	\$ 375.00		Nephrectomy	\$ 300.00
Pervenous or Transvenous insertion of Pacemaker	\$ - \$ 187.50		Lithotripsy	\$ 187.50
	\$ -		Kidney Transplant	\$ 468.75
<b>ARTERIES</b>	\$ -		Cystotomy	\$ 187.50
Arteriotomy, extramity	\$ 225.00		Cystectomy – partial	\$ 262.50
Thromboendarterectomy	\$ 450.00		Cystectomy – complete	\$ 375.00
Carotid endarterectomy	\$ 450.00		Urethroscopy or Cystoscopy	\$ 18.75
Excision and graft, Abdominal Aortic Aneurysm	\$ - \$ 562.50		Cystoplasty	\$ 300.00
Injection – Varicose Veins	\$ 3.75		Dilation of Urethra	\$ 7.50
	\$ -			\$ -
<b>HEMIC AND LYPHATIC SYSTEMS</b>	\$ -		<b>GENITAL SYSTEM</b>	\$ -
Splenectomy	\$ 225.00			\$ -
Biopsy of Lymph Node	\$ 18.75		<b>MALE</b>	\$ -
Radical Lymphadenectomy	\$ 191.25		Circumcision	\$ 11.25
	\$ -		Orchlectomy	\$ 75.00
<b>DIGESTIVE SYSTEM</b>	\$ -		Reduction of Torsion of Testis	\$ 112.50
Gastrotomy	\$ 187.50		Excision of Epididymis, Hydrocele, Varicocele	\$ 37.50 \$ 112.50
Gastrectomy, Total	\$ 375.00		Vasectomy	\$ 56.25
Gastrectomy, Partial	\$ 300.00		Biopsy, Prostate	\$ 62.50
Gastroscopy	\$ 56.25		Prostatectomy – partial	\$ 300.00
Gastro Gastrorrhaphy	\$ 187.50		Prostatectomy – radical	\$ 375.00
Enterectathy	\$ 225.00			\$ -
Enterectomy	\$ 262.50		<b>FEMALE</b>	\$ -
Colostomy	\$ 300.00		Hysterectomy, Vaginal or Abdominal	\$ 225.00
Enterostomy	\$ 187.50		Hysterectomy, radical for cancer Including lymph nodes	\$ - \$ 375.00
Enterolysis	\$ 150.00		Salpingo – oophorectomy	\$ 168.75
Diverticulectomy	\$ 187.50		Repair of cystocele or rectocele	\$ 131.25
Appendectomy	\$ 150.00		Repair of cystocele and rectocele	\$ 195.00
Proctectomy	\$ 375.00		Tubal Ligation	\$ 150.00
Protosigmoidoscopy	\$ 11.25		Biopsy or removal of cervical lesion or polyp	\$ - \$ 112.50
Proctoplasty	\$ 150.00		Dilation and curettage	\$ 56.25
	\$ -		Myomectomy	\$ 187.50
	\$ -		Repair of uterine suspension	\$ 150.00
	\$ -		Cesarian Section	\$ 187.50
	\$ -		Obstetrical Delivery	\$ 75.00
	\$ -		Amniocentesis	\$ 18.75
	\$ -			\$ -

<b>ENDOCRINE SYSTEM</b>	\$	-		
Incision and drainage of	\$	-		
Thyroid Gland	\$	11.25		
Local excision of thyroid cyst	\$	-		
Or adenoma	\$	150.00		
Thyroidectomy or parathyroidectomy	\$	262.50		
Adrenalectomy	\$	300.00		
	\$	-		
<b>NERVOUS SYSTEM</b>	\$	-		
Burr Holes	\$	112.50		
Cranioplasty	\$	375.00		
Craniotomy or Craniectomy	\$	150.00		
Laminectomy	\$	375.00		
Spinal Puncture	\$	7.50		
Paravertebral block, lumbar,	\$	-		
Or thoracic nerve	\$	18.75		
Median nerve decompression	\$	-		
(Carpal Tunnel)	\$	112.50		
	\$	-		
<b>EYE</b>	\$	-		
Removal of eye	\$	150.00		
Excision of pterygium	\$	93.75		
Sclerotomy – anterior	\$	187.50		
Sclerotomy – posterior	\$	112.50		
Iridectomy	\$	187.50		
Extraction of lens (including	\$	-		
Cataract extraction)	\$	300.00		
Reattachment of retina	\$	375.00		
Muscle operation (one or more muscles)	\$	225.00		
Excision of lacrimal gland or sac	\$	187.50		
	\$	-		
<b>EAR</b>	\$	-		
Drainage of abscess	\$	7.50		
Otосcopy	\$	7.50		
Myringotomy	\$	11.25		
Tympanotomy (diagnostic)	\$	187.50		
Tympanotomy with insertion of	\$	-		
Collar Button Tube	\$	93.75		
Mastoidectomy – simple	\$	187.50		
Tympanoplasty	\$	375.00		
Labyrinthotomy or Labyrinthectomy	\$	375.00		





## CONTINENTAL AMERICAN INSURANCE COMPANY

Home Office: 2801 Devine Street, Columbia, South Carolina 29205  
(herein called Continental American)

This Rider is a part of the Group Policy/Certificate to which it is attached. Unless amended by this Rider, Group Policy/Certificate Definitions, terms and other Provisions apply to this Rider.

### Portability Privilege

When coverage would otherwise terminate under the Plan because you end employment with the Employer, you may elect to continue your coverage. The coverage you may continue is that which you had on the date your employment terminated, including dependent coverage then in effect.

1. Coverage may not be continued for any of the following reasons:
  - a. the insured failed to pay any required premium;
  - b. the insured having attained age 70;
  - c. the Group Policy terminates.
  
2. To keep your insurance in force the insured must:
  - a. make written application to the Company within 31 days after the date insurance would otherwise terminate; and
  - b. pay the required premium to the Company no later than 31 days after the date insurance would otherwise terminate.
  
3. Insurance will cease on the earliest of these dates:
  - a. the date the you fail to pay any required premium;
  - b. the date the Group Policy is terminated.

If you qualify for this Portability Privilege as described, then the same benefits, Plan provisions, and premium rate as shown in the Group Policy/certificate as previously issued will apply.

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 • 2801 Devine Street • Columbia, South Carolina 29205 1-800-433-3036 toll-free

# Dependent Spouse Rider Certificate



## CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205  
800.433.3036

### DEPENDENT SPOUSE BENEFIT RIDER TO CERTIFICATE OF INSURANCE FOR SUPPLEMENTAL HOSPITAL INDEMNITY COVERAGE

This rider is a part of the certificate to which it is attached. We have issued this rider to you because: (1) you paid the additional premium for this rider; and (2) we relied on the application you made. Unless amended by this rider, Certificate Definitions, other Provisions and terms apply to 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 becomes effective, this rider will have a later Effective Date, which will be shown in the Rider Schedule issued with this rider. The insurance of a spouse will become effective on the rider date if such person is active on that date. Otherwise, the Effective Date will be deferred until the day following the date he or she becomes active.

#### DEFINITIONS

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

<b>YOU, YOUR</b>	Means the insured named in the Rider Schedule.
<b>SPOUSE</b>	Means your legal spouse who is between the ages of 18 and 64.
<b>ACTIVE</b>	"Active" as used refers a dependent 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 sex.
<b>TREATMENT</b>	Means consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

#### BENEFITS

If your insured spouse qualifies for benefits under the certificate to which this rider is attached because of a covered accident or a covered sickness, we will provide the benefits contained in the certificate under the Benefit Provisions. The appropriate benefit amounts payable for you insured spouse are shown in the Benefit Schedule issued with this rider.





## LIMITATIONS AND EXCLUSIONS

### PRE-EXISTING CONDITION

A pre-existing condition means those conditions for which medical advice or treatment was received or recommended during the 12-month period prior to the effective date of your spouse's coverage.

Pre-existing conditions aren't covered unless the loss for such conditions begins more than 12 months after the effective date of your spouse's coverage. Also, those medical conditions excluded from coverage by name or specific description when the loss begins, aren't covered.

### EXCLUSIONS

We will not pay benefits for loss caused by pre-existing conditions (except as stated in the previous provision).

We will not pay benefits for loss contributed to, caused by, or resulting from:

1. War - participating in war or any act of war, declared or not, or 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.
2. Suicide - committing or attempting to commit suicide, while sane or insane.
3. Self-Inflicted Injuries - injuring or attempting to injure yourself intentionally.
4. Traveling - traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, Virgin Islands, Bermuda, and Jamaica.
5. Racing - Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
6. Aviation - operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those which are not motor-driven.
7. Intoxication - being legally intoxicated, or being under the influence of any narcotic, unless such is taken under the direction of a physician.
8. Illegal Acts - participating or attempting to participate in an illegal activity, or working at an illegal job.
9. Sports - participating in any organized sport: professional or semi-professional.
10. Routine physical exams and rest cures.
11. Custodial care. This is care meant simply to help people who cannot take care of themselves.
12. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.

13. Services performed by a relative.
14. Services related to sex change, sterilization, in vitro fertilization, reversal of a vasectomy or tubal ligation.
15. A service or a supply furnished by or on behalf of any government agency unless payment of the charge is required in the absence of insurance.
16. Elective abortion.
17. Treatment, services, or supplies received outside the United States and its possessions or Canada.
18. Injury or Sickness for which benefits are paid or payable by Worker's Compensation.
19. Dental services or treatment.
20. Cosmetic surgery, except when due to medically necessary reconstructive plastic surgery.
21. Mental or emotional disorders without demonstrable organic disease.
22. Alcoholism, drug addiction, or chemical dependency.

#### **GENERAL PROVISIONS**

If your spouse's coverage is terminated because of attainment of the limiting age, we will still pay benefits for any covered accident or sickness which occurred while he/she was covered under this rider.

**TIME LIMIT  
ON CERTAIN  
DEFENSES**

After this rider has been in force for a period of two years it shall become incontestable as to the statements contained in the application.

**CONTRACT**

This rider is part of the certificate, and will terminate when the certificate terminates, or when premiums are no longer paid for this rider.

This rider is subject to all of the terms of the certificate to which it is attached unless any such terms are inconsistent with the terms of this rider.

Signed by the Company at its Home Office,



Paul S. Amos II, President



J. Matthew Loudermilk, Secretary

**DEPENDENT SPOUSE RIDER BENEFIT SCHEDULE**

**PLEASE SEE THE CERTIFICATE SCHEDULE**

# Dependent Children Rider Certificate



## CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205  
800.433.3036

### DEPENDENT CHILDREN BENEFIT RIDER TO CERTIFICATE OF INSURANCE FOR SUPPLEMENTAL HOSPITAL INDEMNITY COVERAGE

This rider is a part of the certificate to which it is attached. We have issued this rider to you because: (1) you paid the additional premium for this rider; and (2) we relied on the application you made. Unless amended by this rider, Certificate Definitions, other Provisions and terms apply to 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 becomes effective, this rider will have a later Effective Date, which will be shown in the Dependent Rider Schedule issued with this rider. The insurance of a dependent will become effective on the rider date if such person is active on that date. Otherwise, the Effective Date will be deferred until the day following the date he or she becomes active.

#### DEFINITIONS

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

**YOU, YOUR** Means the insured named in the Dependent Rider Schedule.

**CHILD or CHILDREN** Means your natural child, step-child, foster child, legally adopted child or child placed for adoption, who are:

1. Unmarried;
2. Chiefly dependent on you or your spouse for support; **and**
3. Younger than age 19, or younger than age 25, if they are full-time students. The definition of "full-time student" will be based on the criteria of the learning institution at which the student is enrolled.

"Child or Children" also includes children, regardless of age, who:

1. Are mentally or physically handicapped;
2. Became or become handicapped prior to age 19; **and**
3. Cannot support themselves because of their handicap.

A child born after the Effective Date of this rider will also be covered from the moment of live birth. No notice or additional premium is required.

**DEPENDENT** Means your child or children covered under this rider.



**ACTIVE**

"Active" as used refers a dependent 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 sex.

**TREATMENT**

Means consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

**BENEFITS**

If a dependent qualifies for benefits under the certificate to which this rider is attached because of a covered accident or a covered sickness, we will provide the benefits contained in the certificate under the Benefit Provisions. The appropriate benefit amounts payable for the dependent are shown in the Benefit Schedule issued with this rider.

**LIMITATIONS AND EXCLUSIONS**

**PRE-EXISTING  
CONDITION**

A pre-existing condition means those conditions for which medical advice or treatment was received or recommended during the 12-month period prior to the effective date of this rider.

Pre-existing conditions aren't covered unless the loss for such conditions begins more than 12 months after the effective date of this rider. Also, those medical conditions excluded from coverage by name or specific description when the loss begins, aren't covered.

Children added after the effective date of this rider will be covered from the moment of birth or placement as applicable.

**EXCLUSIONS**

We will not pay benefits for loss caused by pre-existing conditions (except as stated in the previous provision).

We will not pay benefits for loss contributed to, caused by, or resulting from:

1. War - participating in war or any act of war, declared or not, or 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.
2. Suicide - committing or attempting to commit suicide, while sane or insane.
3. Self-Inflicted Injuries - injuring or attempting to injure yourself intentionally.
4. Traveling - traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, Virgin Islands, Bermuda, and Jamaica.
5. Racing - Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
6. Aviation - operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those which are not motor-driven.

7. Intoxication - being legally intoxicated, or being under the influence of any narcotic, unless such is taken under the direction of a physician.
8. Illegal Acts - participating or attempting to participate in an illegal activity, or working at an illegal job.
9. Sports - participating in any organized sport: professional or semi-professional.
10. Routine physical exams and rest cures.
11. Custodial care. This is care meant simply to help people who cannot take care of themselves.
12. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
13. Services performed by a relative.
14. Services related to sex change, sterilization, in vitro fertilization, reversal of a vasectomy or tubal ligation.
15. A service or a supply furnished by or on behalf of any government agency unless payment of the charge is required in the absence of insurance.
16. Elective abortion.
17. Treatment, services, or supplies received outside the United States and its possessions or Canada.
18. Injury or Sickness for which benefits are paid or payable by Worker's Compensation.
19. Dental services or treatment.
20. Cosmetic surgery, except when due to medically necessary reconstructive plastic surgery.
21. Mental or emotional disorders without demonstrable organic disease.
22. Alcoholism, drug addiction, or chemical dependency.

### **GENERAL PROVISIONS**

If your dependent child's coverage is terminated because of marriage or attainment of the limiting age, we will still pay benefits for any covered accident or sickness which occurred while the dependent was covered under this rider.

### **TIME LIMIT ON CERTAIN DEFENSES**

After this rider has been in force for a period of two years it shall become incontestable as to the statements contained in the application.



**CONTRACT**

This rider is part of the certificate, and will terminate when the certificate terminates, or when premiums are no longer paid for this rider.

This rider is subject to all of the terms of the certificate to which it is attached unless any such terms are inconsistent with the terms of this rider.

Signed by the Company at its Home Office,



**Paul S. Amos II, President**



**J. Matthew Loudermilk, Secretary**



**DEPENDENT RIDER BENEFIT SCHEDULE**

**PLEASE SEE THE CERTIFICATE SCHEDULE**





## CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205  
800.433.3036

### Child or Children Definition Rider

This rider is a part of the document to which it is attached. Unless amended by this rider Policy, Certificate and Dependent Rider Definitions, Exclusions and Limitations, other term and provisions apply to this rider.

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

**Child or Children** means your natural children, step-children, foster children, legally adopted children or children placed for adoption, which are under age 26.

- a. Coverage on a Child or Children will terminate on the child's 26<sup>th</sup> birthday. However, if any child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on a parent(s) for support, the above age of twenty-six (26) shall not apply. Proof of such incapacity and dependency must be furnished to the Company within thirty-one (31) days following such 26th birthday, and not more frequently than annually from then forward.
- b. Newborn Children of an Employee and/or his/her insured spouse and newborn Adopted Children shall automatically be covered from the moment of birth, under the same terms and conditions that apply to the natural, dependent children of covered persons.
- c. Other foster children and adopted children shall be treated the same as newborn infants and are eligible for coverage on the same basis upon placement in the Employee's home, under the same terms and conditions that apply to the natural, dependent children of covered persons.
- d. If a parent is required by a court or administrative order to provide health benefit plan coverage for a child, and the parent is eligible for family health benefit plan coverage through a health insurer, the health insurer:
  - i. Must 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.
  - ii. Must 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.
  - iii. May not disenroll or eliminate coverage of the child unless the health insurer is provided satisfactory written evidence that the court or administrative order is no longer in effect or the child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect not later than the effective date of disenrollment.
  - iv. Will not impose pre-ex limitations or waiting periods.



- e. If Dependent Child(ren) Children Child or Children are covered under the plan, Dependent Child(ren) Children Child or Children born or placed in the Employee's home after the Effective Date of this Rider will also be covered from the moment of birth. No notice or additional premium is required and the enrollment period will be waived. The company will not impose pre-ex limitations or waiting periods for newborn children, foster and adopted children if they are enrolled upon placement or children covered by the court or administrative order.

This rider is subject to all of the terms of the document to which it is attached unless any such terms are inconsistent with the terms of this Rider.

Signed by the Company at its Home Office,



Paul S. Amos II, President



J. Matthew Loudermilk, Secretary